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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 able to bear children, the 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	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 (e.g., topical medications, phototherapy).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

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

Prior Authorization Group	ADAGEN
Other Criteria	

Prior Authorization Group	ADCIRCA
Drug Names	ADCIRCA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Treatment with nitrate therapy on a regular or intermittent basis. Concomitant treatment with a guanylate cyclase stimulator (e.g., Adempas).
Required Medical Information	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	Treatment with a nitrate or nitric oxide donor medication (e.g., amyl nitrite) on a regular or intermittent basis. Concomitant treatment with a phosphodiesterase inhibitor (e.g., sildenafil, tadalafil, vardenafil, dipyridamole, theophylline).
Required Medical Information	For pulmonary arterial hypertension (PAH) (WHO Group 1): 1) PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI) or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 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	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, classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma

Prior Authorization Group	AFINITOR
	subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangioleiomyomatosis.
Exclusion Criteria	
Required Medical Information	Breast cancer: 1) The patient has advanced hormone receptor positive, HER2 negative disease, AND 2) Afinitor will be used in combination with exemestane, AND 3) The patient's disease a) has progressed within 12 months prior to starting Afinitor, OR b) was previously treated with a nonsteroidal aromatase inhibitor, OR c) was previously treated with tamoxifen. Renal cell carcinoma: 1) The disease is relapsed or medically unresectable, AND 2) For disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. Classical Hodgkin lymphoma: 1) The disease is relapsed or refractory AND 2) Afinitor will be used as a single agent. Thymomas and Thymic carcinomas: 1) The disease has progressed on a platinum-based chemotherapy regimen AND 2) Afinitor will be used as a single agent. Soft tissue sarcoma: 1) The patient has one of the following subtypes of STS: a) perivascular epithelioid cell tumors (PEComa), or b) angiomyolipoma, or c) lymphangioleiomyomatosis, AND 2) Afinitor will be used as a single agent. Subependymal giant cell astrocytoma associated with tuberous sclerosis complex (TSC): The patient is not a candidate for curative surgical resection. Renal angiomyolipoma associated with TSC: The 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	The diagnosis of mucopolysaccharidosis I is confirmed by either an enzyme assay showing a deficiency of alpha-L-iduronidase enzyme activity or by DNA testing. Patients with Scheie syndrome must have moderate to severe symptoms.
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	

Prior Authorization Group	ALECENSA
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ALGLUCOSIDASE
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 acid alpha-glucosidase (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	ALOSETRON
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 biological female or a person that self-identifies as a female 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	ALPHA1-PROTEINASE INHIBITOR
Drug Names	ARALAST NP, 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-

Prior Authorization Group	ALPHA1-PROTEINASE INHIBITOR
	bronchodilation FEV1 greater than, or equal to, 25 percent and less than, or equal to, 80 percent of predicted.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ALUNBRIG
Drug Names	ALUNBRIG
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	AMPYRA
Drug Names	AMPYRA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For new starts: Prior to initiating therapy, patient demonstrates 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, Cachexia associated with AIDS (HIV-wasting) or due to chronic disease or 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	

Prior Authorization Group	ANABOLIC STEROIDS
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	ANADROL
Drug Names	ANADROL-50
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting), Fanconi's anemia.
Exclusion Criteria	Pregnancy. Carcinoma of the prostate or breast in male patients. Carcinoma of the breast in women with hypercalcemia. Nephrosis or the nephrotic phase of nephritis. Severe hepatic dysfunction.
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	ARCALYST
Drug Names	ARCALYST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Prevention of gout flares in patients initiating or continuing urate-lowering therapy.
Exclusion Criteria	
Required Medical Information	For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (new starts): all of the following criteria must be met: 1) serum uric acid concentration greater than or equal to 445 micromol/L (7.5 mg/dL) prior to initiating Arcalyst, 2) two or more gout flares within the previous 12 months, 3) inadequate response, intolerance or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, and 4) concurrent use with urate-lowering therapy (i.e., allopurinol or febuxostat). For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (continuation): 1) Member must have achieved or maintain a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days)

Prior Authorization Group	ARCALYST
	compared to baseline and 2) have continued use of urate-lowering therapy concurrently with Arcalyst.
Age Restrictions	CAPS: 12 years of age or older. Gout: 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	For prevention of gout flares: 4 months. Other: Plan Year
Other Criteria	Abbreviation: CAPS = Cryopyrin-Associated Periodic Syndromes.

Prior Authorization Group	AUSTEDO
Drug Names	AUSTEDO
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	AVASTIN
Drug Names	AVASTIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, endometrial cancer, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma subtypes: angiosarcoma, solitary fibrous tumor, and hemangiopericytoma, malignant pleural mesothelioma, choroidal neovascularization associated with: ocular histoplasmosis, pathologic myopia, angioid streaks, inflammatory conditions, or of idiopathic etiology, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema due to retinal vein occlusion, diabetic macular edema, ocular neovascularization of the choroid, retina, or iris associated with proliferative diabetic retinopathy, neovascular glaucoma, and retinopathy of prematurity.
Exclusion Criteria	
Required Medical Information	For CRC, Avastin (AV) will be used with a fluoropyrimidine- or irinotecan-based regimen (i.e., capecitabine, CapeOx, FOLFIRI, FOLFOX, FOLFOXIRI, or 5-FU with leucovorin) for: 1) perioperative (neoadjuvant/adjuvant/postoperative) therapy for advanced or metastatic disease or 2) treatment (tx) of unresectable advanced or metastatic disease. For NSCLC, the disease is unresectable, locally advanced, recurrent, or metastatic for patients with tumors of non-squamous cell histology, and no hx of recent hemoptysis and 1) AV will be used as first-line therapy or as subsequent therapy after prior therapy with erlotinib, afatinib, gefitinib or crizotinib a) AV will be used with cisplatin- or carboplatin-based regimens and b) Patient has distant mets or locoregional recurrence with evidence of disseminated disease, OR 2) AV will be used as a continuation maintenance

Prior Authorization Group	AVASTIN
	tx (i.e., continuation of AV as first-line therapy beyond 4-6 cycles in the absence of disease progression) for tumor that is negative or unknown for both EGFR and ALK mutations and a) AV will be used alone or in combination with pemetrexed if previously used with a firstline pemetrexed/platinum chemotherapy regimen and b) Patient has achieved tumor response or stable disease following first-line chemotherapy. For malignant sex cord-stromal tumors, AV is used for clinical relapse in patient with granulosa cell tumors. For breast CA, 1) HER2-negative recurrent or metastatic disease and 2) AV is used with paclitaxel. For endometrial CA, AV is used alone for patients who progressed on prior cytotoxic chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Colorectal cancer perioperative therapy: 3 months. Other: Plan Year.
Other Criteria	For angiosarcoma, Avastin is used as a single-agent. For solitary fibrous tumor or hemangiopericytoma, Avastin is used with temozolomide. For malignant pleural mesothelioma, Avastin is used with pemetrexed and cisplatin. For RCC, 1) relapsed or for surgically unresectable RCC and 2) Avastin is used as a) first-line tx with interferon alfa-2 for disease with clear cell histology or b) first-line tx as a single-agent for disease with non-clear cell histology, or c) subsequent tx as a single-agent for disease with predominant clear cell histology following prior cytokine tx. 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	B VS. D
Drug Names	ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ADRUCIL, 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, APREPITANT, AZACITIDINE, AZATHIOPRINE, BENDEKA, BICNU, BLEOMYCIN SULFATE, BUDESONIDE, BUSULFAN, BUSULFEX, CALCITONIN-SALMON, CALCITRIOL, CARBOPLATIN, 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%, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DACARBAZINE, DAUNORUBICIN HCL, DEPO-PROVERA, DEXRAZOXANE, DIPHTHERIA/TETANUS TOXOID, DOCEFREZ, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HCL LIPOSOME, DRONABINOL, DURAMORPH, ELITEK, EMEND, EMEND TRIPACK, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FLUDARABINE PHOSPHATE, FLUOROURACIL, FORTICAL, FREAMINE HBC 6.9%, FREAMINE III, FUSILEV, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE

Prior Authorization Group	B VS. D
	HCL, HYDROXYPROGESTERONE CAPRO, IDARUBICIN HCL, IFEX, IFOSFAMIDE, INTRALIPID, INTRON A, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTODAX (OVERFILL), KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVOCARNITINE, LEVOLEUCOVORIN, LEVOLEUCOVORIN CALCIUM, LIDOCAINE HCL, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MIACALCIN, 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, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE, PROGRAF, PROLEUKIN, PROSOL, RAPAMUNE, RECOMBIVAX HB, SANDIMMUNE, SIROLIMUS, TACROLIMUS, TAXOTERE, TENIVAC, TETANUS/DIPHTHERIA TOXOID, TOPOSAR, TOPOTECAN HCL, TPN ELECTROLYTES, TRAVASOL, TREANDA, TRISENOX, TROPHAMINE, VINBLASTINE SULFATE, VINCASAR PFS, VINCRISTINE SULFATE, VINORELBINE TARTRATE, XATMEP, ZOLEDRONIC ACID, ZORTRESS
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 has Familial Short QT Syndrome.
Required Medical Information	
Age Restrictions	1 year of age or older.
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	

Prior Authorization Group	BELEODAQ
Required Medical Information	
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. Severe active central nervous system lupus.
Required Medical Information	Diagnosis of active, autoantibody-positive systemic lupus erythematosus (SLE). Member is currently receiving standard therapy for SLE (eg, corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) or has tried and had an inadequate response or intolerance to standard therapy for SLE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Renewal: Plan Year.
Other Criteria	For renewals, member 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 (e.g., 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	BEXAROTENE
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

Prior Authorization Group	BEXAROTENE
	lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).
Exclusion Criteria	
Required Medical Information	For capsule formulation: Patient has any of the following types of cutaneous T-cell lymphomas: mycosis fungoides, Sezary syndrome, primary cutaneous anaplastic large cell lymphoma, lymphomatoid papulosis. For primary cutaneous anaplastic large cell lymphoma and lymphomatoid papulosis: 1) The disease is CD30-positive, and 2) bexarotene will be used as a single agent. For gel formulation: For cutaneous T-cell lymphoma, patient has a diagnosis of stage I to III mycosis fungoides. For primary cutaneous B-cell lymphoma, patient has either primary cutaneous marginal zone lymphoma or primary cutaneous follicle center lymphoma.
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	Patient has had 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.
Exclusion Criteria	
Required Medical Information	Diagnosis of CML was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets any of the following: 1) Patient has chronic phase CML and meets one of the following conditions: a) experienced intolerance or toxicity to a prior tyrosine kinase inhibitor (TKI) (eg, imatinib, dasatinib, nilotinib, ponatinib), or b) experienced resistance to a prior TKI and is negative for T315I mutation, OR 2) Patient has accelerated or blast phase CML and meets one of the following: a) has not received prior therapy with a TKI, b) experienced intolerance or toxicity to

Prior Authorization Group	BOSULIF
	a prior TKI, or c) experienced resistance to a prior TKI and is negative for T315I mutation, OR 3) Patient received a hematopoietic stem cell transplant.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
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 drug is being prescribed for the treatment of opioid dependence AND 2) If the patient is pregnant and being prescribed buprenorphine for induction therapy and/or subsequent maintenance therapy for 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	BUPRENORPHINE HCL/NALOXON, SUBOXONE
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	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, 2) disease is symptomatic and/or progressive, 3) disease is iodine-refractory, and 4) patient has unresectable recurrent or persistent locoregional disease 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	

Prior Authorization Group	CAYSTON
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 or 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 or poor metabolizers taking a strong CYP3A inhibitor (e.g., ketoconazole). CYP2D6 indeterminate metabolizers (i.e., CYP2D6 genotype cannot be determined). CYP2D6 ultra-rapid metabolizers. Use concomitantly with enzyme replacement therapy.
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. Member 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) or eliglustat (Cerdelga)
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. For Type 1 Gaucher disease, the patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. For Type 3 Gaucher disease, the 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	CHANTIX
Drug Names	CHANTIX, CHANTIX CONTINUING MONTH, CHANTIX STARTING MONTH PA
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	CINRYZE
Drug Names	CINRYZE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnostic laboratory testing for HAE has been performed (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels). For patients with HAE with C1 inhibitor deficiency, C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test. For patients with HAE with normal C1 inhibitor, other causes of angioedema have been ruled out (eg, drug-induced) and EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema.
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	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) (e.g., escitalopram, sertraline) or a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., duloxetine, venlafaxine ER) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic

Prior Authorization Group	CLORAZEPATE
	relief in acute alcohol withdrawal AND 4) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
Other Criteria	

Prior Authorization Group	CLOZAPINE ODT
Drug Names	CLOZAPINE ODT
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
Exclusion Criteria	
Required Medical Information	Medullary thyroid cancer which meets one of the following: 1) Unresectable locoregional disease that is symptomatic or structurally progressive, 2) Asymptomatic distant metastases if structurally progressive and unresectable, 3) Symptomatic or progressive metastatic disease
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	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	CYSTARAN
Drug Names	CYSTARAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing. The patient has corneal cystine crystal accumulation.
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 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	Criteria will be applied consistent with current AASLD-IDSA guidance
Other Criteria	For HCV/HIV coinfection, patient meets criteria for requested regimen.

Prior Authorization Group	DEFERASIROX
Drug Names	EXJADE

Prior Authorization Group	DEFERASIROX
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) 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	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) (e.g., escitalopram, sertraline) or a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., duloxetine, venlafaxine ER) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of skeletal muscle spasms OR 4) For adjunctive therapy in the treatment of convulsive disorders AND 5) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
Other Criteria	

Prior Authorization Group	ELIQUIS
Drug Names	ELIQUIS

Prior Authorization Group	ELIQUIS
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	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 thoughts and behavior and clinical worsening AND 2) Patient experienced an inadequate treatment response to any one of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (SNRIs (e.g., venlafaxine)), selective serotonin reuptake inhibitors (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	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	EPCLUSA
Drug Names	EPCLUSA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current prescribing information and AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	For HCV and HIV coinfection, patient meets the criteria for approval for the requested regimen above. Patient will not receive treatment with efavirenz, etravirine or nevirapine. Patient will not receive treatment with tipranavir.

Prior Authorization Group	EPO
Drug Names	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). 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. 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. 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. 2) For initial therapy, pretreatment serum erythropoietin level is less than or equal to 500 mU/mL. 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. 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	16 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 (e.g., 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

Prior Authorization Group	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 nodal or distant metastatic basal cell carcinoma (BCC), OR 2) patient has residual or recurrent disease and further surgery and radiation are contraindicated or not appropriate, OR 3) patient cannot achieve negative margins by Mohs surgery or more extensive surgical procedures.
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. For initial and continuation: Esbriet will not be used in combination with Ofev.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months, Renewal: Plan Year
Other Criteria	For continuation only: The patient has experienced a reduction in disease progression.

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 was confirmed by an enzyme assay demonstrating a 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 two prior regimens, including bortezomib and an immunomodulatory agent (eg, lenalidomide, thalidomide, pomalidomide). Farydak will be used in combination with bortezomib and dexamethasone. The patient does not have a baseline QTc interval greater than, or equal to, 450 ms. The patient will be monitored for severe diarrhea.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	FENTANYL PATCH
Drug Names	FENTANYL
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 fentanyl patch AND 2) The patient can safely take the requested dose based on their current opioid use history. [Note: Fentanyl patch is indicated for use in opioid-tolerant patients. Patients considered opioid-tolerant are those who are taking, for one week or longer, at least 60mg of morphine daily, or at least 30mg of oral oxycodone daily, or at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid.] AND 3) Fentanyl patch is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	FERRIPROX
Drug Names	FERRIPROX
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	FILGRASTIM
Drug Names	GRANIX, NEUPOGEN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL), 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 prior to or following chemotherapy or radiotherapy. For treatment of chemotherapy-induced FN, patient received prophylactic pegylated G-CSF (e.g., Neulasta) during the current chemotherapy cycle.
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For the treatment of anemia in MDS patients must meet all of the following: 1) Patient has symptomatic anemia, 2) The requested G-CSF product will be used in combination with epoetin or darbepoetin, 3) Patient has MDS with a low or intermediate-1 risk stratification, 4) The serum erythropoietin level is less than, or equal to, 500 mU/ml. For neutropenia in MDS: 1) Member is neutropenic, 2) Patient experiences recurrent or resistant infections.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For prevention of neutropenia: Patient will not receive chemotherapy and radiotherapy concurrently

Prior Authorization Group	FIRAZYR
Drug Names	FIRAZYR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, ACE inhibitor-induced angioedema.
Exclusion Criteria	
Required Medical Information	For hereditary angioedema (HAE): Diagnostic laboratory testing for HAE has been performed (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels). For patients with HAE with C1 inhibitor deficiency, C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test. For patients with HAE with normal C1 inhibitor: Other causes of angioedema have been ruled out (eg, drug induced) and EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year

Prior Authorization Group	FIRAZYR
Other Criteria	For HAE, Firazyr is being requested for the treatment of acute HAE attacks.
Prior Authorization Group	FORTEO
Drug Names	FORTEO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For postmenopausal osteoporosis (OP): 1) A hx of fragility fractures, OR 2) Patient (pt) has ONE of the following (a. or b.): a) A pre-treatment (pre-tx) T-score of less than or equal to -2.5, OR b) a pre-tx T-score of less than or equal to -1 but greater than -2.5 with a pre-tx FRAX score of either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture AND pt has ONE of the following (i. or ii.): i) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR ii) Pt has failed prior treatment with or is intolerant to previous OP therapy (oral bisphosphonates or injectable antiresorptive agents). For primary or hypogonadal OP: Pt has a) a hx of an osteoporotic vertebral or hip fracture OR b) a pre-tx T-score of less than or equal to -2.5 OR c) a pre-tx T-score of less than or equal to -1 but greater than -2.5 AND a pre-tx FRAX score of either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. For glucocorticoid-induced OP: Pt has had an oral bisphosphonate trial of at least 1-year duration unless contraindicated or intolerant to an oral bisphosphonate AND meets EITHER of the following (1. or 2.): 1) Postmenopausal women and men 50 years of age or older: i) Pt is currently receiving or will be initiating glucocorticoid therapy, and ii) Pt has a) a hx of fragility fracture OR b) a pre-tx T-score of less than or equal to -2.5 OR c) a pre-tx FRAX score of either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture, OR 2) Premenopausal women and men less than 50 years of age: i) Pt is currently receiving or will be initiating glucocorticoid therapy, and ii) The anticipated glucocorticoid length of therapy is at least 3 months, and iii) Pt has a hx 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	

Prior Authorization Group	FYCOMPA
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	Patient was dependent on parenteral support for at least 12 months prior to initiation of therapy with Gattex. For continuation: requirement for parenteral support has decreased 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 (e.g., 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	For non-small cell lung cancer (NSCLC), patient meets either of the following: 1) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) Patient had EGFR mutation testing and is positive for exon 19 deletions or exon 21 (L858R) substitution mutations AND Gilotrif is prescribed for use as any of the following: a) First-line therapy as a single agent for recurrent or metastatic disease (EGFR mutation discovered prior to first-line chemotherapy or during first-line chemotherapy), or b) Subsequent therapy as a single agent for recurrent or metastatic disease following disease progression on afatinib or erlotinib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GLATIRAMER
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 (e.g., 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GROWTH HORMONE
Drug Names	NORDITROPIN FLEXPRO
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-associated wasting/cachexia and SBS).
Required Medical Information	Pediatric GHD, TS, CKD, SHOXD, NS: 1) younger than 2.5 yrs old, when applicable: pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity, 2) 2.5 yrs old or older: pre-tx 1-year ht velocity more than 2 SD below mean OR pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) failed 2 growth hormone (GH) stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) patient is a neonate or was diagnosed with GHD as a neonate. TS: confirmed by karyotyping. Growth failure associated with CKD: not post-kidney transplant. SGA: 1) birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2. PWS: confirmed by one of the following: 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 GH stimulation tests (peak below 5 ng/mL) prior to starting tx, OR 2) structural abnormality of the hypothalamus/pituitary and 3 or more pituitary hormone deficiencies, OR 3) childhood-onset GHD with congenital (genetic or

Prior Authorization Group	GROWTH HORMONE
	structural) abnormality of the hypothalamus/pituitary, OR 4) low pre-tx IGF-1 and failed 1 GH stimulation test (peak below 5 ng/mL) prior to starting tx.
Age Restrictions	SGA: 2 years of age or older. NS and SHOXD: 3 years of age or older.
Prescriber Restrictions	Endocrinologist, Geneticist, Pediatric nephrologist, Infectious disease specialist, Gastroenterologist/Nutritional support specialist.
Coverage Duration	HIV-associated wasting: 12 wks. All other indications: Plan Year.
Other Criteria	HIV-associated wasting/cachexia: 1) on antiretroviral treatment, AND 2) suboptimal response to at least 1 other therapy for wasting or cachexia (eg, megestrol, dronabinol, cyproheptadine, or testosterone therapy if hypogonadal) OR contraindication or intolerance to alternative therapies, AND 3) prior to starting GH tx, body mass index (BMI) less than 18.5 kg/m2 AND experienced unintentional weight loss greater than 5 percent of body weight in the previous 6 months. SBS: Used in conjunction with optimal management of SBS. Renewal for pediatric GHD, TS, NS, CKD, SGA, PWS patients with open epiphyses, ISS, or SHOXD: patient is experiencing improvement. Also for renewal for PWS only: body composition and psychomotor function have improved or stabilized. Renewal for PWS patients with closed epiphyses: current IGF-1 level is not elevated for age and gender. Renewal for adult GHD patients: current IGF-1 level is normal for age and gender (does not apply to patients with: a) structural abnormality of the hypothalamus/pituitary and 3 or more pituitary hormone deficiencies, and b) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary). Renewal for HIV-associated wasting: demonstrated response to GH therapy (ie, BMI has improved or stabilized).

Prior Authorization Group	HAEGARDA
Drug Names	HAEGARDA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	This medication is being used for the prevention of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	HARVONI - PENDING CMS REVIEW
Drug Names	HARVONI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Prior Authorization Group	HARVONI - PENDING CMS REVIEW
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the 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 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	Criteria applied consistent with current AASLD-IDSA guidance.Reminder for 8wk option if appropriate.
Other Criteria	Harvoni will not be used with other drugs containing sofosbuvir, including Sovaldi.

Prior Authorization Group	HERCEPTIN
Drug Names	HERCEPTIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, esophageal and esophagogastric junction cancer, leptomeningeal metastases from HER2-positive breast cancer
Exclusion Criteria	
Required Medical Information	For HER2-positive breast cancer, Herceptin is used either: 1) For neoadjuvant treatment in combination with chemotherapy, OR 2) For adjuvant treatment in combination with chemotherapy for tumors at least 0.6cm or node positive, OR 3) For recurrent or metastatic disease in combination with aromatase inhibition for hormone-receptor positive disease, OR 4) For recurrent or metastatic disease in patients without previous treatment with Herceptin for recurrent or metastatic disease who meet 4a or 4b. 4a) Patients are hormone-receptor negative or are hormone-receptor positive and endocrine refractory, have symptomatic visceral disease, or visceral crisis. 4b) Patients use Herceptin as a single agent, in combination with chemotherapy, in combination with pertuzubab and docetaxel or paclitaxel, OR 5) For recurrent or metastatic disease in patient with previous treatment with Herceptin for recurrent or metastatic disease who meet 5a or 5b. 5a) Patients are hormone-receptor negative or are hormone-receptor positive and endocrine refractory, have symptomatic visceral disease, or visceral crisis, OR 5b) Patients use Herceptin in combination with capecitabine, in combination with lapitinib without chemotherapy, in combination with pertuzubumab with or without chemotherapy and the patient previous received chemotherapy and Herceptin in the absence of pertuzumab. For esophageal, gastric, or esophagogastric junction cancer: 1) The disease is locally advanced or metastatic, AND 2) Herceptin is used with cisplatin and fluorouracil or cisplatin and capecitabine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Prior Authorization Group	HERCEPTIN
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	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 (e.g., 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	CYPROHEPTADINE HCL, DISOPYRAMIDE PHOSPHATE, GUANFACINE ER, NORPACE CR, SCOPOLAMINE, 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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
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

Prior Authorization Group	HRM-ANTICONVULSANTS
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
Prior Authorization Group	HRM-ANTIDEPRESSANTS TCA
Drug Names	AMITRIPTYLINE HCL, DOXEPIN HCL, IMIPRAMINE HCL, TRIMIPRAMINE MALEATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Neuropathic pain for amitriptyline or imipramine.
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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Depression: 1) Two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Neuropathic pain

Prior Authorization Group	HRM-ANTIDEPRESSANTS TCA
	for amitriptyline or imipramine: Two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
Prior Authorization Group	HRM-ANTIPARKINSON
Drug Names	BENZTROPINE MESYLATE, TRIHEXYPHENIDYL 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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) EPS: 1) One non-HRM alternative formulary drug amantadine has not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug amantadine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug amantadine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug amantadine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Parkinson's: Two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole have not been tried. AND 2) The patient has a contraindication to two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
Prior Authorization Group	HRM-ANTIPSYCHOTICS
Drug Names	THIORIDAZINE HCL

Prior Authorization Group	HRM-ANTIPSYCHOTICS
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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone. AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone. AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER have been tried. AND 5) The patient experienced an inadequate treatment response OR

Prior Authorization Group	HRM-CLOMIPRAMINE
	intolerance to two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
Prior Authorization Group	HRM-DIGOXIN
Drug Names	DIGITEK, DIGOX, DIGOXIN
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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Reduction in dose is inappropriate AND 2) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
Prior Authorization Group	HRM-ESTROGENS
Drug Names	ESTRADIOL, FYAVOLV, JINTELI, NORETHINDRONE ACETATE/ETH
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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
Prior Authorization Group	HRM-GLYBURIDE
Drug Names	GLYBURIDE, GLYBURIDE MICRONIZED
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

Prior Authorization Group	HRM-GLYBURIDE
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs glimepiride, glipizide, or metformin have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs glimepiride, glipizide, or metformin AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs glimepiride, glipizide, or metformin have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs glimepiride, glipizide, or metformin AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group	HRM-HYDROXYZINE
Drug Names	HYDROXYZINE HCL, HYDROXYZINE PAMOATE
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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For pruritus 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 for this patient. 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 for this patient. For anxiety 1) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group	HRM-HYDROXYZINE INJ
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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Alcohol Withdrawal Syndrome:1) One non-HRM alternative formulary drug clorazepate or lorazepam have not been tried AND 2) The patient has a contraindication to one non-HRM alternative formulary drug clorazepate or lorazepam AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative formulary drug clorazepate or lorazepam have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug clorazepate or lorazepam AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient Anxiety: 1)Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER have not been tried AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 7) If being requested for nausea/vomiting, prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group	HRM-HYPNOTICS
Drug Names	ESZOPICLONE, ZOLPIDEM TARTRATE
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. (The American Geriatrics Society identifies the use of this

Prior Authorization Group	HRM-HYPNOTICS
	medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
Prior Authorization Group	HRM-MEGESTROL AC
Drug Names	MEGESTROL ACETATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, oral suspension - palliative treatment of advanced carcinoma of the breast or endometrium (i.e., recurrent, inoperable, or metastatic disease).
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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
Prior Authorization Group	HRM-NITROFURANTOIN
Drug Names	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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs cephalexin,

Prior Authorization Group	HRM-NITROFURANTOIN
	ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. 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. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Rhinitis: 1) One non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal have not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient Urticaria: 1) One non-HRM alternative formulary drug levocetirizine have not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug levocetirizine have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 7) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 8) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient
Prior Authorization Group	HRM-SKELETAL MUSCLE RELAXANTS
Drug Names	CARISOPRODOL, CYCLOBENZAPRINE HCL, METHOCARBAMOL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	

Prior Authorization Group	HRM-SKELETAL MUSCLE RELAXANTS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
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, axial spondyloarthritis, uveitis.
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): Patient meets at least one of the following criteria: 1) Inadequate response to at least a 3-month trial of methotrexate (MTX) despite adequate dosing (i.e., titrated to 25 mg/week), 2) Intolerance or contraindication to MTX, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD or a targeted synthetic DMARD (e.g., Xeljanz), 4) Intolerance to a prior biologic DMARD or a targeted synthetic DMARD, 5) Severely active RA. For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): Patient meets ANY of the following criteria: 1) Inadequate response to at least a 3-month trial of MTX, 2) Intolerance or contraindication to MTX, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD, 4) Intolerance to a prior biologic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (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. 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, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy.
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

Prior Authorization Group	HUMIRA
	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): Patient 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, c) clinically relevant extra-articular manifestations (e.g., extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), 6) Active enthesitis and/or dactylitis (i.e., sausage finger), 7) Predominant axial disease (i.e., extensive spinal involvement).
Prior Authorization Group	HYPNOTIC BENZODIAZEPINES
Drug Names	TEMAZEPAM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	This Prior Authorization requirement only applies to patients 65 years of age or older.(The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has not been tried. AND 2) The patient has a contraindication to two non-HRM alternative drugs Silenor (3mg or 6mg) and trazodone. AND 3) Prescriber must acknowledge that medication benefits outweigh potential risk in a patient 65 years of age or older. OR 4) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug Silenor (3mg or 6mg) or trazodone. AND 6) Prescriber must acknowledge that medication benefits outweigh potential risk in a patient 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	IBRANCE
Drug Names	IBRANCE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Single-agent therapy for the treatment of well-differentiated/dedifferentiated liposarcoma for retroperitoneal sarcomas.

Prior Authorization Group	IBRANCE
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	For CML or Ph+ ALL, diagnosis 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	

Prior Authorization Group	IDHIFA
Drug Names	IDHIFA
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	IMATINIB
Drug Names	IMATINIB MESYLATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Ph+ lymphoblastic lymphoma, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, and melanoma.
Exclusion Criteria	
Required Medical Information	For CML or Ph+ ALL/lymphoblastic lymphoma, diagnosis 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 (eg, dasatinib, nilotinib, bosutinib, ponatinib). For melanoma, c-Kit mutation is positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Prior Authorization Group	IMATINIB
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 experiencing improvement 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: 1) Inlyta will be used as a single agent and 2) the disease is relapsed or medically unresectable. For disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. For thyroid carcinoma: 1) The disease has papillary, Hurthle cell, or follicular histology, 2) Nexavar is not an appropriate option for the patient, 3) the disease is unresectable or metastatic, 4) the disease is radioiodine refractory, and 5) the disease is progressive or symptomatic.
Age Restrictions	

Prior Authorization Group	INLYTA
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	ISOTRETINOIN
Drug Names	AMNESTEEM, CLARAVIS, MYORISAN, ZENATANE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cutaneous T-cell Lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), Keratosis follicularis (Darier Disease), Lamellar ichthysosis, Neuroblastoma, Pityriasis rubra pilaris, Transient acantholytic dermatosis (Grover Disease), severe refractory Rosacea, refractory Acne, Reduction of the development of skin cancer (squamous cell cancers) in high risk patients.
Exclusion Criteria	
Required Medical Information	For acne (severe recalcitrant nodular or refractory) or severe refractory rosacea and patient had inadequate treatment responses to any topical acne product and an oral antibiotic [Note: topical products include salicylic acid, benzoyl peroxide, azelaic acid, adapalene, tretinoin, tazarotene, clindamycin, erythromycin, or metronidazole for rosacea] [Note: oral antibiotics include minocycline, doxycycline, tetracycline, erythromycin, trimethoprim-sulfamethoxazole, trimethoprim, azithromycin].
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acne (severe recalcitrant nodular or refractory) or severe refractory rosacea treatment will be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course.

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.

Prior Authorization Group	ITRACONAZOLE
Exclusion Criteria	Current use of certain drugs metabolized by CYP3A4. If the patient has the diagnosis of onychomycosis, evidence of ventricular dysfunction, such as congestive heart failure (CHF).
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 DIF, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, primary immunodeficiency, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), 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 CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL OR 2) History of recurrent bacterial infections, patient is not able to take combination antiretroviral therapy, and antibiotic prophylaxis was not effective. For dermatomyositis and polymyositis: standard first-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 myasthenia gravis: IVIG is requested for worsening weakness, acute exacerbation or use in preparation for surgery. PRCA is secondary to parvovirus B19 infection.

Prior Authorization Group	IVIG
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	
Required Medical Information	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), 2) Prior to initiation of treatment with Juxtapid, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin, rosuvastatin), fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, 3) Prior to initiation of treatment with Juxtapid, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated LDL-C greater than 160 mg/dL. For renewal of therapy: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	
Prescriber Restrictions	Lipid specialist, cardiometabolic specialist, cardiologist, or endocrinologist
Coverage Duration	Plan Year
Other Criteria	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, b) Diagnosis of definite FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic

Prior Authorization Group	JUXTAPID
	Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of definite FH must be confirmed by one of the following: 1) Genetic diagnosis: 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.
Prior Authorization Group	KALYDECO
Drug Names	KALYDECO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Use in combination with Orkambi
Required Medical Information	The patient has a diagnosis of cystic fibrosis. The patient has one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data.
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	KEYTRUDA
Drug Names	KEYTRUDA

Prior Authorization Group	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. Keytruda will be used as a single agent. Keytruda is used for first-line therapy OR Keytruda is used for second-line therapy and patient meets both of the following criteria: 1) Patient has experienced disease progression, AND 2) Patient has not received Keytruda previously. For HNSCC, patient has recurrent or metastatic disease and the patient has experienced disease progression on or after platinum-containing chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	KISQALI
Drug Names	KISQALI, KISQALI FEMARA 200 DOSE, KISQALI FEMARA 400 DOSE, KISQALI FEMARA 600 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	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 has had surgery that was not curative or 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	

Prior Authorization Group	KUVAN
Required Medical Information	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: 2 months. 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	
Required Medical Information	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), 2) Prior to initiation of treatment with Kynamro, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin, rosuvastatin), fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, 3) Prior to initiation of treatment with Kynamro, patient is/was experiencing an inadequate response to such combination regimen, as demonstrated by treated LDL-C greater than 160 mg/dL. For renewal of therapy, 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	
Prescriber Restrictions	Lipid specialist, cardiometabolic specialist, cardiologist, or endocrinologist
Coverage Duration	Plan Year
Other Criteria	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, b) Diagnosis of definite FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, sudden premature cardiac death. Diagnosis of definite FH must be confirmed by one of the following: 1) Genetic diagnosis: 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

Prior Authorization Group	KYNAMRO
	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.
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	For differentiated thyroid cancer: 1) histologic subtype is papillary, follicular, or Hurthle cell, 2) disease is symptomatic and/or progressive, 3) disease is iodine-refractory, and 4) patient has unresectable recurrent or persistent locoregional disease OR metastatic disease.
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	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, prevention and treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL) or acute myeloid leukemia (AML), neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia.
Exclusion Criteria	Use of Leukine within 24 hours prior to or following chemotherapy or radiotherapy. For treatment of chemotherapy-induced FN, patient received prophylactic pegylated G-CSF (eg, Neulasta) during the current chemotherapy cycle.

Prior Authorization Group	LEUKINE
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced FN the patient must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN the patient must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For MDS: Patient has neutropenia and experiences recurrent or resistant infections.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For prevention of neutropenia: Patient will not receive chemotherapy and radiotherapy concurrently

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 (including treatment-related neuropathy [e.g. neuropathy associated with radiation treatment or chemotherapy]).
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	LUPRON
Drug Names	LEUPROLIDE ACETATE, LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH), LUPRON DEPOT-PED (1-MONTH, LUPRON DEPOT-PED (3-MONTH
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, in combination with growth hormone for children with growth failure and advancing puberty (leuprolide acetate only), breast cancer (Lupron Depot 3.75mg only), malignant sex cord-stromal tumors (Lupron 3.75mg and 11.25 mg only), epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer (Lupron Depot 3.75mg only), preoperative use for uterine leiomyomata (Lupron Depot 3.75mg and 11.25mg only).
Exclusion Criteria	Undiagnosed abnormal vaginal bleeding (Lupron 3.75mg and 11.25mg only). Pregnancy (Lupron 3.75mg and 11.25mg only). Breast feeding (Lupron 3.75mg and 11.25mg only).
Required Medical Information	For central precocious puberty (CPP), patients not currently receiving therapy must meet ALL of the following criteria: 1) Diagnosis of CPP confirmed by: a) A pubertal response to a GnRH agonist OR a pubertal level of a third generation LH assay AND, b) Assessment of bone age versus chronological age AND, c) Appropriate diagnostic imaging of the brain to exclude an intracranial tumor. 2) The onset of sexual characteristics occurred prior to eight years of age for female patients OR prior to nine years of age for male patients. For prostate cancer (PC): If the patient has regional disease as initial ADT, metastatic disease as initial ADT, progressive castration-naive disease, or recurrent disease as defined as a biochemical failure after previous therapy, then no further information is required. If the patient has lymph node-positive disease found during pelvic lymph node dissection (PLND), then Lupron Depot must be used without external beam radiation therapy (EBRT) as adjuvant therapy. If the patient has none of the abovementioned criteria and has intermediate risk stratification (IRS), then Lupron Depot must be used with EBRT as initial ADT. If the patient has none of the abovementioned criteria and has high or very high risk stratification, then Lupron Depot must be used with EBRT or EBRT and docetaxel as initial ADT. If the patient has none of the abovementioned criteria and has very high risk stratification and is not a candidate for definitive therapy, Lupron Depot may be used without EBRT as initial ADT. For endometriosis (ENDO) retreatment patient must meet all of the following: 1) Patient has had a recurrence of symptoms, 2) Patient will be receiving add-back therapy (e.g., norethindrone), AND 3) Bone mineral density is within normal limits.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For PC with IRS: 6 months (MO). Fibroids: 3 MO: Max 6 MO. ENDO: 6 MO: max 12 MO. Others: Plan Year.
Other Criteria	For prostate cancer: Use as neoadjuvant therapy prior to radical prostatectomy is not approvable. For uterine fibroids patient must meet one of the following: 1) Diagnosis of anemia (e.g., hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) Lupron Depot will be used in the preoperative setting to facilitate surgery. For uterine fibroids retreatment, bone mineral density is within normal limits. For epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer:

Prior Authorization Group	LUPRON
	Lupron (3.75mg only) will be used as a single agent AND disease is persistent or recurrent. For breast cancer (3.75mg only) patient must meet all of the following: 1) Premenopausal woman, 2) Hormone receptor positive disease.
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	MAVYRET - PENDING CMS REVIEW
Drug Names	MAVYRET
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants where applicable, liver transplantation status if applicable. Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants 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	8-16 weeks per package insert or Criteria will be applied consistent w/ current AASLD-IDSA guidance
Other Criteria	
Prior Authorization Group	MEGESTROL
Drug Names	MEGESTROL ACETATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	

Prior Authorization Group	MEGESTROL
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	
Required Medical Information	Mekinist will be used as a single agent or in combination with Tafinlar for patients with a diagnosis of unresectable or metastatic melanoma AND tumor is positive for BRAF V600E or V600K mutation. For non-small cell lung cancer, tumor is positive for BRAF V600E mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	MEMANTINE
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	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	NAGLAZYME
Drug Names	NAGLAZYME

Prior Authorization Group	NAGLAZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of mucopolysaccharidosis VI (MPS VI) disease was confirmed by an enzyme assay demonstrating a deficiency of 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	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, 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	Initial: 6 months Renewal: Plan Year
Other Criteria	

Prior Authorization Group	NERLYNX
Drug Names	NERLYNX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient has early stage HER2-positive breast cancer. Nerlynx is initiated within two years after completing adjuvant trastuzumab based therapy.
Age Restrictions	
Prescriber Restrictions	

Prior Authorization Group	NERLYNX
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	NEXAVAR
Drug Names	NEXAVAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, osteosarcoma, soft tissue sarcoma subtypes: angiosarcoma, desmoid tumors (aggressive fibromatosis), gastrointestinal stromal tumor (GIST), medullary thyroid carcinoma, acute myeloid leukemia.
Exclusion Criteria	
Required Medical Information	For hepatocellular carcinoma: 1) Nexavar will be used as a single agent and 2) the disease is a) metastatic, OR b) unresectable and the patient is not a candidate for liver transplantation, OR c) the patient is not a candidate for surgery due to performance status or comorbidities. For renal cell carcinoma: 1) The patient has relapsed or medically unresectable disease, 2) Nexavar will be used as a single agent, and 3) for disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) The disease is unresectable or metastatic, 2) the disease is radioiodine-refractory, and 3) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For osteosarcoma: Nexavar will be used as a single agent. For gastrointestinal stromal tumor: The disease has progressed after treatment with imatinib, sunitinib, or regorafenib. For acute myeloid leukemia: 1) The disease is relapsed or refractory, 2) the patient has FLT3-ITD mutation-positive disease, 3) the patient cannot tolerate more aggressive regimens, and 4) Nexavar will be used in combination with azacitidine or decitabine.
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	NORTHERA
Drug Names	NORTHERA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Prior to initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing, supported by serial blood pressure measurements. Northera will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) Dopamine beta hydroxylase deficiency, OR 3) Non-diabetic autonomic neuropathy
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	Patients currently on Northera must experience a sustained decrease in dizziness to continue on therapy.

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	
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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	NUVIGIL
Drug Names	ARMODAFINIL
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, SANDOSTATIN LAR DEPOT
Covered Uses	All FDA-approved indication not otherwise covered under Part D, meningiomas, thymomas and thymic carcinomas, adrenal gland neuroendocrine tumors (NETs), NETs of the gastrointestinal (GI) tract, thymus, and lung, pancreatic NETs, and poorly differentiated (high-grade)/large or small cell NETs.
Exclusion Criteria	
Required Medical Information	Meningiomas: 1) Patient has recurrent or progressive disease (dx), 2) Dx is unresectable, 3) Dx is refractory to radiation therapy, and 4) Somatostatin receptor status (SRS) is positive. Thymomas and thymic carcinomas: 1) Patient has locally advanced, advanced, or recurrent dx, 2) Dx is unresectable OR patient has residual dx following resection, 3) Patient has progressed on at least one prior chemotherapy regimen, and 4) SRS is positive OR patient has symptoms of carcinoid syndrome. NETs of GI tract: Patient has 1) distant metastases OR 2) unresectable dx, OR 3) primary site of tumor is gastric, tumor is less than or equal to 2 cm, AND patient has hypersecretion of gastrin. NETs of thymus: Patient has distant metastases OR unresectable dx. NETs of lung: 1) Patient has distant metastases OR 2) Patient has a) NET that is low-grade (typical carcinoid) or intermediate-grade (atypical carcinoid), AND b) Stage IIIB dx that is T4 due to multiple lung nodules or Stage IV dx, AND c) SRS is positive or patient has symptoms of carcinoid syndrome. Pancreatic NETs: 1) For gastrinoma, glucagonoma, and VIPoma, patient's SRS is positive OR patient has hormone-related symptoms, OR 2) For insulinoma, non-functioning pancreatic tumor, somatostatinoma, pancreatic polypeptidoma, cholecystokininoma, ACTH-secreting pancreatic NET, and parathyroid hormone-related protein-secreting pancreatic NET, patient has a) distant metastases or unresectable dx AND b) SRS is positive OR patient has hormone-related symptoms. Adrenal gland NETs: 1) Patient has a diagnosis of non-ACTH dependent Cushing's syndrome, and 2) Cortisol production is symmetric, and 3) Tumors are less than 4 cm, and 4) SRS is positive. Poorly differentiated (high-grade)/large or small cell NETs (excluding lung): 1) Patient has metastatic or unresectable dx, 2) SRS is positive, and 3) Patient has hormone-related symptoms.
Age Restrictions	

Prior Authorization Group	OCTREOTIDE
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Acromegaly: Patient has 1) clinical evidence of acromegaly, 2) a high pre-treatment IGF-1 level for age and/or gender, and 3) an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why patient has not had surgery or radiotherapy. For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.
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. For initial and continuation: Ofev will not be used in combination with Esbriet.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months, Renewal: Plan Year
Other Criteria	For continuation only: The patient has experienced a reduction in disease progression.
Prior Authorization Group	ONFI
Drug Names	ONFI

Prior Authorization Group	ONFI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	2 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	OPSUMIT
Drug Names	OPSUMIT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	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	FENTANYL CITRATE ORAL TRA, FENTORA
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 CANCER related pain AND 2) The ICD diagnosis code provided supports the CANCER RELATED diagnosis [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER RELATED diagnosis.] AND 3) The drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain AND 4) 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, Onsolis, 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	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 (e.g., 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	6 years of age or older
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. 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 where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines. 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

Prior Authorization Group	PEGASYS
	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	PHENYLBUTYRATE
Drug Names	BUPHENYL, SODIUM PHENYLBUTYRATE
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: 1) The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent (ie, thalidomide, lenalidomide) AND a proteasome inhibitor (ie, bortezomib, carfilzomib), 2) Pomalyst will be used as a single agent or in combination with dexamethasone, and 3) the patient will be monitored for thromboembolism. For systemic light chain amyloidosis: 1) Pomalyst will be used in combination with dexamethasone and 2) the patient will be monitored for thromboembolism.
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	

Prior Authorization Group	PRALUENT
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), myasthenia

Prior Authorization Group	PRIVIGEN
	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 CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections, patient is not able to take combination antiretroviral therapy, and antibiotic prophylaxis was not effective. For dermatomyositis and polymyositis: standard first-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 myasthenia gravis: IVIG is requested for worsening weakness, acute exacerbation or use in preparation for surgery. PRCA is secondary to parvovirus B19 infection.
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	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): 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. 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: 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

Prior Authorization Group	PROMACTA
	75,000/mcL. For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): 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. 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 = IRP
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	PULMOZYME
Drug Names	PULMOZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
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	QUININE SULFATE
Drug Names	QUININE SULFATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Babesiosis, uncomplicated Plasmodium vivax malaria
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	RAVICTI
Drug Names	RAVICTI

Prior Authorization Group	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. 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 (e.g., 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	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, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation 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) The patient has a contraindication to an oral drug indicated for opioid-induced

Prior Authorization Group	RELISTOR
	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. Behcet's syndrome. Granulomatosis with polyangiitis (Wegener's granulomatosis). Hidradenitis suppurativa. Juvenile idiopathic arthritis. Pyoderma gangrenosum. Sarcoidosis. Takayasu's arteritis. Uveitis.
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 Remicade (or other biologic). For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) Inadequate response to at least a 3-month trial of self-injectable TNF inhibitor (eg, Cimzia, Humira) OR 3) Intolerance to a self-injectable TNF inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (eg, corticosteroids, sulfasalazine, azathioprine, mesalamine) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Remicade will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (eg, Cimzia, Humira) or intolerance to a self-injectable TNF inhibitor. For active ankylosing spondylitis and axial spondyloarthritis (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	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For active psoriatic arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of MTX, sulfasalazine, or leflunomide OR 2) Intolerance or contraindication to MTX, sulfasalazine, or leflunomide OR 3) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (eg, Humira, Cimzia), OR 4) Intolerance to a self-injectable TNF inhibitor, OR 5) 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 (eg, extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), OR 6) Active enthesitis and/or dactylitis (ie, sausage finger) OR 7) Predominant axial disease (ie, extensive spinal involvement). For chronic moderate to severe plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial

Prior Authorization Group	REMICADE
	body areas (e.g., feet, hands, face, neck and/or groin) are affected AND 2) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (e.g., Humira) or intolerance to a self-injectable TNF inhibitor. For juvenile idiopathic arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (e.g., Humira) OR 2) Intolerance to a self-injectable TNF inhibitor. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis (e.g., methotrexate, azathioprine, or mycophenolate mofetil).
Prior Authorization Group	REMODULIN
Drug Names	REMODULIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has had NYHA Functional Class II, III, or 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	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	REVLIMID
Drug Names	REVLIMID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, classical Hodgkin lymphoma, non-Hodgkin's lymphoma with the following subtypes: chronic lymphocytic leukemia/small lymphocytic lymphoma, 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, multicentric Castleman's disease.
Exclusion Criteria	
Required Medical Information	For all indications: The patient will be monitored for thromboembolism. For multiple myeloma: Revlimid is prescribed for primary, maintenance, or salvage therapy. For primary therapy: 1) The prescribed regimen includes dexamethasone, OR 2) The prescribed regimen is Revlimid, melphalan, and prednisone for a patient who is not a stem cell transplant candidate. For myelodysplastic syndrome (MDS): 1) Patient must have low- to intermediate-1 risk MDS with symptomatic anemia. For multicentric Castleman's disease:

Prior Authorization Group	REVLIMID
	1) The disease has progressed following treatment of relapsed, refractory, or progressive disease AND 2) Revlimid will be used as monotherapy. For all subtypes of NHL except Castleman's disease: 1) The disease is relapsed, refractory, or progressive AND 2) Revlimid will be used as monotherapy or in combination with rituximab. For systemic light chain amyloidosis: Revlimid will be used with either: a) dexamethasone OR b) dexamethasone AND cyclophosphamide.
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, lymphoblastic lymphoma, Castleman's disease], acute lymphoblastic leukemia, refractory immune or idiopathic thrombocytopenic purpura (ITP), acquired blood factor VIII deficiency, autoimmune hemolytic anemia, chronic graft-versus-host disease (GVHD), 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): 1) Rituxan is used in combination with methotrexate unless methotrexate is contraindicated or not tolerated and 2) member has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (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 conditions: 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	

Prior Authorization Group	RITUXAN
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	RITUXAN HYCELA
Drug Names	RITUXAN HYCELA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	RUBRACA
Drug Names	RUBRACA
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	RYDAPT
Drug Names	RYDAPT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For newly diagnosed FLT3 mutation-positive AML, Rydapt is/was used in combination with standard cytarabine with daunorubicin or idarubicin induction followed by cytarabine consolidation chemotherapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	SABRIL
Drug Names	SABRIL, VIGABATRIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Prior Authorization Group	SABRIL
Required Medical Information	For infantile spasms (IS): The requested drug 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) The requested drug is used as adjunctive therapy.
Age Restrictions	Initial treatment of infantile spasms: 1 month to 2 years. CPS: 10 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
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 has had pituitary surgery that was not curative or the patient is not a candidate for surgery. 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	SILDENAFIL
Drug Names	REVATIO, SILDENAFIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Treatment with a nitrate therapy on a regular or intermittent basis. Concomitant treatment with a guanylate cyclase stimulator (e.g., Adempas).
Required Medical Information	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	SIRTURO
Drug Names	SIRTURO

Prior Authorization Group	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	
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, adrenal gland neuroendocrine tumors (NETs), NETs of the gastrointestinal (GI) tract, thymus, and lung, pancreatic NETs, and poorly differentiated (high-grade)/large or small cell NETs.
Exclusion Criteria	
Required Medical Information	Acromegaly: Patient has 1) clinical evidence of acromegaly, AND 2) a high pre-treatment IGF-1 level for age and/or gender, AND 3) had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. NETs of the GI tract: Patient has 1) distant metastases, OR 2) unresectable disease, OR 3) primary site of the tumor is gastric, tumor is less than or equal to 2 centimeters, AND the patient has hypersecretion of gastrin. NETs of the thymus: Patient has distant metastases OR unresectable disease. NETs of the lung: Patient has distant metastases OR unresectable disease. Pancreatic NETs: 1) For gastrinoma, glucagonoma, and VIPoma, patient's somatostatin receptor status is positive OR patient has hormone-related symptoms, OR 2) For insulinoma, non-functioning pancreatic tumor, somatostatinoma, pancreatic polypeptidoma, cholecystokininoma, ACTH-secreting pancreatic NET, and parathyroid hormone-related protein-secreting pancreatic NET, patient has a) distant metastases or unresectable disease AND b) somatostatin receptor status is positive OR patient has hormone-related symptoms. Adrenal Gland NETs: 1) Patient has a diagnosis of non-ACTH dependent Cushing's syndrome, AND 2) The cortisol production is symmetric, AND 3) Tumors are less than 4 centimeters, AND 4) Somatostatin receptor status is positive. Poorly differentiated (high-grade)/large or small cell NETs (excluding lung): 1) Patient has metastatic or unresectable disease, AND 2) Somatostatin receptor status is positive, AND 3) Patient has hormone-related symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

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) Patient has clinical evidence of acromegaly, AND 2) Patient has a high pre-treatment IGF-1 level for age and/or gender, AND 3) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy, AND 4) Patient had an inadequate or partial response to a) octreotide (Sandostatin or Sandostatin LAR), or b) lanreotide (Somatuline Depot), or c) pasireotide (Signifor LAR) OR patient is intolerant or has a contraindication to a) octreotide, or b) lanreotide, or c) pasireotide.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

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	Criteria will be applied consistent with current AASLD-IDSA guidance
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 5 cm or less in diameter in pts with single hepatocellular carcinoma OR 3 tumor nodules or less, each 3 cm 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	For CML or Ph+ ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) high or intermediate risk for disease progression, or b) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have PDGFRA D842V mutation and disease progression on imatinib, sunitinib, or regorafenib.
Age Restrictions	15 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/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, chordoma (bone cancer), lung neuroendocrine tumor, thymic carcinoma.
Exclusion Criteria	

Prior Authorization Group	SUTENT
Required Medical Information	For renal cell carcinoma: 1) The disease is relapsed or medically unresectable and 2) Sutent will be used as a single agent. For gastrointestinal stromal tumor: The patient experienced disease progression on imatinib or was intolerant to imatinib. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) Nexavar is not an appropriate option for the patient, 2) the disease is unresectable or metastatic, 3) the disease is radioiodine-refractory, and 4) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For thymic carcinoma: 1) Sutent will be used as a single agent and 2) the disease has progressed on a platinum-based chemotherapy regimen.
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) The patient is currently receiving optimal mealtime insulin therapy AND 2) The patient has experienced an inadequate treatment response to insulin AND 3) The patient has a diagnosis of type 1 or type 2 diabetes mellitus
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Prior Authorization Group	SYMLIN
Other Criteria	1) If the patient has been receiving 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, and non-small cell lung cancer.
Exclusion Criteria	
Required Medical Information	For unresectable or metastatic melanoma: 1) Tafinlar will be used in combination with Mekinist for patients with a diagnosis of BRAF V600E or V600K mutation positive disease OR 2) Tafinlar will be used as a single agent for BRAF V600E or V600K mutation positive disease AND clinical deterioration is anticipated in less than or equal to 12 weeks. For CNS metastases: Tafinlar has activity against the primary tumor (melanoma) AND Tafinlar will be used as a single agent. For NSCLC: The tumor is positive for the 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 (RCC).
Exclusion Criteria	
Required Medical Information	For locally advanced, recurrent or metastatic non-small cell lung cancer (NSCLC) with positive EGFR mutation (exon 19 deletions or exon 21 L858R substitution mutations), Tarceva is prescribed for use as ANY of the following: 1) First-line therapy as a single agent (EGFR mutation discovered prior to first-line chemotherapy or during first-line chemotherapy), 2) Subsequent therapy as a single agent following disease progression on erlotinib, 3) Subsequent therapy in combination with chemotherapy following disease progression on afatinib or erlotinib, or 4) Subsequent therapy as a single agent following progression on a cytotoxic regimen for metastatic disease in members who have not previously received erlotinib. For metastatic NSCLC with negative or unknown EGFR mutation, Tarceva is prescribed for use as subsequent therapy as a single agent following progression on a cytotoxic regimen in a patient who has not previously received erlotinib. For pancreatic cancer, Tarceva is prescribed in combination with gemcitabine for locally advanced unresectable or metastatic pancreatic cancer. For chordoma, Tarceva is prescribed as a single agent for recurrent disease. For RCC, Tarceva is prescribed as a single agent for relapsed or unresectable stage IV disease with non-clear cell histology.
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	For CML or Ph+ ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) high or intermediate risk for disease progression, or b) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. 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. If patient relapsed after or is refractory to initial tyrosine kinase inhibitor-containing therapy for ALL, patient is negative for T315I

Prior Authorization Group	TASIGNA
	mutation. 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	TAZAROTENE, 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 the requested drug 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 the requested drug) OR 3) patient experienced an adverse event, intolerance, or contraindication to topical corticosteroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For 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 the requested drug.

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	TESTOSTERONE CYPIONATE INJ
Drug Names	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 a male patient with congenital or acquired primary hypogonadism (i.e., testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchidectomy) who had or

Prior Authorization Group	TESTOSTERONE CYPIONATE INJ
	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 a male patient with congenital or acquired hypogonadotropic hypogonadism (i.e., gonadotropin or luteinizing hormone-releasing hormone [LHRH] deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation) who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values OR 3) 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	14 years of age or older (female-to-male gender reassignment)
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 is 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 a pre-menopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor OR 3) 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 4) Drug is being prescribed for delayed puberty in a male patient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TETRABENAZINE
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	Active suicide ideation. Untreated or inadequately treated depression.
Required Medical Information	
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 aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, HIV-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, myelofibrosis with myeloid metaplasia, multicentric Castleman's disease.
Exclusion Criteria	
Required Medical Information	For all indications: The patient will be monitored for thromboembolism. For cachexia: Cachexia must be due to cancer or HIV-infection. For Kaposi's sarcoma: The patient has HIV infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TOBRAMYCIN
Drug Names	TOBRAMYCIN
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	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	TOPICAL LIDOCAINE
Drug Names	LIDOCAINE, LIDOCAINE HCL, LIDOCAINE HCL JELLY, LIDOCAINE/PRILOCAINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Months

Prior Authorization Group	TOPICAL LIDOCAINE
Other Criteria	1) The prescribed quantity falls within the manufacturer's published dosing guidelines. 2) If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use. 3) 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	TOPICAL TESTOSTERONES
Drug Names	ANDRODERM, AXIRON, TESTOSTERONE
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	TOPICAL TRETINOIN
Drug Names	AVITA, TRETINOIN
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	TRELSTAR
Drug Names	TRELSTAR MIXJECT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, adjuvant therapy for prostate cancer, initial ADT for prostate cancer, progressive, metastatic, and recurrent prostate cancer.
Exclusion Criteria	
Required Medical Information	If the patient has regional disease as initial ADT, metastatic disease as initial ADT, progressive castration-naive disease, or recurrent disease as defined as a biochemical failure after previous therapy, then no further information is required. If the patient has lymph node-positive disease found during pelvic lymph node dissection (PLND), then Trelstar must be used without external beam radiation therapy (EBRT) as adjuvant therapy. If the patient has none of the abovementioned criteria and has intermediate risk stratification, then Trelstar must be used with EBRT as initial ADT. If the patient has none of the

Prior Authorization Group	TRELSTAR
	abovementioned criteria and has high or very high risk stratification, then Trelstar must be used with EBRT or EBRT and docetaxel as initial ADT. If the patient has none of the abovementioned criteria and has very high risk stratification and is not a candidate for definitive therapy, Trelstar may be used without EBRT as initial ADT.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For immediate risk stratification: 6 months. Others: 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 will be used in combination with: 1) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) for a postmenopausal woman with hormone receptor-positive disease, or 2) capecitabine or trastuzumab (without cytotoxic therapy) for a patient who has received prior trastuzumab-containing regimen. For metastatic CNS lesions, 1) member has recurrent HER2-positive breast cancer, 2) Tykerb is active against the primary tumor (breast), and 3) Tykerb will be used in combination with capecitabine in a patient 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	Plan Year
Other Criteria	
Prior Authorization Group	UPTRAVI
Drug Names	UPTRAVI

Prior Authorization Group	UPTRAVI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	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, adult T-cell leukemia/lymphoma, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
Exclusion Criteria	
Required Medical Information	Lymphomatoid papulosis: Valchlor will be used as a single agent
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	

Prior Authorization Group	VELCADE
Drug Names	VELCADE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease.
Exclusion Criteria	
Required Medical Information	For multiple myeloma: Velcade is prescribed for primary, maintenance, or salvage therapy. For primary therapy: 1) the prescribed regimen includes dexamethasone, OR 2) the prescribed regimen is Velcade, melphalan, and prednisone for a patient who is not a stem cell transplant candidate. For multicentric Castleman's disease: 1) The disease has progressed following treatment of relapsed, refractory, or progressive disease, and 2) Velcade will be prescribed as monotherapy or in combination with rituximab.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Prior Authorization Group	VELCADE
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	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	VENTAVIS
Drug Names	VENTAVIS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has had NYHA Functional Class III or 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	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	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	VOLTAREN GEL
Drug Names	DICLOFENAC SODIUM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Use during the peri-operative period in the setting of coronary artery bypass graft (CABG) surgery. Experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDS.
Required Medical Information	The patient is unable to tolerate or not a suitable candidate for oral NSAID therapy (e.g., bleeding ulcer, etc.).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	VOSEVI - PENDING CMS REVIEW
Drug Names	VOSEVI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants 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 weeks or Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	

Prior Authorization Group	VOTRIENT
Drug Names	VOTRIENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, dermatofibrosarcoma protuberans, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma.
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma: 1) The disease is relapsed or medically unresectable and 2) Votrient will be used as a single agent. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma and 2) the patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk sarcoma. For GIST, the disease has progressed on treatment with imatinib, sunitinib, or regorafenib. For angiosarcoma or

Prior Authorization Group	VOTRIENT
	pleomorphic rhabdomyosarcoma, Votrient will be used as a single agent. For retroperitoneal/intra-abdominal sarcoma or extremity/superficial trunk sarcoma, Votrient will be used as a single agent for progressive, unresectable, or metastatic disease. For uterine sarcoma: 1) Votrient will be used as a single agent and 2) for stage I disease, the disease is medically inoperable. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) Nexavar is not an appropriate option for the patient, 2) the disease is unresectable or metastatic, 3) the disease is radioiodine-refractory, and 4) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For dermatofibrosarcoma protuberans: 1) The disease is metastatic and 2) Votrient will be used as a single agent.
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, non-small cell lung cancer (NSCLC) with MET amplification, inflammatory myofibroblastic tumors (IMT).
Exclusion Criteria	
Required Medical Information	For NSCLC, patient meets all of the following: 1) Tumor is ALK-positive, ROS1-positive, or demonstrates MET amplification, and 2) Patient has recurrent or metastatic disease, and 3) Xalkori is being used as a single agent. For IMT, the tumor is ALK-positive and 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/Xeljanz XR or previous biologic DMARD. For moderately to severely active rheumatoid arthritis (new starts only), patient meets at least one of the following criteria:1) Inadequate response to at least a 3-month trial of

Prior Authorization Group	XELJANZ
	methotrexate (MTX) despite adequate dosing (i.e., titrated to 25 mg/week), 2) Intolerance or contraindication to MTX, 3) Inadequate response to at least a 3-month trial of any prior biologic DMARD (eg, adalimumab), 4) Intolerance to any prior biologic DMARD.
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, renewal = Plan Year. All other dx = Plan Year.
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. 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.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Reduction in risk of overt HE recurrence-6 Months, IBS-D-Plan Year
Other Criteria	

Prior Authorization Group	XOLAIR
Drug Names	XOLAIR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Prior Authorization Group	XOLAIR
Required Medical Information	For allergic asthma: 1) Xolair is used in combination with other medications for long-term control of asthma, and 2) Patient has a rapid-acting beta2-agonist available for rescue therapy. For initial therapy only: 1) Patient has a diagnosis of moderate to severe persistent asthma, 2) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 3) Patient has baseline IgE level greater than or equal to 30 IU/mL, 4) Asthma is inadequately controlled despite use of inhaled corticosteroid at the optimal dose (unless patient has an intolerance or contraindication to inhaled corticosteroid therapy), and 5) Patient is optimizing the use of a long-acting inhaled beta2-agonist, leukotriene modifier, or sustained-release theophylline (unless patient has an intolerance or contraindication to such therapies). For continuation therapy only: Patient's asthma control has improved on Xolair treatment since initiation of therapy. For chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks, and 3) Patient has remained symptomatic despite second generation H1 antihistamine therapy with maximized dosing used continuously for at least two weeks (unless patient has an intolerance or contraindication to antihistamine therapy). For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.
Age Restrictions	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.
Prescriber Restrictions	For CIU: allergist, dermatologist, or immunologist
Coverage Duration	Allergic asthma: Plan Year. CIU initial: 6 months. CIU continuation: 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 non-castration-resistant disease, Xtandi will be used in combination with androgen deprivation therapy to: 1) enhance the effectiveness of radiation therapy, 2) supplement androgen deprivation therapy if the patient experienced inadequate testosterone suppression, OR 3) prevent androgen flare in androgen deprivation therapy naive patients who are at risk of developing symptoms.
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 excessive daytime sleepiness in a patient with narcolepsy without cataplexy and 2) The patient experienced an inadequate treatment response or intolerance to a CNS stimulant drug and a CNS promoting wakefulness drug OR 3) 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 are modafinil or armodafinil. Coverage of modafinil or armodafinil or amphetamines or methylphenidates may require prior authorization). OR 4) The drug is being prescribed for the treatment of cataplexy in a patient with narcolepsy.
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, 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 (Opdivo). For the adjuvant treatment of melanoma, member must meet all of the following: 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), member must meet all of the following: 1) Yervoy was active against the primary tumor (melanoma), 2) the disease is recurrent, and 3) Yervoy will be used as a single agent.
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	

Prior Authorization Group	ZAVESCA
Required Medical Information	Diagnosis of Type 1 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 and older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZEJULA
Drug Names	ZEJULA
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	Treatment is being started or was started no later than 8 weeks after the most recent platinum-based chemotherapy.

Prior Authorization Group	ZELBORAF
Drug Names	ZELBORAF
Covered Uses	All FDA-approved uses not otherwise excluded from Part D, melanoma with BRAF V600K mutation, CNS metastases from primary tumor (melanoma), NSCLC with BRAF V600E mutation, and hairy cell leukemia.
Exclusion Criteria	
Required Medical Information	For unresectable or metastatic melanoma: The tumor is positive for either BRAF V600E or V600K mutation AND clinical deterioration is anticipated in less than or equal to 12 weeks. For CNS metastases: Zelboraf has activity against the primary tumor (melanoma) AND Zelboraf will be used as a single agent. For NSCLC: The tumor is positive for the BRAF V600E mutation. For refractory hairy cell leukemia: Zelboraf will be used as a single agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZEPATIER
Drug Names	ZEPATIER
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C). Liver transplant recipient or awaiting liver transplantation

Prior Authorization Group	ZEPATIER
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants (eg, NS5A polymorphisms) where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current prescribing information and AASLD-IDSA treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	For HCV and HIV coinfection, patient meets the criteria for approval for the requested regimen.

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	ZYDELIG
Drug Names	ZYDELIG
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, relapsed or refractory chronic lymphocytic leukemia (CLL) as a single agent, relapsed or refractory small lymphocytic lymphoma as a single agent or in combination with rituximab, refractory or progressive follicular lymphoma, primary cutaneous B-cell lymphoma [primary cutaneous marginal zone lymphoma and follicle center lymphoma], and marginal zone lymphomas [gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].
Exclusion Criteria	History of serious allergic reactions including anaphylaxis or toxic epidermal necrolysis.
Required Medical Information	For relapsed or refractory CLL, Zydelig is used as a single agent or in combination with rituximab. For relapsed or refractory SLL, Zydelig is used as a single agent or in combination with rituximab and the patient has received at least two prior systemic therapies. For relapsed, refractory, or progressive follicular B-cell non-Hodgkin lymphoma, Zydelig is used as a single agent and the patient has received at least two prior systemic

Prior Authorization Group	ZYDELIG
	therapies. For gastric mucosa associated lymphoid tissue (MALT) lymphoma, the disease is recurrent or progressive. For non-gastric MALT and Splenic marginal zone lymphomas, the disease is refractory or progressive.
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, anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor.
Exclusion Criteria	
Required Medical Information	For NSCLC, patient meets all of the following: 1) Tumor is ALK-positive, and 2) Disease is recurrent or metastatic. For ALK-positive inflammatory myofibroblastic tumor: Zykadia is prescribed as a single agent.
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	Tolerability with oral olanzapine has been established.
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	

Molina Dual Options MyCare Ohio Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

You can get this information for free in other formats, such as large print, braille, or audio. Call (855) 665-4623, TTY/TDD: 711, Monday - Friday, 8 a.m. to 8 p.m., local time. The call is free.

MOLINA HEALTHCARE
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MyCareOhio
Connecting Medicare + Medicaid

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To help you talk with us, Molina provides services free of charge:

- Aids and services to people with disabilities
    - Skilled sign language interpreters
    - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
    - Skilled interpreters
    - Written material translated in your language
    - Material that is simply written in plain language

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Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802

You can also email your complaint to civil.rights@molinahealthcare.com. Or, fax your complaint to (562) 499-0610.

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call 1-800-368-1019; TTY 800-537-7697.

MOLINA HEALTHCARE
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English

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Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-665-4623 (TTY: 711).

Chinese
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German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-665-4623 (TTY: 711).

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ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-665-4623 (رقم هاتف الصم والبكم: 711).

Pensylvannia Dutch
Wann du Deitsch Pennsylvania German schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-665-4623 (TTY: 711).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-665-4623 (телетайп: 711).

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-665-4623 (ATS: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-665-4623 (TTY: 711).

Cushite (Oromo language)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-665-4623 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-665-4623 (TTY: 711) 번으로 전화해 주십시오.

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-665-4623 (TTY: 711).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-665-4623（TTY: 711）まで、お電話にてご連絡ください。

Dutch
AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-855-665-4623 (TTY: 711).

Ukrainian
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-665-4623 (телетайп: 711).

Romanian
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-665-4623 (TTY: 711).

Somali
FIIRO GAAR AH: Hadii aad ku hadasho Ingiriisiga, adeega kaalmada luuqada, oo bilaa lacag ah, ayaa kuu diyaar ah. Lahadal 1-855-665-4623 (TTY: 711).

Nepali
ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-665-4623 (टिटिवाइ: 711) ।

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-665-4623 (TTY: 711).

French Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-665-4623 (TTY: 711).

Polish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-665-4623 (TTY: 711).

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-665-4623 (TTY: 711) पर कॉल करें।

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-665-4623 (TTY: 711).