MOLINA HEALTHCARE
Your Extended Family.

Healthy Connections PRIME

This is a list of drugs that requires certain criteria to be met before a drug is covered. For example, diagnosis, lab values, or previous treatments tried and failed.

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	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

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	
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	
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	
Required Medical Information	For pulmonary arterial hypertension (PAH) (WHO Group 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, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
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 subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangioleiomyomatosis, osteosarcoma.
Exclusion Criteria	
Required Medical Information	Breast cancer: 1) The patient has recurrent or metastatic 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 while on or within 12 months of nonsteroidal aromatase inhibitor therapy, OR b) was previously treated with tamoxifen. Renal cell carcinoma: 1) The disease is relapsed or unresectable, AND 2) For disease that is of non- clear cell histology, Afinitor will be used as first-line systemic therapy AND Afinitor will be used as a single agent, AND 3) For disease that is of predominantly clear cell histology, Afinitor will be used as a single agent or in combination with Lenvima AND disease has progressed on prior anti-angiogenic therapy (e.g. sunitinib). Classical Hodgkin lymphoma: 1) Afinitor will be used as a single agent, AND 2) Patient meets ONE of the following: a) The disease is relapsed or refractory, OR b) Afinitor will be used as palliative therapy. 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. Osteosarcoma: Afinitor will be used in combination with sorafenib [Nexavar].

Prior Authorization Group	AFINITOR
	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	Diagnosis of mucopolysaccharidosis I was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic 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	For NSCLC, patient meets all of the following: 1) Tumor is ALK-positive, and 2) Disease is recurrent or metastatic.
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	
Required Medical Information	1) The requested drug 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	

Prior Authorization Group	ALOSETRON
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 micromol/L (80 mg/dl by radial immunodiffusion or 50 mg/dl by nephelometry). Patients must have a pretreatment post-bronchodilation forced expiratory volume in 1 second (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, DALFAMPRIDINE ER
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. 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	ANADROL
Drug Names	ANADROL-50
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting) or due to chronic disease, Fanconi's anemia.
Exclusion Criteria	
Required Medical Information	
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	
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) 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	ARMODAFINIL
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	AURYXIA
Drug Names	AURYXIA
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	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

Prior Authorization Group	AVASTIN
	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, retinopathy of prematurity, and proliferative diabetic retinopathy (as adjunct prior to vitrectomy).
Exclusion Criteria	
Required Medical Information	Colorectal cancer: The disease is unresectable advanced or metastatic. Non-squamous non-small cell lung cancer: the requested drug will be used as first-line therapy, subsequent therapy, or continuation maintenance therapy (ie, continuation of the requested drug as first-line therapy beyond 4-6 cycles in the absence of disease progression).
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	B VS. D
Drug Names	ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ADRUCIL, ALBUTEROL SULFATE, ALIMTA, AMBISOME, 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, BLEOMYCIN SULFATE, BUDESONIDE, BUSULFAN, 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, DEPO-PROVERA, DEXRAZOXANE, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HCL LIPOSOME, DRONABINOL, ELITEK, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FLUDARABINE PHOSPHATE, FLUOROURACIL, FREAMINE HBC 6.9%, FREAMINE III, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, HYDROXYPROGESTERONE CAPRO, IBANDRONATE SODIUM, IFEX, IFOSFAMIDE, INTRALIPID, INTRON A, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVOCARNITINE, LEVOLEUCOVORIN, LEVOLEUCOVORIN CALCIUM, LIDOCAINE HCL, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE SODIUM,

Prior Authorization Group	B VS. D
	METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MIACALCIN, MITOMYCIN, MITOXANTRONE HCL, MORPHINE SULFATE, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEBUPENT, NEPHRAMINE, NIPENT, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE, PROSOL, RAPAMUNE, RECOMBIVAX HB, SANDIMMUNE, SENSIPAR, SIROLIMUS, TACROLIMUS, TAXOTERE, TENIVAC, TETANUS/DIPHTHERIA TOXOID, TOPOSAR, TOPOTECAN HCL, TOPOTECAN HYDROCHLORIDE, TPN ELECTROLYTES, TRAVASOL, 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	
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, adult T-cell leukemia/lymphoma, mycosis fungoides/sezary syndrome, and primary cutaneous CD30+ T cell lymphoproliferative disorders: relapsed or refractory cutaneous anaplastic large cell lymphoma.
Exclusion Criteria	
Required Medical Information	For ATLL: patient must be a non-responder to first-line therapy and belinostat is used for acute disease or lymphoma.

Prior Authorization Group	BELEODAQ
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	Patient has been diagnosed with active, autoantibody-positive systemic lupus erythematosus (SLE). Patient is currently receiving standard therapy for SLE (e.g., corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) OR patient is not currently receiving standard therapy for SLE because patient tried and had an inadequate response or intolerance to standard therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

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 multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode 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 lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).

Prior Authorization Group	BEXAROTENE
Exclusion Criteria	
Required Medical Information	
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	Pulmonary arterial hypertension (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 chronic myelogenous leukemia (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, accelerated phase, or blast phase CML and meets one of the following: a) has not received prior therapy with a tyrosine kinase inhibitor (TKI) (e.g., imatinib, dasatinib, nilotinib, ponatinib), b) experienced intolerance or toxicity to a prior TKI, or c) experienced resistance to a prior TKI and is negative for T315I mutation, OR 2) 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	BRAFTOVI
Drug Names	BRAFTOVI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	

Prior Authorization Group	BRAFTOVI
Age Restrictions	
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 or breastfeeding 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/Breastfeeding Plan Year
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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	

Prior Authorization Group	CALQUENCE
Drug Names	CALQUENCE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For mantle cell lymphoma: Patient has received at least one prior therapy.
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, non-small lung cancer, papillary, follicular, or Hurthle cell thyroid cancer
Exclusion Criteria	
Required Medical Information	For lung cancer, the disease expresses an RET gene rearrangement
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

Prior Authorization Group	CARBAGLU
Other Criteria	

Prior Authorization Group	CAYSTON
Drug Names	CAYSTON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Pseudomonas aeruginosa is present in airway cultures.
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	
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CEREZYME
Drug Names	CEREZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, type 3 Gaucher disease.
Exclusion Criteria	
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CHANTIX
Drug Names	CHANTIX, CHANTIX CONTINUING MONTH, CHANTIX STARTING MONTH PA

Prior Authorization Group	CHANTIX
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 and the angioedema was refractory to a trial of antihistamine (eg, levocetirizine) for at least one month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CLORAZEPATE
Drug Names	CLORAZEPATE DIPOTASSIUM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the 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) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic 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	

Prior Authorization Group	CLORAZEPATE
Coverage Duration	Anxiety Disorders-4 Months, All other Diagnoses-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.)

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

Prior Authorization Group	CYSTAGON
Required Medical Information	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic 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 cystine 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	
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 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	JADENU, JADENU SPRINKLE
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.

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

Prior Authorization Group	DIAZEPAM
Drug Names	DIAZEPAM, DIAZEPAM INTENSOL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the 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) or a serotonin-norepinephrine reuptake inhibitor (SNRI) 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	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.)

Prior Authorization Group	DICLOFENAC GEL 1%
Drug Names	DICLOFENAC SODIUM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The patient has osteoarthritis pain in joints susceptible to topical treatment such as feet, ankles, knees, hands, wrist, and elbow. AND 2) Treatment with the requested drug is necessary due to intolerance or a contraindication to oral nonsteroidal anti-inflammatory (NSAID) drugs.
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	
Required Medical Information	1) Patient experienced an inadequate treatment response, intolerance, or contraindication 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 2) 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	ENDARI
Drug Names	ENDARI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	5 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 AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	

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), anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis.
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	For all uses except surgery: Pretreatment (no erythropoietin treatment in previous month) hemoglobin (Hgb) is less than 10 g/dL (less than 9 g/dL for anemia in CHF only). Additional requirements for primary myelofibrosis (MF), post-polycythemia vera MF, post-essential thrombocythemia MF: 1) Patient has symptomatic anemia and 2) For initial therapy, pretreatment serum erythropoietin level is less than 500 mU/mL. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery and 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	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. For reauthorizations (patient received erythropoietin in previous month): 1) For all uses except surgery, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy, 2) For anemia in chronic kidney disease, MDS, CHF, RA, HIV, hepatitis C treatment, primary MF, post-polycythemia vera MF, post-essential thrombocythemia MF, or patients whose religious beliefs forbid blood transfusions: current Hgb is less than or equal to 12 g/dL, and 3) For anemia due to myelosuppressive cancer chemotherapy: current Hgb is less than 11 g/dL.

Prior Authorization Group	ERIVEDGE
Drug Names	ERIVEDGE
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	ERLEADA
Drug Names	ERLEADA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
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 and meets one of the following: 1) a high-resolution computed tomography (HRCT) study of the chest or surgical lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, or 2) HRCT study of the chest reveals a possible UIP pattern and the diagnosis is supported either by surgical lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if surgical lung biopsy has not been conducted. For initial and continuation: Esbriet will not be used in combination with Ofev.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	FABRAZYME
Drug Names	FABRAZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is an obligate female carrier with a first degree male relative diagnosed with 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	
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	
Required Medical Information	1) The requested drug is being prescribed for pain associated with cancer, a terminal condition, or pain being managed through hospice or palliative care OR 2) The requested drug 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 AND 3) The patient can safely take the requested dose based on their history of opioid use AND 4) The patient has been evaluated and will be monitored for the development of opioid use disorder
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	
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

Prior Authorization Group	FILGRASTIM
	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	
Prior Authorization Group	FIRAZYR
Drug Names	FIRAZYR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Angiotensin-converting enzyme inhibitor (ACEI)-induced angioedema.
Exclusion Criteria	
Required Medical Information	Firazyr is being requested for the treatment of acute angioedema attacks. For hereditary angioedema (HAE), 1) Diagnostic laboratory testing for HAE has been performed (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels), 2) 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 and 3) For patients with HAE with normal C1 inhibitor, other causes of angioedema have been ruled out (eg, drug induced) and EITHER a) Patient tested positive for the F12 gene mutation OR b) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine (eg, levocetirizine) for at least one month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	FORTEO
Drug Names	FORTEO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following (1. or 2.): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or osteopenia with a high pre-treatment FRAX fracture probability and patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous osteoporosis therapy (i.e., oral bisphosphonates or injectable antiresorptive agents). For primary or hypogonadal osteoporosis in men: patient has a) a history of osteoporotic vertebral or hip fracture OR b) a pre-treatment T-score of less than or equal to -2.5 OR c) osteopenia with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: a) patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral

Prior Authorization Group	FORTEO
	bisphosphonate, AND Patient has a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) osteopenia with a high pre-treatment FRAX fracture probability.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months (lifetime)
Other Criteria	Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20% for any major osteoporotic fracture or greater than or equal to 3% for hip fracture

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

Prior Authorization Group	GATTEX
Drug Names	GATTEX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For initial therapy: Patient was dependent on parenteral support for at least 12 months. 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 multiple sclerosis (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 a known sensitizing EGFR mutation (e.g., EGFR exon 19 deletion or exon 21 (L858R) substitution mutation), AND Gilotrif is prescribed for treatment of recurrent or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GLATIRAMER
Drug Names	GLATIRAMER ACETATE, 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 multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GROWTH HORMONE
Drug Names	NORDITROPIN FLEXPRO
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pediatric patients with closed epiphyses (except in patients with PWS).
Required Medical Information	Pediatric GHD: Younger than 2.5 yrs old, when applicable: Pretreatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. Two and a half yrs old or older: a) Pre-tx 1-year ht velocity more than 2 SD below mean OR b) Pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR Patient is a neonate or was diagnosed with GHD as a neonate. TS: 1) Confirmed by karyotyping AND 2) Pre-treatment height is less than the 5th percentile for age. 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

Prior Authorization Group	GROWTH HORMONE
	GA, AND 2) Did not manifest catch-up growth by age 2. Adult GHD: 1) Failed 2 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 structural) abnormality of the hypothalamus/pituitary/CNS, OR 4) Low pre-tx IGF-1 and failed 1 stimulation test (peak below 5 ng/mL) prior to starting tx.
Age Restrictions	SGA: 2 years of age or older
Prescriber Restrictions	Endocrinologist, Pediatric Endocrinologist, Pediatric nephrologist, Infectious disease specialist, Gastroenterologist/Nutritional support specialist, geneticist.
Coverage Duration	Plan Year
Other Criteria	

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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	HARVONI
Drug Names	HARVONI
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 [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.

Prior Authorization Group	HARVONI
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, neoadjuvant treatment for HER2-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction cancer.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: 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	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, DIGITEK, DIGOX, DIGOXIN, DISOPYRAMIDE PHOSPHATE, ESTRADIOL, FYAVOLV, GUANFACINE ER, JINTELI, MEGESTROL ACETATE, NORETHINDRONE ACETATE/ETH, NORPACE CR, SCOPOLAMINE, TRANSDERM-SCOP
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	

Prior Authorization Group	HIGH RISK MEDICATION
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
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 drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative 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 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 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, IMIPRAMINE HYDROCHLORIDE, 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

Prior Authorization Group	HRM-ANTIDEPRESSANTS TCA
	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 drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative 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. Neuropathic pain for amitriptyline or imipramine: 1) Two non-HRM alternative drugs duloxetine, gabapentin, pregabalin, or lidocaine patch have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs duloxetine, gabapentin, pregabalin, or lidocaine patch AND 3) 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 drug amantadine has not been tried. AND 2) The patient has a contraindication to one non-HRM alternative drug amantadine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative drug amantadine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug amantadine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Parkinson's: 1) Two non-HRM drugs amantadine, carbidopa/levodopa, pramipexole, or ropinirole have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM drugs amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 3) 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 drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone. AND 3) 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 drugs escitalopram, fluoxetine, fluvoxamine, sertraline, venlafaxine or venlafaxine ER have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs escitalopram, fluoxetine, fluvoxamine, sertraline, venlafaxine or venlafaxine ER AND 3) 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	

Prior Authorization Group	HRM-GLYBURIDE
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 drugs glimepiride, glipizide, or metformin have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative 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 drugs glimepiride, glipizide, or metformin have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative 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 HYDROCHLORIDE, 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 drug levocetirizine has not been tried. AND 2) The patient has a contraindication to a non-HRM alternative drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) A non-HRM alternative drug levocetirizine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. For anxiety 1) Two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
Prior Authorization Group	HRM-HYDROXYZINE INJ
Drug Names	HYDROXYZINE HCL

Prior Authorization Group	HRM-HYDROXYZINE INJ
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 drug clorazepate or lorazepam have not been tried AND 2) The patient has a contraindication to one non-HRM alternative drug clorazepate or lorazepam AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative drug clorazepate or lorazepam have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug clorazepate or lorazepam AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient Anxiety: 1) Two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER have been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) 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 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-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 drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative 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 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 drugs cephalexin, 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	PROMETHAZINE HCL, PROMETHAZINE HYDROCHLORID
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 drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal has been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient Urticaria: 1) One non-HRM alternative drug levocetirizine has not been tried. AND 2) The

Prior Authorization Group	HRM-PROMETHAZINE
	patient has a contraindication to one non-HRM alternative drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative drug levocetirizine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative 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	
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-CD/UC/HS START, HUMIRA PEN-PS/UV STARTER
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis.
Exclusion Criteria	
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD (e.g., tofacitinib). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): Patient meets ANY of the following: 1) Inadequate response, intolerance or contraindication to MTX, OR 2) Inadequate response or intolerance to a prior biologic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial at maximum recommended or tolerated dose OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face,

Prior Authorization Group	HUMIRA
	neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) 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. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one immunosuppressant therapy (e.g., corticosteroids, azathioprine, mercaptopurine), OR 2) Intolerance or contraindication to immunosuppressant therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

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	
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) 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.

Prior Authorization Group	IBRANCE
Drug Names	IBRANCE

Prior Authorization Group	IBRANCE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, well-differentiated/dedifferentiated retroperitoneal liposarcoma.
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 chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (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, Philadelphia chromosome positive (Ph+) lymphoblastic lymphoma, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, and melanoma.
Exclusion Criteria	
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (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

Prior Authorization Group	IMATINIB
	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
Other Criteria	

Prior Authorization Group	IMBRUVICA
Drug Names	IMBRUVICA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, lymphoplasmacytic lymphoma.
Exclusion Criteria	
Required Medical Information	
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: the disease is relapsed or unresectable. For thyroid carcinoma: 1) the disease has papillary, Hurthle cell, or follicular histology, and 2) the disease is unresectable or metastatic
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	For non-small cell lung cancer (NSCLC): 1) Patient had EGFR mutation testing and is positive for a known sensitizing EGFR mutation (e.g., EGFR exon 19 deletion OR exon 21 (L858R) substitution mutation), AND 2) Iressa is prescribed for treatment of recurrent or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ISOTRETINOIN
Drug Names	AMNESTEEM, CLARAVIS, ISOTRETINOIN, MYORISAN, ZENATANE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, refractory acne, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), reduction of the development of skin cancer (squamous cell cancers) in high risk patients, transient acantholytic dermatosis (Grover Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ITRACONAZOLE
Drug Names	ITRACONAZOLE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Coccidioidomycosis, Cryptococcosis, Microsporidiosis, Penicilliosis, Sporotrichosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea manuum/Tinea pedis.
Exclusion Criteria	
Required Medical Information	If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed by a fungal diagnostic test.
Age Restrictions	
Prescriber Restrictions	

Prior Authorization Group	ITRACONAZOLE
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	IVIG
Drug Names	BIVIGAM, CARIMUNE NANOFILTERED, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PRIVIGEN
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, Stiff-person syndrome, 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	
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: at least one standard first-line treatment (corticosteroids or immunosuppressants) has been tried but was 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. For Stiff-person syndrome: inadequate response or intolerance to at least one first-line therapy such as a benzodiazepine (eg, diazepam) and/or baclofen unless contraindicated.
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, low-risk, intermediate-risk, accelerated phase, or blast phase myelofibrosis.
Exclusion Criteria	

Prior Authorization Group	JAKAFI
Required Medical Information	
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), AND 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, AND 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 or 100 mg/dl if the patient has coronary heart disease or other atherosclerotic cardiovascular disease, OR diabetes, OR a family history of very early coronary heart disease (less than 45 years of age in men and less than 55 years of age in women), OR current smoker, OR two or more coronary heart disease risk factors, OR lipoprotein(a) levels of 50 mg/dl or greater. 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, or 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, 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, or 2) Simon-Broome Diagnostic Criteria for definite FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL,

Prior Authorization Group	JUXTAPID
	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	
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: 12 months of age or older, Tablets: 6 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Kalydeco will not be used in combination with Orkambi.
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, ergot alkaloids, alprazolam or simvastatin.
Required Medical Information	1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis, OR 2) The requested drug is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Prior Authorization Group	KEYTRUDA
Drug Names	KEYTRUDA
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	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	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	KUVAN
Drug Names	KUVAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For patients who have not yet received a therapeutic trial of Kuvan, the patient's pretreatment, including before dietary management, phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients for whom this is the first treatment after a therapeutic trial of Kuvan: a) The patient must have experienced a reduction in blood phenylalanine level from baseline OR b) the 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

Prior Authorization Group	KYNAMRO
	(see Other Criteria), AND 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, AND 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 or 100 mg/dl if the patient has coronary heart disease or other atherosclerotic cardiovascular disease, OR diabetes, OR a family history of very early coronary heart disease (less than 45 years of age in men and less than 55 years of age in women), OR current smoker, OR two or more coronary heart disease risk factors, OR lipoprotein(a) levels of 50 mg/dl or greater. 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, or 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, or 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	LENVIMA
Drug Names	LENVIMA 10 MG DAILY DOSE, LENVIMA 12MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 4 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE
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, AND 2) disease is iodine-refractory. For renal cell carcinoma

Prior Authorization Group	LENVIMA
	which meets all of the following: 1) Patient has relapsed or advanced disease, 2) Lenvima will be used in combination with everolimus, 3) For disease that is of predominantly clear cell histology, Lenvima will be used as subsequent therapy for disease that has progressed on prior anti-angiogenic therapy (e.g., bevacizumab, sunitinib, sorafenib).
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	Pulmonary arterial hypertension (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	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 colorectal cancer: The disease is unresectable advanced or metastatic. Patient has progressed on treatment with EITHER a) FOLFOXIRI

Prior Authorization Group	LONSURF
	(fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	LUMIZYME
Drug Names	LUMIZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
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 (3.75 mg only), malignant sex cord-stromal tumors (3.75 mg and 11.25 mg), epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer (3.75 mg only), preoperative use for uterine leiomyomata (3.75 mg and 11.25 mg).
Exclusion Criteria	
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 gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay AND b) Assessment of bone age versus chronological age, and 2) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. For endometriosis retreatment patient must meet all of the following: 1) Patient has had a recurrence of symptoms, and 2) Patient will be receiving add-back therapy (eg, norethindrone). For uterine fibroids patient must meet one of the following: 1) Diagnosis of anemia (eg, 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 epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: Lupron (3.75mg only) will be used as a single agent AND disease is

Prior Authorization Group	LUPRON
	persistent or recurrent. For breast cancer (3.75mg only), patient must be premenopausal with hormone receptor positive disease.
Age Restrictions	CPP: Less than 12 years old if female and less than 13 years old if male. Endometriosis, fibroids, breast cancer, stromal tumors, epithelial ovarian/fallopian tube/primary peritoneal cancer: 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year
Other Criteria	

Prior Authorization Group	LYNPARZA
Drug Names	LYNPARZA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For HER2-negative, recurrent or metastatic breast cancer patient must meet both of the following criteria: 1) patient has a deleterious or suspected deleterious germline BRCA mutation, and 2) patient has received prior treatment with chemotherapy or endocrine therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	LYRICA CR
Drug Names	LYRICA CR
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
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

Prior Authorization Group	MAVYRET
	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	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	MEKINIST
Drug Names	MEKINIST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer (NSCLC) with BRAF V600E mutation.
Exclusion Criteria	
Required Medical Information	For unresectable or metastatic melanoma, the tumor is positive for BRAF V600E or V600K mutation and Mekinist is used as a single agent or in combination with dabrafenib. For NSCLC, tumor is positive for BRAF V600E mutation and Mekinist is used in combination with dabrafenib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	MEKTOVI
Drug Names	MEKTOVI
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	MEMANTINE
Drug Names	MEMANTINE HCL, MEMANTINE HYDROCHLORIDE, MEMANTINE HYDROCHLORIDE E, 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. [Note: Common indicators of moderate to severe disease include MMSE scores of less than or equal to 20 and/or when ADLs are significantly impacted.]
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	MYLOTARG
Drug Names	MYLOTARG
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, acute promyelocytic leukemia (APL).
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	

Prior Authorization Group	NAGLAZYME
Drug Names	NAGLAZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of mucopolysaccharidosis VI disease was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing.

Prior Authorization Group	NAGLAZYME
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.
Required Medical Information	Natpara is prescribed to control hypocalcemia associated with hypoparathyroidism. Total serum calcium levels are inadequately controlled despite treatment with calcitriol.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	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	
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 renal cell carcinoma: the patient has relapsed or unresectable disease. For follicular, papillary, or Hurthle cell thyroid carcinoma: the disease is unresectable or metastatic. For medullary thyroid carcinoma: the patient has progressive or metastatic disease. 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, and 2) the patient has FLT3-ITD mutation-positive disease.

Prior Authorization Group	NEXAVAR
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, multiple myeloma in combination with dexamethasone and lenalidomide, relapsed, refractory, or progressive multiple myeloma in combination with dexamethasone
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. 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	
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	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	

Prior Authorization Group	NUEDEXTA
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	
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	OCTREOTIDE
Drug Names	OCTREOTIDE ACETATE, SANDOSTATIN LAR DEPOT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, meningiomas, thymomas and thymic carcinomas, and neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, pancreas and adrenal gland.
Exclusion Criteria	
Required Medical Information	For acromegaly: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) 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. For NETs of the GI tract, thymus, and lung: patient has metastatic or unresectable disease. For adrenal gland NETs: patient has non-adrenocorticotropic hormone (non-ACTH) dependent Cushing's syndrome. For meningiomas: patient has unresectable disease. For thymomas and thymic carcinomas: patient has progressed on at least one prior chemotherapy regimen.
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	ODOMZO
Drug Names	ODOMZO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	

Prior Authorization Group	ODOMZO
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 and meets one of the following: 1) a high-resolution computed tomography (HRCT) study of the chest or surgical lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, or 2) HRCT study of the chest reveals a possible UIP pattern and the diagnosis is supported either by surgical lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if surgical lung biopsy has not been conducted. For initial and continuation: Ofev will not be used in combination with Esbriet.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ONFI
Drug Names	ONFI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	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	Pulmonary arterial hypertension (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

Prior Authorization Group	OPSUMIT
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	
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.
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) 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	
Required Medical Information	The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Orkambi will not be used in combination with Kalydeco.

Prior Authorization Group	OXANDROLONE
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 to enhance growth in patients with Turner's Syndrome.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	PEGASYS
Drug Names	PEGASYS, PEGASYS PROCLICK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myeloproliferative neoplasm (primary myelofibrosis and post-polycythemia vera or post-essential thrombocytopenia myelofibrosis).
Exclusion Criteria	
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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HCV=Criteria will be applied consistent with current AASLD-IDSA guidance. HBV=48 wks.Other=Plan Yr
Other Criteria	

Prior Authorization Group	PHENYLBUTYRATE
Drug Names	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. Requested drug 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	Multiple myeloma: 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, ixazomib).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	PRALUENT
Drug Names	PRALUENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Member must have one of the following conditions (new starts and continuation): 1) Prior clinical atherosclerotic cardiovascular disease (ASCVD) or cardiovascular event (see Other Criteria) OR, 2) Heterozygous familial hypercholesterolemia (HeFH): 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 low density lipoprotein (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. 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 OR intolerance to any dose of two statins. For continuation: Response to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Prior clinical atherosclerotic cardiovascular disease (ASCVD) or cardiovascular event is 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 [TIA], non-cardiac peripheral

Prior Authorization Group	PRALUENT
	arterial disease of presumed atherosclerotic origin, or obstructive coronary artery disease [defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization]. 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 FH: Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL in patients over 16 years of age or total cholesterol greater than 260 mg/dl or LDL-C greater than 155 mg/dl in patients less than 16 years of age and one of the following: a)Tendon xanthomas in the patient, first (parent, sibling or child) or second degree relative (grandparent, uncle or aunt), b)Family history of myocardial infarction in a first degree relative before the age of 60 or in a second degree relative before the age of 50, c) Total cholesterol greater than 290 mg/dl in an adult first or second degree relative, d) Total cholesterol greater than 260 mg/dl in a child, brother, or sister aged younger than 16 years. 3) Dutch Lipid Clinic Network Criteria for definite or probable FH: Total score greater than 5 points.
Prior Authorization Group	PROMACTA
Drug Names	PROMACTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) patient has had an inadequate response or is intolerant to corticosteroids, immunoglobulins or splenectomy, AND b) untransfused platelet count at time of diagnosis is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, platelet (plt) count response to Promacta: a) current plt count is 50,000-200,000/mcL OR b) current plt count is less than 50,000/mcL and sufficient to avoid clinically important bleeding OR c) current plt count is less than 50,000/mcL and patient has not received a maximal dose of Promacta for at least 4 weeks OR d) current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: a) Promacta is used for initiation and maintenance of interferon-based therapy, AND b) untransfused platelet count at time of diagnosis is less than 75,000/mcL. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): 1) For new starts: a) patient has had an inadequate response to immunosuppressive therapy, AND b) untransfused platelet count at time of diagnosis is less than or equal to 30,000/mcL. 2) For continuation of therapy, plt count response to Promacta: 1) 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 less than 50,000/mcL and patient is transfusion-independent OR d) current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.
Age Restrictions	

Prior Authorization Group	PROMACTA
Prescriber Restrictions	
Coverage Duration	HCV:6mo, INITIAL:ITP/AA-6mo, REAUTH:1)ITP/AA APR-Plan Yr, 2)ITP IPR-3mo, 3)AA IPR-16wks
Other Criteria	APR:adequate platelet response (greater than or equal to 50k/mcL), IPR:inadequate platelet response (less than 50k/mcL)

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	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	

Prior Authorization Group	REGRANEX
Drug Names	REGRANEX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	

Prior Authorization Group	RELISTOR INJ
Drug Names	RELISTOR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for opioid-induced constipation in an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care OR 2) The requested drug 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 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	For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease, OR 2) Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab). For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide, AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor (e.g., adalimumab) or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial at maximum recommended or tolerated dose OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis

Prior Authorization Group	REMICADE
	(new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor (e.g., adalimumab). For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a self-injectable TNF inhibitor (e.g., adalimumab). 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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	REVLIMID
Drug Names	REVLIMID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, classical Hodgkin lymphoma, myelofibrosis-associated anemia, 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, adult T-cell leukemia/lymphoma, mycosis fungoides/Sezary syndrome, angioimmunoblastic T-cell lymphoma, peripheral T-cell lymphoma not otherwise specified, enteropathy-associated T-cell lymphoma, primary cutaneous anaplastic large cell lymphoma
Exclusion Criteria	
Required Medical Information	Myelodysplastic syndrome (MDS): Low- to intermediate-1 risk MDS with symptomatic anemia
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

Prior Authorization Group	RITUXAN
	lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma, lymphoblastic lymphoma, Castleman's disease], acute lymphoblastic leukemia (ALL), autoimmune hemolytic anemia, chronic graft-versus-host disease (GVHD), refractory immune or idiopathic thrombocytopenic purpura (ITP), Waldenstrom's macroglobulinemia, lymphoplasmacytic lymphoma, Sjogren syndrome, thrombotic thrombocytopenic purpura, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis.
Exclusion Criteria	
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Rituxan is used in combination with methotrexate (MTX) unless MTX is contraindicated or not tolerated, AND 2) Patient has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab) or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). Hematologic malignancies must be CD20-positive. For Burkitt lymphoma and ALL, Rituxan is used as a component of a chemotherapy regimen. For Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA), Rituxan will be used in combination with glucocorticoids. For multiple sclerosis: 1) Patient has a diagnosis of relapsing remitting multiple sclerosis, AND 2) Patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	
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	

Prior Authorization Group	RUBRACA
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	
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	
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. 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	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	SILDENAFIL
Drug Names	SILDENAFIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (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
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The requested drug is being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis, or infection caused by the non-tuberculous mycobacteria
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, neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, pancreas, and adrenal gland.
Exclusion Criteria	
Required Medical Information	For acromegaly: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) 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. For NETs of the GI tract, thymus, and lung: patient has metastatic or unresectable disease. For adrenal gland NETs: patient has non-adrenocorticotropic hormone (non-ACTH) dependent Cushing's syndrome.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Prior Authorization Group	SOMATULINE DEPOT
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 meets both of the following criteria: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) 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.
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.
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. 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 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) patient is 21 years of age or younger, or b) high or intermediate risk for disease progression, or c) 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	
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 colorectal cancer: The disease is unresectable advanced or metastatic. The patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.
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	
Required Medical Information	For renal cell carcinoma: Either 1) The disease is relapsed or unresectable OR 2) the patient is at high risk of disease recurrence following nephrectomy. For gastrointestinal stromal tumor: the patient experienced disease progression on imatinib or was intolerant to imatinib. For follicular, papillary,

Prior Authorization Group	SUTENT
	or Hurthle cell thyroid carcinoma: the disease is unresectable or metastatic. For medullary thyroid carcinoma: the patient has progressive or metastatic disease. For thymic carcinoma: 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, myelofibrosis
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	SYMDEKO
Drug Names	SYMDEKO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductase regulator (CFTR) gene or the patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Symdeko will not be used in combination with Orkambi or Kalydeco.

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 chronic myeloid leukemia (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).

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

Prior Authorization Group	TADALAFIL (PAH)
Drug Names	ADCIRCA, TADALAFIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (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	TAFINLAR
Drug Names	TAFINLAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer (NSCLC).
Exclusion Criteria	
Required Medical Information	For unresectable or metastatic melanoma, the tumor is positive for BRAF V600E or V600K mutation, and Tafinlar will be used as a single agent or in combination with trametinib. For NSCLC, the tumor is positive for the BRAF V600E mutation and Tafinlar will be used as a single agent or in combination with trametinib.
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

Prior Authorization Group	TAGRISSO
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 non-small cell lung cancer (NSCLC), patient meets any of the following: 1) Tarceva is used as first-line therapy (EGFR mutation discovered prior to first-line chemotherapy or during first-line chemotherapy) or as subsequent therapy following disease progression on first-line therapy with erlotinib AND the patient has recurrent or metastatic NSCLC with a known sensitizing EGFR mutation (e.g., EGFR exon 19 deletion or exon 21 (L858R) substitution mutation) confirmed by EGFR mutation testing, OR 2) Tarceva is used for metastatic NSCLC as maintenance therapy or as second or greater line treatment after progression following at least one prior chemotherapy regimen in patients with an EGFR exon 19 deletion or exon 21 (L858R) substitution mutation confirmed by EGFR mutation testing. For pancreatic cancer, Tarceva is prescribed in combination with gemcitabine for locally advanced unresectable or metastatic pancreatic cancer. For chordoma, Tarceva is prescribed for recurrent disease. For RCC, Tarceva is prescribed 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 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) patient is 18 years of age or younger, b) high or intermediate risk for disease progression, or c) 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 progressed on imatinib, sunitinib or regorafenib.
Age Restrictions	

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

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 Dysphoria in Female-to-Male transgender patients
Exclusion Criteria	
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Requested drug is being prescribed for female-to-male gender reassignment in a patient who is 12 years of age or older and able to make an informed, mature decision to engage in therapy
Age Restrictions	12 years of age or older (applies to gender reassignment only)

Prior Authorization Group	TESTOSTERONE CYPIONATE INJ
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) Requested 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) Requested 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) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 4) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 5) Requested 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, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	THALOMID
Drug Names	THALOMID

Prior Authorization Group	THALOMID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myelofibrosis-related anemia, 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, multicentric Castleman's disease.
Exclusion Criteria	
Required Medical Information	Cachexia: Cachexia must be due to cancer or HIV-infection. Kaposi's sarcoma: The patient has HIV infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TIBSOVO
Drug Names	TIBSOVO
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	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	GLYDO, 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
Other Criteria	1) If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use. 2) 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, ANDROGEL, ANDROGEL PUMP, TESTOSTERONE, TESTOSTERONE PUMP
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who 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.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TREPROSTINIL INJ
Drug Names	REMODULIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (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	TYKERB
Drug Names	TYKERB
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, metastatic CNS lesions from HER2-positive breast cancer.
Exclusion Criteria	
Required Medical Information	For HER2-positive breast cancer, the requested drug will be used in combination with: 1) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane), or 2) capecitabine, or 3) trastuzumab.
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	

Prior Authorization Group	TYSABRI
Required Medical Information	For Crohn's disease (CD), patient must have an inadequate response, intolerance or contraindication to one conventional CD therapy (e.g., corticosteroid, azathioprine, mesalamine) AND one tumor necrosis factor (TNF) inhibitor (e.g., adalimumab).
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	Adult T-cell leukemia/lymphoma: The disease is chronic or smoldering.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	VELCADE
Drug Names	BORTEZOMIB, 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	
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	VENCLEXTA
Drug Names	VENCLEXTA, VENCLEXTA STARTING PACK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, small lymphocytic lymphoma.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	

Prior Authorization Group	VENCLEXTA
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	Pulmonary arterial hypertension (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	
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	VERZENIO
Drug Names	VERZENIO
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	VOSEVI
Drug Names	VOSEVI

Prior Authorization Group	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: the disease is relapsed or unresectable. 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 follicular, papillary, or Hurthle cell thyroid carcinoma: the disease is unresectable or metastatic. For medullary thyroid carcinoma: the patient has progressive or metastatic disease. For dermatofibrosarcoma protuberans: the disease is metastatic.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	VRAYLAR
Drug Names	VRAYLAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: Latuda, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.

Prior Authorization Group	VRAYLAR
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 high-level MET amplification or MET exon 14 skipping mutation, inflammatory myofibroblastic tumors (IMT).
Exclusion Criteria	
Required Medical Information	For (ALK)-positive NSCLC, patient has recurrent or metastatic disease. For ROS1-positive NSCLC, patient has recurrent or metastatic disease. For NSCLC with high-level MET amplification or MET exon 14 skipping mutation, patient has recurrent or metastatic disease. 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	
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), or 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab). For active psoriatic arthritis (new starts only): Patient meets BOTH of the following criteria: 1) Inadequate response to methotrexate (MTX) or other nonbiologic disease-modifying antirheumatic drugs (DMARDs) (e.g., leflunomide, sulfasalazine, etc.) OR a prior biologic DMARD (e.g., adalimumab), and 2) Xeljanz/Xeljanz XR is used in combination with a nonbiologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, etc.). For moderately to severely active ulcerative colitis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to at least one conventional therapy option (e.g., oral aminosalicylates, corticosteroids), or 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Prior Authorization Group	XELJANZ
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 hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy (eg, zoledronic acid, pamidronate).
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	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	
Required Medical Information	For allergic asthma initial therapy: 1)Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2)Patient has baseline IgE level greater than or equal to 30 IU/mL, 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on Xolair treatment since initiation of therapy. 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. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.

Prior Authorization Group	XOLAIR
Age Restrictions	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.
Prescriber Restrictions	
Coverage Duration	Allergic asthma: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year.
Other Criteria	

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	
Required Medical Information	1) The drug is being prescribed for the treatment of 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. Example of a CNS wakefulness promoting drug is armodafinil. Coverage of 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), small cell lung cancer
Exclusion Criteria	
Required Medical Information	For CNS metastases from primary tumor (melanoma), member must meet all of the following: 1) Yervoy was active against the primary tumor (melanoma) AND 2) the disease is recurrent. For small cell lung cancer, Yervoy will be used on combination with nivolumab.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZAVESCA
Drug Names	MIGLUSTAT, ZAVESCA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	18 years of age or 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, non-small cell lung cancer (NSCLC) with BRAF V600E mutation, and hairy cell leukemia.
Exclusion Criteria	

Prior Authorization Group	ZELBORAF
Required Medical Information	For unresectable or metastatic melanoma, the tumor is positive for either BRAF V600E or V600K mutation, and Zelboraf is used as a single agent or in combination with cobimetinib. For NSCLC, the tumor is positive for the BRAF V600E mutation. For refractory hairy cell leukemia, Zelboraf will be used as a single agent for disease progression after non-response to purine analog therapy.
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
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 AASLD-IDSA treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	

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

Prior Authorization Group	ZYDELIG
Drug Names	ZYDELIG

Prior Authorization Group	ZYDELIG
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, relapsed or refractory chronic lymphocytic leukemia (CLL)/ small lymphocytic lymphoma (SLL) as a single agent or in combination with rituximab, refractory, relapsed 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	
Required Medical Information	For relapsed or refractory CLL/SLL, Zydelig is used as a single agent or in combination with rituximab. 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, and 3) Zykadia is prescribed as a single agent. 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	
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 and newly diagnosed metastatic or high-risk locally advanced prostate cancer.
Exclusion Criteria	
Required Medical Information	For metastatic castration-resistant prostate cancer: 1) Patient has been previously treated with Xtandi unless the patient has a contraindication to Xtandi therapy and 2) Zytiga will be used in combination with prednisone. For metastatic or locally advanced prostate cancer: 1) Zytiga will be used in combination with prednisone and concurrent androgen-deprivation therapy. Androgen deprivation therapy is not required in patients who have had bilateral orchiectomy, 2) Disease is newly diagnosed and metastatic, node-positive, high-risk locally advanced, or was previously treated with radical surgery or radiotherapy and is now relapsing with high risk features.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Molina Dual Options Medicare-Medicaid Plan is a health plan that contracts with both Medicare and South Carolina Healthy Connections Medicaid to provide benefits of both programs to enrollees.

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MOLINA HEALTHCARE
Your Extended Family.

Healthy Connections PRIME

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  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
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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.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

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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Healthy Connections PRIME

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Falam	RALRINNAK: Falam (Laizo) `ong na thiam asile, man lo tein `onglettu bawmh le hna`uan seknak nangmah hrangah aum. ah ko aw 1-855-735-5831 (TTY: 711).
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Amharic	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-735-5831 (መስማት ለተሳናቸው: 711).
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