# *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, Lichen planus, Keratosis follicularis (Darier Disease). |
| ***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*** | 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*** | - |
| ***Prescriber Restrictions*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ADEMPAS |
| ***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, neuroendocrine tumor of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), osteosarcoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For breast cancer: 1) The patient has recurrent or metastatic hormone receptor positive, HER2 negative disease, 2) Afinitor will be used in combination with exemestane, and 3) The patient's disease either a) has progressed while on or within 12 months of nonsteroidal aromatase inhibitor therapy, OR b) was previously treated with tamoxifen. For renal cell carcinoma: 1) The disease is relapsed, metastatic or unresectable, and 2) For disease that is of predominantly clear cell histology, disease has progressed on prior antigiogenic therapy (e.g., sunitinib). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | AIMOVIG |
| ***Drug Names*** | AIMOVIG |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial 3 Months, Reauthorization Plan year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ALDURAZYME |
| ***Drug Names*** | ALDURAZYME |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |

| | |
|---|---|
| ***Prior Authorization Group*** | ALDURAZYME |
| ***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, anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***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*** | - |
| ***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 |

| | |
|---|---|
| ***Prior Authorization Group*** | ALPHA1-PROTEINASE INHIBITOR |
| | 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*** | 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 the requested medication. |
| ***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), 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 |

| | |
|---|---|
| ***Prior Authorization Group*** | 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): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, AND 3) 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 maintained a clinical benefit (i.e., fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | For prevention of gout flares: 4 months. Other: Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***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 Shift Work Disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography |
| ***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. |

| | |
|---|---|
| ***Prior Authorization Group*** | AURYXIA |
| ***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, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity. |
| ***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*** | B VS. D |
| ***Drug Names*** | ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ADRUCIL, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMINOSYN II, AMINOSYN-PF, AMINOSYN-PF 7%, AMPHOTERICIN B, APREPITANT, AZACITIDINE, AZATHIOPRINE, BENDEKA, BLEOMYCIN SULFATE, BUDESONIDE, CALCITONIN-SALMON, CALCITRIOL, |

| | |
|---|---|
| ***Prior Authorization Group*** | B VS. D |
| | CARBOPLATIN, CINACALCET HYDROCHLORIDE, CISPLATIN, 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%, CLINOLIPID, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DACARBAZINE, DEPO-PROVERA, DEXRAZOXANE, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HYDROCHLORIDE, DRONABINOL, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FLUOROURACIL, FREAMINE HBC 6.9%, FREAMINE III, FULVESTRANT, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, IBANDRONATE SODIUM, IFEX, IFOSFAMIDE, IMOVAX RABIES (H.D.C.V.), INTRALIPID, INTRON A, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVALBUTEROL HYDROCHLORID, LEVOCARNITINE, LIDOCAINE HCL, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MITOMYCIN, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEBUPENT, NEPHRAMINE, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE, PROGRAF, PROSOL, RABAVERT, RAPAMUNE, RECOMBIVAX HB, SANDIMMUNE, SENSIPAR, SIROLIMUS, TACROLIMUS, TAXOTERE, TDVAX, TENIVAC, TOPOSAR, TOPOTECAN HCL, TOPOTECAN HYDROCHLORIDE, TPN ELECTROLYTES, TRAVASOL, TROPHAMINE, VINBLASTINE SULFATE, 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*** | BALVERSA |
| ***Drug Names*** | BALVERSA |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |

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

| | |
|---|---|
| ***Prior Authorization Group*** | BERINERT |
| ***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), chronic or smoldering adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BOSENTAN |
| ***Drug Names*** | BOSENTAN, 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 |

| | |
|---|---|
| ***Prior Authorization Group*** | BOSENTAN |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BOSULIF |
| ***Drug Names*** | BOSULIF |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, relapsed/refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Diagnosis of CML was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) Patient has chronic phase CML, OR 2) Patient has accelerated or blast phase CML, OR 3) Patient received a hematopoietic stem cell transplant. |
| ***Age Restrictions*** | - |
| ***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*** | - |
| ***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*** | 4 years of age or older (tablets and oral solution). |
| ***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 requested drug is being prescribed for the treatment of opioid dependence AND 2) If the patient is pregnant or breastfeeding and being |

| | |
|---|---|
| ***Prior Authorization Group*** | BUPRENORPHINE |
| | prescribed the requested drug for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) If the requested drug is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) If the requested drug is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 12 Months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | BUPRENORPHINE PATCH |
| ***Drug Names*** | BUPRENORPHINE, BUTRANS |
| ***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, sickle cell disease, a terminal condition, or pain being managed through 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 [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] 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*** | CABOMETYX |
| ***Drug Names*** | CABOMETYX |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CALCIPOTRIENE |
| ***Drug Names*** | CALCIPOTRIENE, CALCITRENE, ENSTILAR |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |

| | |
|---|---|
| ***Prior Authorization Group*** | CALCIPOTRIENE |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is being prescribed for the treatment of psoriasis AND<br>2) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic topical steroid. |
| ***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*** | - |
| ***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 and differentiated thyroid carcinoma: papillary, follicular, Hurthle cell. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): the requested drug is used for NSCLC with RET gene rearrangements. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

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

| | |
|---|---|
| ***Prior Authorization Group*** | CAYSTON |
| ***Drug Names*** | CAYSTON |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Pseudomonas aeruginosa is present in the patient's airway cultures OR the patient has a history of pseudomonas aeruginosa infection or colonization in the airways. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | 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 |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CHANTIX |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 Months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CLOMIPRAMINE |
| ***Drug Names*** | CLOMIPRAMINE HCL |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, Depression, Panic Disorder. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) Obsessive-Compulsive Disorder (OCD) or Panic Disorder AND 2) The patient has experienced an inadequate treatment response, intolerance or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI), mirtazapine OR 3) Depression AND 4) The patient has experienced an inadequate treatment response, intolerance or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI), mirtazapine, bupropion. |
| ***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, 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 OR 4) For the short-term relief of the symptoms of anxiety 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*** | Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year |

| | |
|---|---|
| ***Prior Authorization Group*** | CLORAZEPATE |
| ***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*** | - |
| ***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, non-small lung cancer and differentiated thyroid carcinoma: papillary, follicular, Hurthle cell. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer (NSCLC): The requested drug is used for NSCLC with RET gene rearrangements. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | COPIKTRA |
| ***Drug Names*** | COPIKTRA |
| ***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*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | COTELLIC |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | CYSTAGON |
| ***Drug Names*** | CYSTAGON |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Diagnosis of nephropathic cystinosis was confirmed by the presence of increased 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*** | DAURISMO |
| ***Drug Names*** | DAURISMO |
| ***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*** | DEFERASIROX |
| ***Drug Names*** | JADENU, JADENU SPRINKLE |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | DEFERASIROX |
| ***Required Medical Information*** | For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | DEMSER |
| ***Drug Names*** | DEMSER |
| ***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*** | DESVENLAFAXINE |
| ***Drug Names*** | DESVENLAFAXINE ER |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following: a generic serotonin and norepinephrine reuptake inhibitor (SNRI), a generic selective serotonin reuptake inhibitor (SSRI), mirtazapine, bupropion. |
| ***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, 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 OR 5) For the short-term relief of the symptoms of anxiety AND 6) The benefit of therapy |

| | |
|---|---|
| ***Prior Authorization Group*** | DIAZEPAM |
| | with the prescribed medication outweighs the potential risk in a patient 65 years of age or older. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Short-term relief anxiety-1 Month, 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, or 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*** | EMGALITY |
| ***Drug Names*** | EMGALITY |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial 3 Months, Reauthorization Plan year |
| ***Other Criteria*** | - |
| ***Prior Authorization Group*** | EMSAM |
| ***Drug Names*** | EMSAM |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |

| | |
|---|---|
| ***Prior Authorization Group*** | EMSAM |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (e.g., venlafaxine), selective serotonin reuptake inhibitors (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 [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney 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*** | EPIDIOLEX |
| ***Drug Names*** | EPIDIOLEX |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | EPIDIOLEX |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***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) 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 500mU/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 CKD, 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. |

| | |
|---|---|
| ***Prior Authorization Group*** | ERIVEDGE |
| ***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 continuation: The patient does not have a known etiology for interstitial lung disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | FABRAZYME |
| ***Drug Names*** | FABRAZYME |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Diagnosis of Fabry disease 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. |

| | |
|---|---|
| ***Prior Authorization Group*** | FABRAZYME |
| ***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, sickle cell disease, a terminal condition, or pain being managed through 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 [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] 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*** | FETZIMA |
| ***Drug Names*** | FETZIMA, FETZIMA TITRATION PACK |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | FETZIMA |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | FIRAZYR |
| ***Drug Names*** | FIRAZYR, ICATIBANT ACETATE |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug is being used for the treatment of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month. |
| ***Age Restrictions*** | 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: Patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral 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*** | Partial-onset seizures - 4 years of age or older. Primary generalized tonic-clonic seizures - 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 teduglutide 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*** | - |
| ***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 has a known sensitizing epidermal growth factor receptor (EGFR) mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | GILOTRIF |
| ***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*** | GRANIX |
| ***Drug Names*** | GRANIX |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), stem cell transplantation related indications, acute lymphocytic leukemia (ALL), acute myeloid leukemia (AML), severe chronic neutropenia (congenital, cyclic, or idiopathic), myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplantation. |
| ***Exclusion Criteria*** | Use of the requested product within 24 hours prior to or following chemotherapy. |
| ***Required Medical Information*** | For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | GROWTH HORMONE |
| ***Drug Names*** | GENOTROPIN, GENOTROPIN MINIQUICK |
| ***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: 1) Younger than 2.5 yrs old, when applicable: a) Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2) 2.5 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: 1) Failed 2 stimulation |

| | |
|---|---|
| ***Prior Authorization Group*** | GROWTH HORMONE |
| | tests (peak below 10 ng/mL) prior to starting treatment, OR 2) Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) Patient is a neonate or was diagnosed with GHD as a neonate. TS: 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 GA, AND 2) Did not manifest catch-up growth by age 2. Adult GHD: 1) Failed 2 stimulation tests (peak below 5 ng/mL) or test with Macrilen (peak below 2.8 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 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*** | Renewal for pediatric GHD, TS, SGA, and adult GHD: patient is experiencing improvement. |

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

| | |
|---|---|
| ***Prior Authorization Group*** | HARVONI |
| ***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 |

| | |
|---|---|
| ***Prior Authorization Group*** | HARVONI |
| | HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Criteria applied consistent with current AASLD-IDSA guidance.Reminder for 8wk option if appropriate. |
| ***Other Criteria*** | - |
| | |
| ***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*** | HERCEPTIN HYLECTA |
| ***Drug Names*** | HERCEPTIN HYLECTA |
| ***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*** | 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 |

| | |
|---|---|
| ***Prior Authorization Group*** | HETLIOZ |
| | (e.g., nonfunctioning retinas) and 3) unable to perceive light in both eyes. For patients currently on therapy with the requested medication, 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: 6 Months, Renewal: Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | HIGH RISK MEDICATION |
| ***Drug Names*** | CYPROHEPTADINE HCL, DIGITEK, DIGOX, DIGOXIN, GUANFACINE ER, SCOPOLAMINE, TRANSDERM-SCOP |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 70 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 70 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-ANTIPARKINSON |
| ***Drug Names*** | BENZTROPINE MESYLATE, TRIHEXYPHENIDYL HCL, TRIHEXYPHENIDYL HYDROCHLO |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-ANTIPARKINSON |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | This Prior Authorization requirement only applies to patients 70 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 (extrapyramidal symptoms): 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 alternative 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 alternative 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-GLYBURIDE |
| ***Drug Names*** | GLYBURIDE, GLYBURIDE MICRONIZED, GLYBURIDE/METFORMIN HYDRO |
| ***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 70 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 70 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 extended-release 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 extended-release AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-HYDROXYZINE INJ |
| ***Drug Names*** | HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE |
| ***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 70 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 has 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 has 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 |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-HYDROXYZINE INJ |
| | medication benefits outweigh potential risks for this patient Anxiety: 1) Two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release 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 extended-release 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, ZALEPLON, 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 70 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 risks for this patient 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 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 70 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 |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-NITROFURANTOIN |
| | 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 70 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 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 HYDROCHLO, METHOCARBAMOL |

| | |
|---|---|
| ***Prior Authorization Group*** | HRM-SKELETAL MUSCLE RELAXANTS |
| ***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 70 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): 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): 1) Inadequate response, intolerance or contraindication to MTX, 2) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR 2) 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, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or 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*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | HUMIRA |
| ***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 |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, well-differentiated/dedifferentiated 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*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ICLUSIG |
| ***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*** | - |
| ***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, 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), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor (eg, dasatinib, nilotinib, bosutinib, ponatinib). For melanoma, c-Kit mutation is positive. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | IMBRUVICA |
| ***Drug Names*** | IMBRUVICA |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, hairy cell leukemia, and lymphoplasmacytic lymphoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For mantle cell lymphoma: 1) the requested medication will be used in a patient who has received at least one prior therapy, OR 2) the requested medication will be used in combination with rituximab as pretreatment to |

| | |
|---|---|
| ***Prior Authorization Group*** | IMBRUVICA |
| | induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen. For gastric MALT lymphoma and non-gastric MALT lymphoma: 1) disease is recurrent, refractory, or progressive, AND 2) the requested medication will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested medication will be used as a single agent for disease progression. |
| ***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*** | - |
| ***Required Medical Information*** | Must meet all of the following prior to beginning therapy with the requested medication (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) provocative growth hormone test showing a normal or elevated growth hormone level. For renewal, patient is experiencing improvement. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***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, metastatic, or unresectable. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | INREBIC |
| ***Drug Names*** | INREBIC |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | INREBIC |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | IR BEFORE ER |
| ***Drug Names*** | HYSINGLA ER, METHADONE HCL, METHADONE HCL INTENSOL, MORPHINE SULFATE ER, NUCYNTA ER, OXYCONTIN |
| ***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, sickle cell disease, a terminal condition, or pain being managed through 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 [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] 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 AND 5) The request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR 6) The patient has severe continuous pain and has received an immediate-release opioid for at least one week |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | IRESSA |
| ***Drug Names*** | IRESSA |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For non-small cell lung cancer, patient has a known sensitizing EGFR mutation. |
| ***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), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis |

| | |
|---|---|
| ***Prior Authorization Group*** | ISOTRETINOIN |
| | (Grover's 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*** | - |
| ***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, PANZYGA, 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. 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. PRCA is secondary to parvovirus B19 infection. |

| | |
|---|---|
| ***Prior Authorization Group*** | IVIG |
| ***Age Restrictions*** | For pediatric HIV infection: age 12 years or younger. |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

| | |
|---|---|
| ***Prior Authorization Group*** | JAKAFI |
| ***Drug Names*** | JAKAFI |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, low-risk, intermediate-risk, accelerated phase, or blast phase myelofibrosis, polycythemia vera in patients with inadequate response or intolerance to interferon therapy (interferon alfa-2b, peginterferon alfa-2a, or peginterferon alfa-2b). |
| ***Exclusion Criteria*** | - |
| ***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 the requested drug, 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 the requested drug, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated LDL-C greater than 100 mg/dl (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). 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*** | - |
| ***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 |

| | |
|---|---|
| ***Prior Authorization Group*** | JUXTAPID |
| | 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 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 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 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 family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 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 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. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation. |
| ***Age Restrictions*** | 6 months of age or older. |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | The requested drug will not be used in combination with lumacaftor/ivacaftor or tezacaftor/ivacaftor. |
| ***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 |

| | |
|---|---|
| ***Prior Authorization Group*** | KETOCONAZOLE |
| | 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, malignant pleural mesothelioma, Merkel cell carcinoma. |
| ***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. |

| | |
|---|---|
| ***Prior Authorization Group*** | KUVAN |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment, including before dietary management, phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced a reduction in blood phenylalanine level of greater than or equal to 30 percent from baseline OR the patient has demonstrated an improvement in neuropsychiatric symptoms. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Initial: 2 months. All others: Plan Year. |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | KYNAMRO |
| ***Drug Names*** | KYNAMRO |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, 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 the requested drug, patient is/was experiencing an inadequate response to such combination regimen, as demonstrated by treated LDL-C greater than 100 mg/dl (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). 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*** | - |
| ***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 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 FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor |

| | |
|---|---|
| ***Prior Authorization Group*** | KYNAMRO |
| | mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for 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 family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 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, medullary thyroid carcinoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |
| ***Prior Authorization Group*** | LETAIRIS |
| ***Drug Names*** | AMBRISENTAN |
| ***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]). |

| | |
|---|---|
| ***Prior Authorization Group*** | LIDOCAINE PATCHES |
| ***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 (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*** | LORBRENA |
| ***Drug Names*** | LORBRENA |
| ***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*** | 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 and 11.25 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 and 11.25 mg), 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 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 10 g/dL), OR 2) the requested drug will be used prior to surgery for uterine fibroids. |
| ***Age Restrictions*** | CPP: Less than 12 years old if female and less than 13 years old if male. |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year |
| ***Other Criteria*** | For prostate cancer: Use as neoadjuvant therapy prior to radical prostatectomy is not approvable. |

| | |
|---|---|
| ***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*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | LYRICA CR |
| ***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 [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney 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*** | 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. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For melanoma, tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |

| | |
|---|---|
| ***Prior Authorization Group*** | MEKINIST |
| ***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 HCL TITRATION P, MEMANTINE HYDROCHLORIDE, MEMANTINE HYDROCHLORIDE E |
| ***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 edit only applies to patients less than 30 years of age. |

| | |
|---|---|
| ***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. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NAGLAZYME |
| ***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) and expected to recover from the hypoparathyroidism. |
| ***Required Medical Information*** | - |
| ***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 requested medication is initiated within two years after completing adjuvant trastuzumab based therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NEUPOGEN |
| ***Drug Names*** | 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), stem cell transplantation-related indications, myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplantation. |
| ***Exclusion Criteria*** | Use of the requested product within 24 hours prior to or following chemotherapy or radiotherapy. |
| ***Required Medical Information*** | For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 6 months |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NEXAVAR |
| ***Drug Names*** | NEXAVAR |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, acute myeloid leukemia, soft tissue sarcoma subtypes: angiosarcoma, desmoid tumors (aggressive fibromatosis), gastrointestinal stromal tumor (GIST), medullary thyroid carcinoma, osteosarcoma, chordoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma: the patient has relapsed, metastatic, or unresectable disease. For thyroid carcinoma: histology is follicular, papillary, Hurthle cell or medullary. For acute myeloid leukemia: 1) the disease is relapsed or refractory, and 2) the patient has FLT3-ITD mutation-positive disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | NINLARO |
| ***Drug Names*** | NINLARO |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug will be used in combination with lenalidomide and dexamethasone, pomalidomide and dexamethasone, or dexamethasone therapy. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

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

| | |
|---|---|
| ***Prior Authorization Group*** | NORTHERA |
| ***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. The requested drug 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. |

| | |
|---|---|
| ***Prior Authorization Group*** | NUBEQA |
| ***Drug Names*** | NUBEQA |
| ***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*** | 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*** | - |
| ***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*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | OCTREOTIDE |
| ***Drug Names*** | OCTREOTIDE ACETATE |
| ***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 meningiomas: patient has unresectable disease. |
| ***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*** | - |
| ***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*** | For idiopathic pulmonary fibrosis: 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 idiopathic pulmonary fibrosis continuation: The patient does not have a known etiology for interstitial lung disease. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | OFEV |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ONFI |
| ***Drug Names*** | CLOBAZAM |
| ***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 |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ORAL-INTRANASAL FENTANYL |
| ***Drug Names*** | FENTANYL CITRATE, FENTANYL CITRATE ORAL TRA, FENTORA |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 1) The requested drug is indicated for the treatment of breakthrough CANCER related pain only. The requested 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 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.] |
| ***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*** | The requested drug will not be used in combination with ivacaftor or tezacaftor/ivacaftor. |

| | |
|---|---|
| ***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 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 (essential thrombocythemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocythemia myelofibrosis). |
| ***Exclusion Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | PEGASYS |
| ***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 substitutions where applicable, liver and kidney 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. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | PIQRAY |
| ***Drug Names*** | PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | 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 (i.e., |

| | |
|---|---|
| ***Prior Authorization Group*** | POMALYST |
| | 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*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | PROMACTA |
| ***Drug Names*** | PROMACTA |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) patient has had an inadequate response or is intolerant to corticosteroids, immunoglobulins or splenectomy, AND b) untransfused platelet count at any point prior to the requested medication 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 the requested drug: a) current plt count is less than or equal to 200,000/mcL OR b) 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: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): 1) For continuation of therapy, plt count response to the requested drug: a) current plt count is 50,000-200,000/mcL, OR b) current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR c) current plt count is 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*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | HCV:6mo, INITIAL: ITP/AA-6mo, REAUTH: 1) ITP/AA APR-Plan Yr, 2) AA IPR-16wks |

| | |
|---|---|
| ***Prior Authorization Group*** | PROMACTA |
| ***Other Criteria*** | APR: adequate platelet response (greater than 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*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | RELISTOR INJ |
| ***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 tumor necrosis factor (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): 1) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR 2) 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, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab). For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a |

| | |
|---|---|
| ***Prior Authorization Group*** | REMICADE |
| | self-injectable tumor necrosis factor (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/nodal 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 and 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, non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, Castleman's disease, AIDS-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary CNS lymphoma, leptomeningeal |

| | |
|---|---|
| ***Prior Authorization Group*** | RITUXAN |
| | metastases from lymphomas, acute lymphoblastic leukemia, 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) The requested medication 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 Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): The requested medication 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*** | ROZLYTREK |
| ***Drug Names*** | ROZLYTREK |
| ***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*** | RUBRACA |
| ***Drug Names*** | RUBRACA |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | RYDAPT |
| ***Drug Names*** | RYDAPT |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For newly diagnosed FLT3 mutation-positive acute myeloid leukemia (AML), the requested medication 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*** | 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. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | SILDENAFIL |
| ***Drug Names*** | SILDENAFIL CITRATE |
| ***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*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | SILDENAFIL |
| ***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. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy. |

| | |
|---|---|
| ***Prior Authorization Group*** | SOMAVERT |
| ***Drug Names*** | SOMAVERT |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | Patient 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*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | SOMAVERT |
| ***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*** | 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 chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (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, progressive GIST. |
| ***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, |

| | |
|---|---|
| ***Prior Authorization Group*** | SUTENT |
| | solitary fibrous tumor, hemangiopericytoma, chordoma (bone cancer), thymic carcinoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma: Either 1) The disease is relapsed, metastatic, or unresectable, OR 2) The patient is at high risk of disease recurrence following nephrectomy. |
| ***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, polycythemia vera, essential thrombocythemia. |
| ***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*** | 6 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*** | SYMPAZAN |
| ***Drug Names*** | SYMPAZAN |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | SYMPAZAN |
| ***Age Restrictions*** | 2 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***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). |
| ***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, brain metastases from melanoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For melanoma (including brain metastases), tumor is positive for a BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation). For NSCLC, tumor is positive for a BRAF V600 activating mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TAGRISSO |
| ***Drug Names*** | TAGRISSO |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, EGFR mutation-positive recurrent or metastatic non-small cell lung cancer, brain metastases if active against primary tumor (EGFR T790M mutation-positive non-small cell lung cancer). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

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

| | |
|---|---|
| ***Prior Authorization Group*** | TARCEVA |
| ***Drug Names*** | ERLOTINIB HYDROCHLORIDE, 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, patient has a known sensitizing EGFR mutation. For pancreatic cancer, the disease is locally advanced, unresectable, or metastatic. |
| ***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, the 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*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TAZAROTENE |
| ***Drug Names*** | TAZAROTENE, TAZORAC |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For plaque psoriasis, the requested drug is being prescribed to treat 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 transgender male 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 gender dysphoria in a transgender male 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 dysphoria only) |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TESTOSTERONE ENANTHATE INJ |
| ***Drug Names*** | TESTOSTERONE ENANTHATE |

| | |
|---|---|
| ***Prior Authorization Group*** | TESTOSTERONE ENANTHATE INJ |
| ***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 OR 3) 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 4) 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 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 |
| ***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. |

| | |
|---|---|
| ***Prior Authorization Group*** | THALOMID |
| ***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*** | 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*** | 1) The requested drug is being used for topical anesthesia, 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are FDA-approved for topical use |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 3 Months |

| | |
|---|---|
| ***Prior Authorization Group*** | TOPICAL LIDOCAINE |
| ***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 TESTOSTERONES |
| ***Drug Names*** | ANDRODERM, 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*** | Use as neoadjuvant therapy prior to radical prostatectomy is not approvable. |

| | |
|---|---|
| ***Prior Authorization Group*** | TREPROSTINIL INJ |
| ***Drug Names*** | REMODULIN, TREPROSTINIL |

| | |
|---|---|
| ***Prior Authorization Group*** | TREPROSTINIL INJ |
| ***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*** | TRIENTINE |
| ***Drug Names*** | TRIENTINE HYDROCHLORIDE |
| ***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*** | TURALIO |
| ***Drug Names*** | TURALIO |
| ***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*** | 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*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TYKERB |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | TYMLOS |
| ***Drug Names*** | TYMLOS |
| ***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) |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | 24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide) |
| ***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*** | VALCHLOR |
| ***Drug Names*** | VALCHLOR |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, chronic or smoldering adult T-cell leukemia/lymphoma, mycosis fungoides, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***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*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VELCADE |
| ***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, mantle cell lymphoma. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VENTAVIS |
| ***Drug Names*** | VENTAVIS |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | 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*** | - |
| ***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*** | VIGABATRIN |
| ***Drug Names*** | VIGABATRIN, VIGADRONE |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For complex partial seizures (CPS): patient had an inadequate response to at least 2 alternative therapies for CPS (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine). |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | VITRAKVI |
| ***Drug Names*** | VITRAKVI |
| ***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*** | VIZIMPRO |
| ***Drug Names*** | VIZIMPRO |
| ***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 |
| ***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 [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney 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*** | VOTRIENT |
| ***Drug Names*** | VOTRIENT |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma, ovarian cancer (epithelial ovarian, fallopian tube, or primary peritoneal). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For renal cell carcinoma: The disease is relapsed, metastatic, 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, head/neck sarcoma. |
| ***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: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone. |
| ***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 IMT, the tumor is ALK-positive. |
| ***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) The requested drug 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 |
| ***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) or there is a clinical reason to avoid IV bisphosphonate therapy. |
| ***Age Restrictions*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | XGEVA |
| ***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 hepatic encephalopathy 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 the requested drug 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. |
| ***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*** | XOSPATA |
| ***Drug Names*** | XOSPATA |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | 18 years of age or older |
| ***Prescriber Restrictions*** | - |
| ***Coverage Duration*** | Plan Year |
| ***Other Criteria*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | XPOVIO |
| ***Drug Names*** | XPOVIO 100 MG ONCE WEEKLY, XPOVIO 60 MG ONCE WEEKLY, XPOVIO 80 MG ONCE WEEKLY, XPOVIO 80 MG TWICE WEEKLY |
| ***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*** | XTANDI |
| ***Drug Names*** | XTANDI |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | The requested drug will be used to treat prostate cancer. |
| ***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 AND 2) The patient experienced an inadequate treatment response or intolerance to at least one CNS stimulant drug and one CNS promoting wakefulness drug OR 3) the patient has a contraindication to at least one CNS stimulant drug and one 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) |

| | |
|---|---|
| ***Prior Authorization Group*** | XYREM |
| | 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 (sodium oxybate), then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy. |
| ***Prior Authorization Group*** | ZAVESCA |
| ***Drug Names*** | MIGLUSTAT |
| ***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 indications not otherwise excluded from Part D, brain metastases from melanoma, non-small cell lung cancer, hairy cell leukemia, and thyroid carcinoma (papillary, follicular, and Hurthle). |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | For melanoma (including brain metastases), tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation). For non-small cell lung cancer, tumor is positive for the BRAF V600E mutation. For thyroid carcinoma the tumor is positive for BRAF mutation. |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ZELBORAF |
| ***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) |
| ***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 substitutions (eg, NS5A polymorphisms) where applicable, liver and kidney 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 |
| ***Covered Uses*** | All FDA-approved indications not otherwise excluded from Part D, relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), refractory, relapsed or progressive follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma]. |
| ***Exclusion Criteria*** | - |
| ***Required Medical Information*** | - |
| ***Age Restrictions*** | - |
| ***Prescriber Restrictions*** | - |

| | |
|---|---|
| ***Prior Authorization Group*** | ZYDELIG |
| ***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 non-small cell lung cancer (NSCLC), the requested medication is used for the treatment of recurrent or metastatic ALK-positive NSCLC. For inflammatory myofibroblastic tumor, the tumor is ALK-positive. |
| ***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*** | ABIRATERONE ACETATE, 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: The requested drug will be used in combination with prednisone. For castration-sensitive metastatic or locally advanced prostate cancer: 1) The requested drug 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 STAR+PLUS MMP is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

You can get this document for free in other formats, such as large print, braille, or audio. Call (866) 856-8699, TTY/TDD: 711, Monday – Friday, 8 a.m. to 8 p.m., local time. The call is free.