



# **ATRIO Health Plans**

## **2019 Prior Authorization Requirements PPO Plans**

**Effective: 9/1/2019  
Last Updated: 8/21/2019**

# ABALOPARATIDE

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## Products Affected

- TYMLOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., ALENDRONATE, RISEDRONATE, IBANDRONATE).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ABATACEPT IV

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## Products Affected

- ORENCIA (WITH MALTOSE)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL.

# ABATACEPT SQ

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## Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA) PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL.

# ABEMACICLIB

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## Products Affected

- VERZENIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TRIAL OF OR CONTRAINDICATION TO IBRANCE (PALBOCICLIB) REQUIRED WHEN REQUEST IS FOR COMBINATION THERAPY WITH FULVESTRANT FOR HORMONE RECEPTOR (HR)-POSITIVE, HER2-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER.

# ABIRATERONE

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## Products Affected

- ZYTIGA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ABIRATERONE SUBMICRONIZED

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## Products Affected

- YONSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PREVIOUS TRIAL OF OR CONTRAINDICATION TO THE FORMULARY PREFERRED AGENT ZYTIGA (ABIRATERONE ACETATE).



# ACALABRUTINIB

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## Products Affected

- CALQUENCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ADALIMUMAB

## Products Affected

- HUMIRA
- HUMIRA PEDIATRIC CROHNS START
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL FOR RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS, HIDRADENITIS SUPPURATIVA, OR UVEITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.

PA Criteria	Criteria Details
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	<p>INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), AND PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL OF FORMULARY AGENTS NOT REQUIRED. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD) AND ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE.</p>

# AFATINIB DIMALEATE

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## Products Affected

- GILOTRIF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ALECTINIB

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## Products Affected

- ALECENSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ALEMTUZUMAB - LEMTRADA

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## Products Affected

- LEMTRADA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 1 MONTH. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	RENEWAL REQUESTS FOR ALEMTUZUMAB REQUIRE THAT AT LEAST 12 MONTHS HAVE ELAPSED SINCE THE PATIENT RECEIVED THE MOST RECENT COURSE OF LEMTRADA.

# ALIROCUMAB

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## Products Affected

- PRALUENT PEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	PA Criteria: Pending CMS Approval
<b>Exclusion Criteria</b>	PA Criteria: Pending CMS Approval
<b>Required Medical Information</b>	PA Criteria: Pending CMS Approval
<b>Age Restrictions</b>	PA Criteria: Pending CMS Approval
<b>Prescriber Restrictions</b>	PA Criteria: Pending CMS Approval
<b>Coverage Duration</b>	PA Criteria: Pending CMS Approval
<b>Other Criteria</b>	PA Criteria: Pending CMS Approval

# ALPELISIB

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## Products Affected

- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# AMANTADINE

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## Products Affected

- GOCOVRI ORAL  
CAPSULE, EXTENDED RELEASE  
24HR 137 MG, 68.5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ANAKINRA

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## Products Affected

- KINERET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RHEUMATOID ARTHRITIS (RA) RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL.

# APALUTAMIDE

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## Products Affected

- ERLEADA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	NON METASTATIC CASTRATION RESISTANT PROSTATE CANCER: THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS) AND MEETS ONE OF THE FOLLOWING: (1) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST OR (2) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY.

# APREMILAST

## Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI.

# ASFOTASE

## Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION, SERUM ALKALINE PHOSPHATASE (ALP) LEVEL, SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS, URINE PHOSPHOETHANOLAMINE (PEA) LEVEL, RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP)
Age Restrictions	PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP): 6 MONTHS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET. JUVENILE-ONSET HYPOPHOSPHATASIA (HPP): 18 YEARS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET.
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, A GENETICIST, OR A METABOLIC SPECIALIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: FOR PATIENTS WITH PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.) RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.) PRESENCE OF TWO OR MORE OF THE FOLLOWING: RACHITIC CHEST DEFORMITY, CRANIOSYNOSTOSIS (PREMATURE CLOSURE OF SKULL BONES), DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, NEPHROCALCINOSIS, OR HISTORY OF ELEVATED SERUM CALCIUM. HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. FOR PATIENTS WITH JUVENILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-</p>

PA Criteria	Criteria Details
	<p>PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.)URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.)RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, OSTEOMALACIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.)PRESENCE OF TWO OR MORE OF THE FOLLOWING:RACHITIC DEFORMITIES (RACHITIC CHEST, BOWED LEGS, KNOCK-KNEES),PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, OR HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. STRENSIQ WILL NOT BE APPROVED FOR THE FOLLOWING PATIENTS: PATIENTS CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE [E.G., BONIVA (IBANDRONATE), FOSAMAX (ALENDRONATE), ACTONEL (RISEDRONATE)], PATIENTS WITH SERUM CALCIUM OR PHOSPHATE LEVELS BELOW THE NORMAL RANGE, PATIENTS WITH A TREATABLE FORM OF RICKETS. RENEWAL: PATIENT HAS EXPERIENCED AN IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HYPOPHOSPHATASIA (HPP) (E.G., IMPROVEMENT OF THE IRREGULARITY OF THE PROVISIONAL ZONE OF CALCIFICATION, PHYSEAL WIDENING, METAPHYSEAL FLARING, RADIOLUCENCIES, PATCHY OSTEOSCLEROSIS, RATIO OF MID-DIAPHYSEAL CORTEX TO BONE THICKNESS, GRACILE BONES, BONE FORMATION AND FRACTURES.</p>

# ASPARAGINASE

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## Products Affected

- ONCASPAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 MONTHS
<b>Other Criteria</b>	



# ATEZOLIZUMAB

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## Products Affected

- TECENTRIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# AVATROMBOPAG

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## Products Affected

- DOPTELET (10 TAB PACK)
- DOPTELET (15 TAB PACK)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	PATIENT HAS A PLANNED PROCEDURE 10 TO 13 DAYS AFTER INITIATION OF DOPTELET. PATIENT IS NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G. ROMIPLOSTIM, ELTROMBOPAG, ETC.).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, OR ENDOCRINOLOGIST.
<b>Coverage Duration</b>	1 MONTH
<b>Other Criteria</b>	

# AVELUMAB

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## Products Affected

- BAVENCIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# AXITINIB

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## Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TRIAL OF AT LEAST ONE SYSTEMIC THERAPY FOR THE TREATMENT OF RCC SUCH AS NEXAVAR (SORAFENIB), TORISEL (TEMSIROLIMUS), SUTENT (SUNITINIB), VOTRIENT (PAZOPANIB), OR AVASTIN (BEVACIZUMAB) IN COMBINATION WITH INTERFERON.

# BARICITINIB

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## Products Affected

- OLUMIANT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL.

# BECAPLERMIN

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## Products Affected

- REGRANEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	NON-DIABETIC ULCERS, NEOPLASM AT APPLICATION SITE, PRESSURE OR VENOUS STASIS ULCERS AND ULCERS THAT DO NOT EXTEND THROUGH THE DERMIS.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST, PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC OR INFECTIOUS DISEASE SPECIALIST.
<b>Coverage Duration</b>	3 MONTHS
<b>Other Criteria</b>	

# BEDAQUILINE FUMARATE

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## Products Affected

- SIRTURO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 WEEKS
<b>Other Criteria</b>	SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS.

# BELIMUMAB

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## Products Affected

- BENLYSTA INTRAVENOUS
- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	AUTOANTIBODY POSITIVE LUPUS TEST.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. NO APPROVAL FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS, SEVERE CENTRAL NERVOUS SYSTEM LUPUS OR CONCURRENT USE OF BIOLOGIC AGENTS OR INTRAVENOUS CYCLOPHOSPHAMIDE. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.



# BELINOSTAT

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## Products Affected

- BELEODAQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# BENDAMUSTINE

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## Products Affected

- BENDEKA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# BENRALIZUMAB

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## Products Affected

- FASENRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	CONCURRENT USE OF XOLAIR
<b>Required Medical Information</b>	BLOOD EOSINOPHIL LEVEL IS GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE LAST 4 WEEKS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
<b>Coverage Duration</b>	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PATIENT IS CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION WHICH INCLUDES ANY OF THE FOLLOWING: LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, OR ORAL CORTICOSTEROID. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS EXPERIENCED IMPROVEMENT IN ASTHMA EXACERBATIONS FROM BASELINE AND A REDUCTION IN ORAL CORTICOSTEROID DOSE (IF THE PATIENT WAS ON A MAINTENANCE REGIMEN OF ORAL CORTICOSTEROIDS AT THE INITIATION OF TREATMENT).

# BEVACIZUMAB

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## Products Affected

- AVASTIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# BEVACIZUMAB-AWWB

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## Products Affected

- MVASI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# BEXAROTENE

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## Products Affected

- *bexarotene*
- TARGRETIN TOPICAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# BINIMETINIB

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## Products Affected

- MEKTOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# BLINATUMOMAB

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## Products Affected

- BLINCYTO INTRAVENOUS KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: RELAPSED OR REFRACTORY B-CELL: 3 MOS. MRD-POSITIVE B-CELL: 2 MOS. RENEWAL: 12 MOS.



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RELAPSED OR REFRACTORY B-CELL PRECURSOR ALL: APPROVAL IS FOR 2 CYCLES, MAY APPROVE FOR 1 ADDITIONAL CYCLE DUE TO TREATMENT INTERRUPTION FOR DOSE MODIFICATION.</p> <p>RENEWAL: FOR DIAGNOSIS OF RELAPSED OR REFRACTORY B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED COMPLETE REMISSION (CR) OR CR WITH PARTIAL HEMATOLOGICAL RECOVERY OF PERIPHERAL BLOOD COUNTS AFTER 2 CYCLES OF TREATMENT. RENEWAL IS NOT APPROVED FOR PATIENTS WHO RECEIVED AN ALLOGENEIC HEMATOPOIETIC STEM-CELL TRANSPLANT.</p> <p>FOR DIAGNOSIS OF MINIMAL RESIDUAL DISEASE (MRD)-POSITIVE B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED UNDETECTABLE MINIMAL RESIDUAL DISEASE (MRD) WITHIN ONE CYCLE OF BLINCYTO TREATMENT AND IS RELAPSE-FREE (I.E., HEMATOLOGICAL OR EXTRAMEDULLARY RELAPSE, OR SECONDARY LEUKEMIA).</p>

# BORTEZOMIB

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## Products Affected

- BORTEZOMIB
- VELCADE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# BOSUTINIB

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## Products Affected

- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	CML: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT BOTH T315I AND V299L MUTATIONS ARE NOT PRESENT.

# BRIGATINIB

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## Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# BRODALUMAB

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## Products Affected

- SILIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. PATIENT HAS BEEN COUNSELED ON AND EXPRESSES UNDERSTANDING OF THE RISK OF SUICIDAL IDEATION AND BEHAVIOR. RENEWAL: PATIENT HAS NOT DEVELOPED OR REPORTED WORSENING DEPRESSIVE SYMPTOMS OR SUICIDAL IDEATION AND BEHAVIORS WHILE ON TREATMENT WITH SILIQ.

# C1 ESTERASE INHIBITOR-CINRYZE, BERINERT

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## Products Affected

- CINRYZE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# C1 ESTERASE INHIBITOR-HAEGARDA, RUCONEST

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## Products Affected

- HAEGARDA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# CABOZANTINIB

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## Products Affected

- COMETRIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# CABOZANTINIB S-MALATE - CABOMETYX

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# CANAKINUMAB

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## Products Affected

- ILARIS (PF) SUBCUTANEOUS RECON SOLN 150 MG/ML
- ILARIS (PF) SUBCUTANEOUS SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR AN IMMUNOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# CANNABIDIOL

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## Products Affected

- EPIDIOLEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	LENNOX-GASTAUT SYNDROME: TRIAL OF OR CONTRAINDICATION TO TOPIRAMATE OR LAMOTRIGINE AND CLOBAZAM (TABLET OR SUSPENSION).

# CANNABINOIDS

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## Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO CONVENTIONAL ANTIEMETIC THERAPIES SUCH AS ONDANSETRON, STEROIDS INDICATED FOR EMESIS OR EMEND. NO ADDITIONAL REQUIREMENTS FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS.

# CANNABINOIDS ORAL SOLUTION

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## Products Affected

- SYNDROS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO FORMULARY DRONABINOL CAPSULES AND ONE CONVENTIONAL ANTIEMETIC THERAPY SUCH AS ONDANSETRON, STEROIDS INDICATED FOR EMESIS OR APREPITANT. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS REQUIRES A TRIAL OF OR CONTRAINDICATION TO FORMULARY DRONABINOL CAPSULES.

# CAPLACIZUMAB YHDP

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## Products Affected

- CABLIVI INJECTION KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# CARFILZOMIB

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## Products Affected

- KYPROLIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# CEMIPLIMAB

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## Products Affected

- LIBTAYO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# CERITINIB

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## Products Affected

- ZYKADIA ORAL CAPSULE
- ZYKADIA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# CERTOLIZUMAB PEGOL

## Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PATIENT HAS ONE OF THE FOLLOWING OBJECTIVE SIGNS OF INFLAMMATION: 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS OR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS/NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	<p>INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. PATIENTS WHO ARE PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT ARE EXCLUDED FROM STEP CRITERIA FOR ALL INDICATIONS.</p>

# CLADRIBINE

## Products Affected

- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	48 WEEKS
Other Criteria	

# CLOBAZAM

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## Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TRIAL OF OR CONTRAINDICATION TO LAMOTRIGINE OR TOPIRAMATE. REQUESTS FOR ORAL SUSPENSION APPROVABLE IF PATIENT IS UNABLE TO SWALLOW OR IS UNDER THE AGE OF 5 YEARS.

# CLOBAZAM-SYMPAZAN

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## Products Affected

- SYMPAZAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PHYSICIAN ATTESTATION THAT THE PATIENT IS UNABLE TO TAKE TABLETS OR SUSPENSION. TRIAL OF OR CONTRAINDICATION TO A FORMULARY CLOBAZAM AGENT.

# COBIMETINIB FUMARATE

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## Products Affected

- COTELLIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# COPANLISIB DI-HCL

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## Products Affected

- ALIQOPA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# CORTICOTROPIN

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## Products Affected

- ACTHAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INFANTILE SPASMS AND MULTIPLE SCLEROSIS: 28 DAYS. OTHER FDA APPROVED INDICATIONS:12 MONTHS.
<b>Other Criteria</b>	ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS REQUIRE A TRIAL OF OR CONTRAINDICATION TO IV CORTICOSTEROIDS. NOT APPROVED FOR DIAGNOSTIC PURPOSES.

# CRIZOTINIB

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## Products Affected

- XALKORI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# DABRAFENIB MESYLATE

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## Products Affected

- TAFINLAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# DACLATASVIR

## Products Affected

- DAKLINZA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDS A GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDS A GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDS A GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI, OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDS A GUIDANCE. NO APPROVALS FOR CONCURRENT USE WITH ANY OF THESE (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN.

# DACOMATINIB

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## Products Affected

- VIZIMPRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# DALFAMPRIDINE

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## Products Affected

- *dalfampridine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	NEUROLOGIST
<b>Coverage Duration</b>	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT IN WALKING ABILITY.

# DARATUMUMAB

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## Products Affected

- DARZALEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# DASATINIB

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## Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PREVIOUSLY-TREATED CHRONIC MYELOID LEUKEMIA (CML) REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, T315A, F317L/V/I/C.



# DEFERASIROX

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## Products Affected

- *deferasirox*
- JADENU
- JADENU SPRINKLE

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
<b>Coverage Duration</b>	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
<b>Other Criteria</b>	CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L. NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT) INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L AND LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L OR LIC OF 3 MG FE/G DRY WEIGHT OR GREATER

# DEFERIPRONE

## Products Affected

- FERRIPROX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL CRITERIA: REQUIRES TRIAL OF EXJADE (DEFERASIROX), JADENU, OR GENERIC DEFEROXAMINE AND ONE OF THE FOLLOWING CRITERIA 1) PHYSICIAN ATTESTATION THAT PATIENT IS EXPERIENCING INTOLERABLE TOXICITIES, CLINICALLY SIGNIFICANT ADVERSE EFFECTS, OR CONTRAINDICATION TO THESE THERAPIES OR 2) INADEQUATE CHELATION DEFINED BY ONE OF THE FOLLOWING: A) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 2500 MCG/L OR B) EVIDENCE OF CARDIAC IRON ACCUMULATION. RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L

# DEFEROXAMINE

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## Products Affected

- *deferoxamine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	AT LEAST 3 YEARS OF AGE OR OLDER
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000MCG/L RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# DEFLAZACORT

## Products Affected

- EMFLAZA ORAL SUSPENSION
- EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING DMD DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL CRITERIA: REQUIRE TRIAL OF PREDNISONE OR PREDNISOLONE AND PATIENT MEETS ONE OF THE FOLLOWING: 1) REQUEST DUE TO ADVERSE EFFECTS OF PREDNISONE OR PREDNISOLONE OR 2) REQUEST DUE TO LACK OF EFFICACY OF PREDNISONE OR PREDNISOLONE AND ALL OF THE FOLLOWING CRITERIA ARE MET: A) PATIENT IS NOT IN STAGE 1 (PRE-SYMPTOMATIC PHASE) B) STEROID MYOPATHY HAS BEEN RULED OUT C) PHYSICIAN ATTESTATION OF DETERIORATION IN AMBULATION, FUNCTIONAL STATUS, OR PULMONARY FUNCTION CONSISTENT WITH ADVANCING DISEASE. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION).

# DELAFLOXACIN

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## Products Affected

- BAXDELA ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	ONE MONTH
<b>Other Criteria</b>	PREScribed BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST OR ABSSSI ORGANISM ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO ONE PREFERRED FORMULARY STANDARD OF CARE AGENT OR IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED FORMULARY AGENTS: A PENICILLIN, A FLUOROQUINOLONE, A CEPHALOSPORIN, OR A GRAM POSITIVE TARGETING ANTIBIOTIC

# DENOSUMAB-XGEVA

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## Products Affected

- XGEVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# DESIRUDIN

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## Products Affected

- IPRIVASK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 MONTH
<b>Other Criteria</b>	

# DEUTETRABENAZINE

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## Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	TARDIVE DYSKINESIA: PATIENT HAS A PRIOR HISTORY OF USING ANTIPSYCHOTIC MEDICATIONS OR METOCLOPRAMIDE PER PHYSICIAN ATTESTATION
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HUNTINGTON DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# DEXTROMETHORPHAN QUINIDINE

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## Products Affected

- NUEDEXTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# DICHLORPHENAMIDE

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## Products Affected

- KEVEYIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	HEPATIC INSUFFICIENCY, PULMONARY OBSTRUCTION, OR A HEALTH CONDITION THAT WARRANTS CONCURRENT USE OF HIGH-DOSE ASPIRIN
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 YEARS AND OLDER
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 2 MONTHS RENEWAL: 12 MONTHS
<b>Other Criteria</b>	RENEWAL REQUIRES PHYSICIAN ATTESTATION OF IMPROVEMENT.

# DICLOFENAC EPOLAMINE

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## Products Affected

- *diclofenac epolamine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# DICLOFENAC TOPICAL

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## Products Affected

- *diclofenac sodium topical gel 3 %*
- PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PENNSAID 2% TOPICAL SOLUTION: TRIAL OF OR CONTRAINDICATION TO FORMULARY DICLOFENAC SODIUM 1% TOPICAL GEL.

# DIMETHYL FUMARATE

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## Products Affected

- TECFIDERA ORAL  
CAPSULE, DELAYED  
RELEASE(DR/EC) 120 MG, 120 MG  
(14)- 240 MG (46), 240 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# DINUTUXIMAB

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## Products Affected

- UNITUXIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# DROXIDOPA

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## Products Affected

- NORTHERA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE (LYING FACE UP) POSITION AT BASELINE AND RENEWAL.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
<b>Coverage Duration</b>	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: DIAGNOSIS OF ORTHOSTATIC HYPOTENSION AS DOCUMENTED BY A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION. RENEWAL: PATIENT HAD AN INCREASE IN SYSTOLIC BLOOD PRESSURE FROM BASELINE OF AT LEAST 10 MMHG UPON STANDING FROM A SUPINE (LYING FACE UP) POSITION.

# DUPILUMAB

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## Products Affected

- DUPIXENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	INITIAL: ASTHMA: CONCURRENT USE OF XOLAIR OR ANTI-IL5 BIOLOGIC (E.G., NUCALA, CINQAIR, FASENRA).
<b>Required Medical Information</b>	INITIAL APPROVAL FOR ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 6 MONTHS (IF EOSINOPHILIC ASTHMA).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ATOPIC DERMATITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ALLERGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL: ATOPIC DERMATITIS: 6 MONTHS. ASTHMA: 12 MONTHS. RENEWAL: 12 MONTHS (ALL INDICATIONS).



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL APPROVAL FOR ATOPIC DERMATITIS REQUIRES: 1) PREVIOUS TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: TOPICAL CORTICOSTEROIDS, TOPICAL CALCINEURIN INHIBITORS [E.G., ELIDEL (PIMECROLIMUS), GENERIC TACROLIMUS OINTMENT], OR TOPICAL PDE4 INHIBITOR [E.G., EUCRISA (CRISABOROLE)]. 2) ATOPIC DERMATITIS INVOLVING AT LEAST 10% OF BODY SURFACE AREA (BSA) OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS. 3) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN. INITIAL APPROVAL FOR ASTHMA: 1) PATIENT IS CONCURRENTLY ON A MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION (E.G., LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE). 2) PATIENT HAS EXPERIENCED AT LEAST 2 ASTHMA EXACERBATIONS IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS). RENEWAL FOR ATOPIC DERMATITIS AND ASTHMA: PHYSICIAN ATTESTATION OF IMPROVEMENT.</p>

# DURVALUMAB

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## Products Affected

- IMFINZI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# DUVELISIB

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## Products Affected

- COPIKTRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# EDARAVONE

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## Products Affected

- RADICAVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ELAGOLIX SODIUM

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## Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PHYSICIAN ATTESTATION OF IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS.
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING CONTRACEPTIVE PREPARATION.

# ELAPEGADEMASE-LVLR

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## Products Affected

- REVCOVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ELBASVIR/GRAZOPREVIR

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## Products Affected

- ZEPATIER

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
<b>Exclusion Criteria</b>	MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD PUGH B OR C)
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS. FOR GENOTYPE 1A -TESTING FOR NS5A RESISTANCE-ASSOCIATED POLYMORPHISMS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO CONCURRENT USE WITH THE FOLLOWING AGENTS: PHENYTOIN, CARBAMAZEPINE, RIFAMPIN, EFAVIRENZ, ATAZANAVIR, DARUNAVIR, LOPINAVIR, SAQUINAVIR, TIPRANAVIR, CYCLOSPORINE, NAFCILLIN, KETOCONAZOLE, MODAFINIL, BOSENTAN, ETRAVIRINE, ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR, ATORVASTATIN AT DOSES GREATER THAN 20MG PER DAY OR ROSUVASTATIN AT DOSES GREATER THAN 10MG PER DAY.</p>



# ELIGLUSTAT TARTRATE

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## Products Affected

- CERDELGA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ELOSULFASE ALFA

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## Products Affected

- VIMIZIM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	LIFETIME OF MEMBERSHIP IN PLAN.
<b>Other Criteria</b>	

# ELOTUZUMAB

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## Products Affected

- EPLICITI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ELTROMBOPAG

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## Products Affected

- PROMACTA ORAL POWDER IN PACKET
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ITP:INITIAL: 2MO.RENEW:12MO.HCV:12MO.SEVERE APLASTIC ANEMIA:12MO
Other Criteria	CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ITP: RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.

# ENASIDENIB

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## Products Affected

- IDHIFA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ENCORAFENIB

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## Products Affected

- BRAFTOVI ORAL CAPSULE 50 MG,  
75 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ENDOTHELIN RECEPTOR ANTAGONISTS

## Products Affected

- *ambrisentan*
- LETAIRIS
- OPSUMIT
- TRACLEER ORAL TABLET
- TRACLEER ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. LETAIRIS (AMBRISENTAN): PATIENT DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS (IPF). TRACLEER: PATIENT DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASES IN BILIRUBIN BY 2 OR MORE TIMES ULN. PATIENT IS NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.

# ENZALUTAMIDE

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## Products Affected

- XTANDI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	DIAGNOSIS OF CASTRATION RESISTANT PROSTATE CANCER AND MEET ONE OF THE FOLLOWING: 1) METASTATIC CASTRATION RESISTANT PROSTATE CANCER, OR 2) NON METASTATIC CASTRATION RESISTANT PROSTATE CANCER: THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS).



# EPOPROSTENOL IV

## Products Affected

- *epoprostenol (glycine)*

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	COVERED UNDER LOCAL COVERAGE POLICY OF APPLICABLE MEDICARE DMERC.
<b>Required Medical Information</b>	FORMULARY DRUG ADMINISTERED IN A LONG TERM CARE FACILITY TO A PATIENT WHOSE PART A COVERAGE HAS EXPIRED OR FORMULARY DRUG NOT ADMINISTERED VIA AN IMPLANTABLE PUMP OR AN EXTERNAL PUMP OR DRUG ADMINISTERED VIA AN IMPLANTABLE PUMP/AN EXTERNAL PUMP. DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT HAS SHOWN IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

# ERDAFITINIB

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## Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ERENUMAB-AOOE

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## Products Affected

- AIMOVIG AUTOINJECTOR
- AIMOVIG AUTOINJECTOR (2 PACK)

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AIMOVIG THERAPY.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL.

# ERLOTINIB

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## Products Affected

- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*
- TARCEVA ORAL TABLET 100 MG, 150 MG, 25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA

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## Products Affected

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

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL ANEMIA IN HEPATITIS C BEING TREATED IN COMBINATION WITH RIBAVIRIN AND INTERFERON ALFA OR PEGINTERFERON ALFA.
Exclusion Criteria	

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>INITIAL: CHRONIC RENAL FAILURE (CRF) AND ANEMIA RELATED TO ZIDOVUDINE THERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT WITH RIBAVIRIN PLUS INTERFERON ALFA/PEGINTERFERON ALFA REQUIRES A HEMOGLOBIN LEVEL LESS THAN 10G/DL AND RIBAVIRIN DOSE REDUCTION (UNLESS CONTRAINDICATED).ELECTIVE NON-CARDIAC OR NON-VASCULAR SURGERY REQUIRES A HEMOGLOBIN LEVEL LESS THAN 13G/DL. RENEWAL: CHRONIC RENAL FAILURE REQUIRES THAT THE PATIENT MEETS ONE OF THE FOLLOWING: IF THE PATIENT IS CURRENTLY RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 11G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 11G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. IF THE PATIENT IS NOT RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT WITH RIBAVIRIN PLUS INTERFERON ALFA/PEGINTERFERON ALFA, OR ANEMIA DUE TO ZIDOVUDINE THERAPY REQUIRES HEMOGLOBIN LEVELS BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	<p>ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE:12 MONTHS.SURGERY:1 MO.HCV:6 MOS.</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	ALL INDICATIONS: TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

# ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA-EPBX

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL ANEMIA IN HEPATITIS C BEING TREATED IN COMBINATION WITH RIBAVIRIN AND INTERFERON ALFA OR PEGINTERFERON ALFA.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: ANEMIA RELATED TO ZIDOVUDINE THERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT WITH RIBAVIRIN PLUS INTERFERON ALFA/PEGINTERFERON ALFA REQUIRES A HEMOGLOBIN LEVEL LESS THAN 10G/DL AND RIBAVIRIN DOSE REDUCTION (UNLESS CONTRAINDICATED). RENEWAL: CHRONIC KIDNEY DISEASE REQUIRES THAT THE PATIENT IS NOT RECEIVING DIALYSIS TREATMENT AND MEETS ONE OF THE FOLLOWING: 1) HEMOGLOBIN LEVEL OF LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT WITH RIBAVIRIN PLUS INTERFERON ALFA/PEGINTERFERON ALFA, OR ANEMIA DUE TO ZIDOVUDINE THERAPY REQUIRES HEMOGLOBIN LEVELS BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE:12 MOS.SURGERY:1 MO.HCV:6 MOS.
<b>Other Criteria</b>	PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

# ESKETAMINE

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## Products Affected

- SPRAVATO NASAL SPRAY, NON-AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# ETANERCEPT

## Products Affected

- ENBREL
- ENBREL SURECLICK

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, PSORIATIC ARTHRITIS: 18 YEARS OR OLDER
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.

# ETEPLIRSEN

## Products Affected

- EXONDYS 51

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING THAT MUTATION IN DUCHENNE MUSCULAR DYSTROPHY (DMD) GENE IS AMENABLE TO EXON 51 SKIPPING.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL CRITERIA: PATIENT IS AMBULATORY AND IS CURRENTLY RECEIVING TREATMENT WITH OR HAS A CONTRAINDICATION TO CORTICOSTEROIDS. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION) DURING THE PAST 24 WEEKS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# EVEROLIMUS

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## Products Affected

- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	ADVANCED RENAL CELL CARCINOMA (RCC); TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR.

# EVOLOCUMAB

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## Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
<b>Coverage Duration</b>	12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>PRIMARY HYPERLIPIDEMIA (E.G., HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH)): DIAGNOSIS DETERMINED BY (1) DEFINITE SIMON BROOME DIAGNOSTIC (SBD) CRITERIA FOR FH, OR (2) DUTCH LIPID NETWORK (DLN) CRITERIA SCORE OF 6 OR GREATER. HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): DIAGNOSIS DETERMINED BY (1) DEFINITE SBD CRITERIA, (2) DLN CRITERIA SCORE OF 8 OR GREATER, OR (3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).</p>

# FENTANYL NASAL SPRAY

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## Products Affected

- LAZANDA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	<p>CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE ER, OXYCODONE ER, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES AND TRIAL OR CONTRAINDICATION TO GENERIC FENTANYL CITRATE LOZENGE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</p>



# FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

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## Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE ER, OXYCODONE ER, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# FINGOLIMOD

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## Products Affected

- GILENYA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# FOSTAMATINIB

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## Products Affected

- TAVALISSE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	

# FREMANEZUMAB-VFRM

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## Products Affected

- AJOVY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AJOVY THERAPY.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL.

# GALCANEZUMAB-GNLM

## Products Affected

- EMGALITY PEN
- EMGALITY SYRINGE  
SUBCUTANEOUS SYRINGE 100  
MG/ML, 120 MG/ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL FOR MIGRAINES: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH EMGALITY THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MIGRAINES: INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. CLUSTER HEADACHE: 12 MONTHS
Other Criteria	INITIAL FOR MIGRAINES: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL.

# GEFITINIB

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## Products Affected

- IRESSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# GEMTUZUMAB OZOGAMICIN

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## Products Affected

- MYLOTARG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# GILTERITINIB

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## Products Affected

- XOSPATA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# GLASDEGIB

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## Products Affected

- DAURISMO ORAL TABLET 100 MG,  
25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# GLATIRAMER ACETATE

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## Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML
- *glatopra subcutaneous syringe 20 mg/ml, 40 mg/ml*
- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# GLECAPREVIR/PIBRENTASVIR

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## Products Affected

- MAVYRET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
<b>Exclusion Criteria</b>	MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD PUGH B OR C)
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED OR CONTRAINDICATED BY THE MANUFACTURER: CARBAMAZEPINE, RIFAMPIN, ETHINYL ESTRADIOL-CONTAINING MEDICATION, ATAZANAVIR, DARUNAVIR, LOPINAVIR, RITONAVIR, EFAVIRENZ, ATORVASTATIN, LOVASTATIN, SIMVASTATIN, ROSUVASTATIN AT DOSES GREATER THAN 10MG, OR CYCLOSPORINE AT DOSES GREATER THAN 100MG PER DAY. PATIENT MUST NOT HAVE PRIOR FAILURE OF A DAA REGIMEN WITH NS5A INHIBITOR AND HCV PROTEASE INHIBITOR.</p>

# GLYCEROL PHENYL BUTYRATE

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## Products Affected

- RAVICTI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYL BUTYRATE (BUPHENYL).

# GOLIMUMAB IV

## Products Affected

- SIMPONI ARIA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL.

# GOLIMUMAB SQ

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## Products Affected

- SIMPONI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, OR ANKYLOSING SPONDYLITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.</p>



# GRANULOCYTE COLONY-STIMULATING FACTORS

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## Products Affected

- GRANIX
- NEUPOGEN
- NIVESTYM

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	A TRIAL OF OR CONTRAINDICATION TO ZARXIO IS REQUIRED EXCEPT WHEN USED TO INCREASE SURVIVAL IN A PATIENT ACUTELY EXPOSED TO MYELOSUPPRESSIVE DOSES OF RADIATION (HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME)

# GUSELKUMAB

## Products Affected

- TREMFYA

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI.

# HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - BENZTROPINE\_TRIHEXYPHENIDYL

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## Products Affected

- *benztropine*
- *trihexyphenidyl*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - CLEMASTINE

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## Products Affected

- *clemastine oral tablet 2.68 mg*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE

## Products Affected

- *phenadoz*
- *promethazine injection solution*
- *promethazine oral*
- *promethazine rectal*
- *promethegan*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OF OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE OR PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. NAUSEA AND VOMITING: PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE DRUG IS CONSIDERED HIGH-RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT TRIAL OF FORMULARY ALTERNATIVES NOR REQUIRING PRESCRIBER ACKNOWLEDGEMENT.

# HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE VC

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## Products Affected

- *promethazine-phenylephrine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - SCOPOLAMINE

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## Products Affected

- *scopolamine base*
- TRANSDERM-SCOP

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING PREScriBER ACKNOWLEDGEMENT.

# HIGH RISK DRUGS IN THE ELDERLY - ANTI- INFECTIVE

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## Products Affected

- *nitrofurantoin macrocrystal*
- *nitrofurantoin monohydrate-crystal*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS. PA REQUIRED FOR PATIENTS 65 YEARS AND OLDER WITH OVER 90 DAYS CUMULATIVE USE OF THE REQUESTED AGENT.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO SULFAMETHOXAZOLE/TRIMETHOPRIM (TMP-SMX) OR TRIMETHOPRIM. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.



# HIGH RISK DRUGS IN THE ELDERLY - BARBITURATE COMBINATIONS

## Products Affected

- *ascomp with codeine*
- *butalbital compound w/codeine*
- *butalbital-acetaminop-caff-cod*
- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-acetaminophen-caff oral capsule 50-325-40 mg*
- *butalbital-acetaminophen-caff oral tablet 50-325-40 mg*
- *butalbital-aspirin-caffeine*
- *capacet*
- *tencon oral tablet 50-325 mg*
- *zebutal oral capsule 50-325-40 mg*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY - CARDIOVASCULAR

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## Products Affected

- *guanfacine oral tablet*
- *nifedipine oral capsule*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	HYPERTENSION: PREVIOUS TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING GENERIC FORMULARY ALTERNATIVES: ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE INHIBITOR), ACE INHIBITOR COMBINATION, ANGIOTENSIN RECEPTOR BLOCKER (ARB), ARB COMBINATION, BETA BLOCKER, BETA BLOCKER COMBINATION, OR CALCIUM CHANNEL BLOCKERS. PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY - DIGOXIN

## Products Affected

- *digitek oral tablet 125 mcg, 250 mcg*
- *digox oral tablet 125 mcg, 250 mcg*
- *digoxin 125 mcg tablet*
- *digoxin injection syringe*
- DIGOXIN ORAL SOLUTION 50 MCG/ML
- *digoxin oral tablet 125 mcg, 250 mcg*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	APPROVAL FOR MEMBERS STABLE ON DOSES GREATER THAN 125MCG PER DAY WITH PHYSICIAN'S ATTESTATION OF THERAPEUTIC DIGOXIN LEVEL TAKEN WITHIN THE PAST YEAR. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY - DIPYRIDAMOLE

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## Products Affected

- *dipyridamole oral*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY - DISOPYRAMIDE

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## Products Affected

- *disopyramide phosphate oral capsule*

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - ESTROGEN

## Products Affected

- *amabelz*
- *dotti*
- DUAVEE
- *estradiol oral*
- *estradiol transdermal patch semiweekly*
- *estradiol transdermal patch weekly*
- *estradiol-norethindrone acet oral tablet 0.5-0.1 mg*
- *estropipate*
- *fyavolv*
- *jinteli*
- MENEST
- *mimvey lo*
- *norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg*
- PREMARIN ORAL
- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS NOT PREVIOUSLY MENTIONED IN THIS SECTION, SUCH AS PALLIATIVE TREATMENT, AND HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - SULFONYLUREAS

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## Products Affected

- *glyburide*
- *glyburide micronized*
- *glyburide-metformin*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF GLIMEPIRIDE, GLIPIZIDE, OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY - KETOROLAC

## Products Affected

- *ketorolac injection cartridge 15 mg/ml, 30 mg/ml*
- *ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)*
- *ketorolac injection syringe 15 mg/ml, 30 mg/ml*
- *ketorolac intramuscular*
- *ketorolac oral*

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	30 DAYS
<b>Other Criteria</b>	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.



# HIGH RISK DRUGS IN THE ELDERLY - NON-BENZODIAZEPINE

## Products Affected

- *eszopiclone*
- *zaleplon*
- *zolpidem oral*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS. PA REQUIRED FOR PATIENTS 65 YEARS AND OLDER WITH OVER 90 DAYS CUMULATIVE USE OF NON-BENZODIAZEPINE AGENTS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF SILENOR AND BELSOMRA OR PRESCRIBER ACKNOWLEDGEMENT/ AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

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## Products Affected

- *carisoprodol*
- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine oral tablet 10 mg, 5 mg*
- *methocarbamol oral*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY

## ANTICHOLINERGICS -

### CYPROHEPTADINE\_CARBINOXAMINE

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#### Products Affected

- *carbinoxamine maleate oral liquid*
- *carbinoxamine maleate oral tablet 4 mg*
- *cyproheptadine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY- ANTICHOLINERGICS- DIPHENHYDRAMINE ELIXIR

## Products Affected

- *diphenhydramine hcl oral elixir*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ANTIHISTAMINIC CONDITIONS (PRURITUS OR URTICARIA): TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. INSOMNIA: TRIAL OF SILENOR AND BELSOMRA. MOTION SICKNESS AND ANTIPARKINSONISM: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS AND ANAPHYLACTIC REACTIONS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY- DIPHENOXYLATE-ATROPINE

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## Products Affected

- *diphenoxylate-atropine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY- HYDROXYZINE

## Products Affected

- *hydroxyzine hcl intramuscular*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate*

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY- INDOMETHACIN

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## Products Affected

- *indomethacin oral capsule 25 mg, 50 mg*
- *indomethacin oral capsule, extended release*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY- MECLIZINE

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## Products Affected

- *meclizine oral tablet 12.5 mg, 25 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>FOR MANAGEMENT OF VERTIGO ASSOCIATED WITH DISEASES AFFECTING THE VESTIBULAR SYSTEM: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR PATIENTS 65 YEARS AND OLDER. FOR NAUSEA, VOMITING, AND DIZZINESS ASSOCIATED WITH MOTION SICKNESS: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR PATIENTS 65 YEARS AND OLDER OR TRIAL OF OR CONTRAINDICATION TO PROCHLORPERAZINE, PROCHLORPERAZINE MALEATE, OR PROCHLORPERAZINE EDISYLATE. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.</p>

# HIGH RISK DRUGS IN THE ELDERLY- MEGESTROL

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## Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY- PAROXETINE

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## Products Affected

- *paroxetine hcl oral tablet*
- *paroxetine hcl oral tablet extended release 24 hr*
- PAXIL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY- TCA

## Products Affected

- *amitriptyline*
- *amitriptyline-chlordiazepoxide*
- *amoxapine*
- *clomipramine*
- *desipramine*
- *doxepin oral*
- *imipramine hcl*
- *imipramine pamoate*
- *nortriptyline*
- *perphenazine-amitriptyline*
- *protriptyline*
- *trimipramine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREScriBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK DRUGS IN THE ELDERLY- BENZODIAZEPINE SEDATIVE HYPNOTICS

## Products Affected

- *estazolam oral tablet 1 mg, 2 mg*
- *flurazepam oral capsule 15 mg, 30 mg*
- *temazepam oral capsule 15 mg, 30 mg*
- *triazolam oral tablet 0.125 mg, 0.25 mg*

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS. PA REQUIRED FOR PATIENTS 65 YEARS AND OLDER WITH OVER 90 DAYS CUMULATIVE USE OF THE REQUESTED AGENT.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PREVIOUS TRIAL OF OR CONTRAINDICATION TO SILENOR AND BELSOMRA OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HIGH RISK MEDICATIONS IN THE ELDERLY- PHENOBARBITAL

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## Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR TREATMENT OF EPILEPSY/SEIZURES IN PATIENTS WHO ARE NOT CURRENTLY STABLE ON PHENOBARBITAL: PATIENT HAS NOT RESPONDED TO OTHER ANTICONVULSANTS OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. PATIENTS WHO ARE STABLE ON PHENOBARBITAL FOR EPILEPSY/SEIZURES ARE APPROVED WITHOUT REQUIRING A TRIAL OF FORMULARY ALTERNATIVES OR PRESCRIBER ACKNOWLEDGEMENT. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

# HYDROXYPROGESTERONE CAPROATE- DELALUTIN GENERIC

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## Products Affected

- *hydroxyprogesterone caproate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# IBRUTINIB

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## Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# IBUPROFEN-FAMOTIDINE

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## Products Affected

- DUEXIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TRIAL OF ONE OF THE FOLLOWING GENERIC, FEDERAL LEGEND HISTAMINE H2-RECEPTOR ANTAGONISTS: FAMOTIDINE, CIMETIDINE, NIZATIDINE, OR RANITIDINE, AND TRIAL OF GENERIC, FEDERAL LEGEND IBUPROFEN.

# IDELALISIB

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## Products Affected

- ZYDELIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# IMATINIB MESYLATE

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## Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ALL DIAGNOSES: 12 MONTHS. ADJUVANT GASTROINTESTINAL STROMAL TUMOR (GIST) TREATMENT: 36 MONTHS.
Other Criteria	PATIENTS WITH PREVIOUSLY-TREATED CML REQUIRE A BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT THE PATIENT IS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, F317L/V/I/C, Y253H, E255K/V, F359V/C/I.

# IMIQUIMOD - ALDARA

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## Products Affected

- *imiquimod topical cream in packet*

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	ACTINIC KERATOSIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. SUPERFICIAL BASAL CELL CARCINOMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR AN ONCOLOGIST.
<b>Coverage Duration</b>	4 MONTHS
<b>Other Criteria</b>	EXTERNAL GENITAL WARTS: TRIAL OF PODOFILOX (CONDYLOX) 0.5% TOPICAL SOLUTION. ACTINIC KERATOSIS BRAND DRUG REQUEST: TRIAL OF GENERIC IMIQUIMOD 5% CREAM. SUPERFICIAL BASAL CELL CARCINOMA: LESS THAN 2CM IN SIZE AND NOT ON THE FACE.

# INFLIXIMAB

## Products Affected

- REMICADE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.</p>

# INFLIXIMAB-ABDA

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## Products Affected

- RENFLEXIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.</p>



# INFLIXIMAB-DYYB

## Products Affected

- INFLECTRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.</p>

# INOTUZUMAB OZOGAMICIN

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## Products Affected

- BESPONSE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# INTERFERON ALFA-2B

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## Products Affected

- INTRON A INJECTION

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. FOR USE TO TREAT HEPATITIS C, CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	HEPATITIS C: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST). NO REQUIREMENT FOR OTHER FDA APPROVED INDICATIONS.
<b>Coverage Duration</b>	6 MONTHS
<b>Other Criteria</b>	LIMITED TO 1 YEAR OF THERAPY EXCEPT 18 MONTHS FOR FOLLICULAR LYMPHOMA. HEPATITIS C GENOTYPE 1, 2, 3, 4, 5, OR 6: REQUIRES A TRIAL OF OR CONTRAINDICATION TO PEGINTERFERON ALFA-2A OR PEGINTERFERON ALFA-2B USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED.

# INTERFERONS FOR MS-AVONEX, PLEGRIDY, REBIF

## Products Affected

- AVONEX (WITH ALBUMIN)
- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- PLEGRIDY
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# INTERFERONS FOR MS-BETASERON, EXTAVIA

## Products Affected

- BETASERON SUBCUTANEOUS KIT
- EXTAVIA SUBCUTANEOUS KIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	TRIAL WITH TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, AND GLATIRAMER
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# IPILIMUMAB

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## Products Affected

- YERVOY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: UNRESECT/MET MELANOMA: 4 MO, RCC/CRC: 3 MO. CUTANEOUS MELANOMA: INITIAL AND RENEWAL: 6 MO
<b>Other Criteria</b>	RENEWAL FOR ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS)

# IVACAFTOR

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## Products Affected

- KALYDECO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE.
<b>Required Medical Information</b>	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# IVACAFTOR - GRANULE PACKETS

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## Products Affected

- KALYDECO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	HOMOZYGOUS F508DEL MUTATION IN CFTR GENE.
<b>Required Medical Information</b>	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# IVOSIDENIB

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## Products Affected

- TIBSOVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# IXAZOMIB

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## Products Affected

- NINLARO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# IXEKIZUMAB

## Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, STELARA, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, STELARA, ENBREL, SKYRIZI.

# LANADELUMAB

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## Products Affected

- TAKHZYRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY) IN HAE ATTACKS WITH ROUTINE PROPHYLAXIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST/IMMUNOLOGIST OR HEMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING.

# LAROTRECTINIB

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## Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# LEDIPASVIR-SOFOSBUVIR

## Products Affected

- HARVONI

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), STRIBILD (ELVITEGRAVIR/COBICISTAT/EMTRICITABINE /TENOFIVIR), OR TIPRANA VIR/RITONA VIR.

# LEDIPASVIR-SOFOSBUVIR-GENERIC

## Products Affected

- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), STRIBILD (ELVITEGRAVIR/COBICISTAT/EMTRICITABINE /TENOFIVIR), OR TIPRANAVIR/RITONAVIR. REQUESTS FOR GENERIC LEDIPASVIR/SOFOSBUVIR REQUIRE TRIAL OF OR CONTRAINDICATION TO BRAND HARVONI.



# LENALIDOMIDE

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## Products Affected

- REVLIMID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# LENVATINIB MESYLATE

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## Products Affected

- LENVIMA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# LETERMIVIR

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## Products Affected

- PREVYMIS INTRAVENOUS SOLUTION 240 MG/12 ML, 480 MG/24 ML
- PREVYMIS ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	4 MONTHS
<b>Other Criteria</b>	

# LEVODOPA

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## Products Affected

- INBRIJA 42 MG INHALATION CAP
- INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# L-GLUTAMINE

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## Products Affected

- ENDARI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	INITIAL CRITERIA FOR ADULTS (18 YEARS OR OLDER): PHYSICIAN ATTESTATION OF ONE OF THE FOLLOWING: (1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR OR (2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING OR (3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME (ACS). INITIAL REQUESTS FOR PATIENTS BETWEEN THE AGES OF 5-17 WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA. RENEWAL FOR ALL PATIENTS: PHYSICIAN ATTESTATION PATIENT HAS MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE.

# LIDOCAINE

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## Products Affected

- *lidocaine topical adhesive patch, medicated*
- *lidocaine topical ointment*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	PATCH: 12 MONTHS. OINTMENT: 3 MONTHS.
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# LIDOCAINE PRILOCAINE

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## Products Affected

- *lidocaine-prilocaine topical cream*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# LIDOCAINE TIRF

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## Products Affected

- ZTLIDO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.



# LOMITAPIDE

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## Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	LDL CHOLESTEROL LEVEL, LDL RECEPTOR STATUS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST.
<b>Coverage Duration</b>	12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>DIAGNOSIS DETERMINED BY (1) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, (2) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR (3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. PREVIOUS TRIAL OF EVOLOCUMAB UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).</p>

# LORLATINIB

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## Products Affected

- LORBRENA ORAL TABLET 100 MG,  
25 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# LUMACAFITOR-IVACAFITOR

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## Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.

# LUSUTROMBOPAG

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## Products Affected

- MULPLETA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 MONTHS
<b>Other Criteria</b>	

# MEPOLIZUMAB

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## Products Affected

- NUCALA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	SEVERE ASTHMA: CONCURRENT USE OF XOLAIR.
<b>Required Medical Information</b>	SEVERE ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE LAST 6 WEEKS OR GREATER THAN OR EQUAL TO 300 CELLS/MCL WITHIN THE LAST 12 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	SEVERE ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE, AN ALLERGIST OR AN IMMUNOLOGIST.
<b>Coverage Duration</b>	INITIAL: SEVERE ASTHMA: 24 WEEKS. EGPA: 12 MONTHS. RENEWAL FOR ALL INDICATIONS: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL THERAPY: SEVERE ASTHMA: PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION WHICH INCLUDES ANY OF THE FOLLOWING: LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, OR ORAL CORTICOSTEROID. RENEWAL: SEVERE ASTHMA: REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED IMPROVEMENT IN ASTHMA EXACERBATIONS FROM BASELINE (PHYSICIAN ATTESTATION) AND A REDUCTION IN ORAL CORTICOSTEROID DOSE (IF THE PATIENT WAS ON A MAINTENANCE REGIMEN OF ORAL CORTICOSTEROIDS AT THE INITIATION OF TREATMENT).</p>

# METHYLNALTREXONE

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## Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	ADVANCED ILLNESS: OPIOID-INDUCED CONSTIPATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 MONTHS FOR PATIENTS RECEIVING PALLIATIVE CARE, 12 MONTHS FOR CHRONIC, NON-CANCER PAIN.
<b>Other Criteria</b>	ADVANCED ILLNESS: PATIENT IS RECEIVING PALLIATIVE CARE. CHRONIC NON-CANCER PAIN: PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA).



# METHYLNALTREXONE ORAL

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## Products Affected

- RELISTOR ORAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA).

# MIDOSTAURIN

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## Products Affected

- RYDAPT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS
<b>Other Criteria</b>	

# MIFEPRISTONE

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## Products Affected

- KORLYM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# MIGALASTAT HCL

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## Products Affected

- GALAFOLD

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	FABRY DISEASE INITIAL: THE PATIENT IS NOT CONCURRENTLY USING ENZYME REPLACEMENT THERAPY (I.E. FABRAZYME). THE PATIENT IS SYMPTOMATIC OR HAS EVIDENCE OF INJURY FROM GL-3 TO THE KIDNEY, HEART, OR CENTRAL NERVOUS SYSTEM RECOGNIZED BY LABORATORY, HISTOLOGICAL, OR IMAGING FINDINGS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS.
<b>Coverage Duration</b>	INITIAL: 6 MOS. RENEWAL: 12 MOS
<b>Other Criteria</b>	FABRY DISEASE RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED IMPROVEMENT OR STABILIZATION.

# MILTEFOSINE

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## Products Affected

- IMPAVIDO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# MIPOMERSEN

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## Products Affected

- KYNAMRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	LDL CHOLESTEROL LEVEL, LDL RECEPTOR STATUS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
<b>Coverage Duration</b>	12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>DIAGNOSIS DETERMINED BY (1) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, (2) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR (3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. PREVIOUS TRIAL OF EVOLOCUMAB UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).</p>

# MOGAMULIZUMAB-KPKC

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## Products Affected

- POTELIGEO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# MOXETUMOMAB PASUDOTOX

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## Products Affected

- LUMOXITI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# NAPROXEN- ESOMEPRAZOLE

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## Products Affected

- VIMOVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TRIAL OF ONE OF THE FOLLOWING GENERIC, FEDERAL LEGEND PROTON PUMP INHIBITORS: OMEPRAZOLE, LANSOPRAZOLE, OR PANTOPRAZOLE AND A TRIAL OF GENERIC, FEDERAL LEGEND NAPROXEN.

# NARCOLEPSY AGENTS

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## Products Affected

- *armodafinil*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# NATALIZUMAB

## Products Affected

- TYSABRI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	MULTIPLE SCLEROSIS: 12 MOS. CROHN'S DISEASE: INITIAL: 6 MOS. RENEWAL: 12 MOS.
Other Criteria	MULTIPLE SCLEROSIS INITIAL CRITERIA: PREVIOUS TRIAL OF TWO AGENTS FOR MULTIPLE SCLEROSIS. CROHN'S DISEASE INITIAL CRITERIA: PREVIOUS TRIAL OF HUMIRA AND STELARA. CROHN'S DISEASE RENEWAL CRITERIA: PATIENT HAS RECEIVED AT LEAST 12 MONTHS OF THERAPY WITH TYSABRI WITH PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT REQUIRED MORE THAN 3 MONTHS OF CORTICOSTEROID USE WITHIN THE PAST 12 MONTHS TO CONTROL THEIR CROHN'S DISEASE WHILE ON TYSABRI, OR PATIENT HAS ONLY RECEIVED 6 MONTHS OF THERAPY WITH TYSABRI WITH PHYSICIAN ATTESTATION THAT THE PATIENT HAS TAPERED OFF CORTICOSTEROIDS DURING THE FIRST 24 WEEKS OF TYSABRI THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# NECITUMUMAB

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## Products Affected

- PORTRAZZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# NERATINIB MALEATE

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## Products Affected

- NERLYNX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	EARLY-STAGE TUMOR (STAGE I-III) AND TUMOR IS HORMONE-RECEPTOR POSITIVE AND THE MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE

# NILOTINIB

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## Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PREVIOUSLY TREATED CML REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, Y253H, E255K/V, AND F359V/C/I.

# NINTEDANIB

## Products Affected

- OFEV

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER). NOT APPROVED IF PATIENT DOES NOT HAVE A PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50 PERCENT OR HAS NOT OBTAINED LIVER FUNCTION TESTS.
Required Medical Information	A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	



# NIRAPARIB TOSYLATE

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## Products Affected

- ZEJULA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# NITISINONE

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## Products Affected

- NITYR
- ORFADIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	DIAGNOSIS OF HEREDITARY TYROSINEMIA TYPE 1 AS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED FORMULARY NITISINONE TABLETS OR CAPSULES. RENEWAL: THE PATIENT'S URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.

# NIVOLUMAB

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## Products Affected

- OPDIVO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	MELANOMA: OPDIVO IS NOT APPROVED FOR COMBINATION THERAPY WITH TAFINLAR, MEKINIST (TRAMETINIB), COTELLIC (COBIMETINIB), OR ZELBORAF.

# OBETICHOLIC ACID

## Products Affected

- OCALIVA

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	PATIENTS WITH COMPLETE BILIARY OBSTRUCTION.
<b>Required Medical Information</b>	DIAGNOSIS OF PRIMARY BILIARY CHOLANGITIS AS CONFIRMED BY AT LEAST TWO OF THE FOLLOWING CRITERIA: AN ALKALINE PHOSPHATASE LEVEL OF AT LEAST 1.5 TIMES THE UPPER LIMIT OF NORMAL (ULN), THE PRESENCE OF ANTIMITOCHONDRIAL ANTIBODIES AT A TITER OF 1:40 OR HIGHER, HISTOLOGIC EVIDENCE OF NON-SUPPURATIVE DESTRUCTIVE CHOLANGITIS AND DESTRUCTION OF INTERLOBULAR BILE DUCTS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST OR HEPATOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	INITIAL: USED IN COMBINATION WITH URSODEOXYCHOLIC ACID (E.G., URSODIOL, URSO 250, URSO FORTE) IN ADULTS WITH AN INADEQUATE RESPONSE TO URSODEOXYCHOLIC ACID AT A DOSAGE OF 13-15 MG/KG/DAY FOR AT LEAST 1 YEAR, OR AS MONOTHERAPY IN ADULTS UNABLE TO TOLERATE URSODEOXYCHOLIC ACID. RENEWAL: PATIENT'S ALKALINE PHOSPHATASE LEVELS ARE LESS THAN 1.67-TIMES THE UPPER LIMIT OF NORMAL OR HAVE DECREASED BY AT LEAST 15% FROM BASELINE WHILE ON TREATMENT WITH OBETICHOLIC ACID.

# OBINUTUZUMAB

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## Products Affected

- GAZYVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 MONTHS
<b>Other Criteria</b>	

# OCRELIZUMAB

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## Products Affected

- OCREVUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): THE PATIENT HAD A PREVIOUS TRIAL OF TWO AGENTS INDICATED FOR TREATMENT OF MS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# OLAPARIB

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## Products Affected

- LYNPARZA ORAL CAPSULE
- LYNPARZA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# OMACETAXINE

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## Products Affected

- SYNRIPO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INDUCTION: 3 MONTHS. POST INDUCTION/RENEWAL: 3 TO 12 MONTHS.
<b>Other Criteria</b>	CML INDUCTION THERAPY: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING AGENTS: GLEEVEC, SPRYCEL, TASIGNA, BOSULIF, OR ICLUSIG. APPROVAL FOR POST-INDUCTION THERAPY DURATION WILL DEPEND ON THE PATIENT'S HEMATOLOGIC RESPONSE, DEFINED AS (1) AN ABSOLUTE NEUTROPHIL COUNT (ANC) GREATER THAN OR EQUAL TO $1.5 \times 10^9/L$ AND PLATELETS GREATER THAN OR EQUAL TO $100 \times 10^9/L$ WITHOUT BLOOD BLASTS OR (2) THE PATIENT HAS BONE MARROW BLASTS AT LESS THAN 5 PERCENT. APPROVAL IS FOR 12 MONTHS IF HEMATOLOGIC RESPONSE IS MET. IF NOT MET, APPROVAL IS FOR 3 MONTHS.



# OMALIZUMAB

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL CRITERIA FOR ASTHMA: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30IU/ML. RENEWAL CRITERIA FOR ASTHMA: PHYSICIAN ATTESTATION OF IMPROVEMENT IN ASTHMA EXACERBATIONS FROM BASELINE OR A REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A SPECIALIST IN ALLERGY, PULMONARY MEDICINE, DERMATOLOGY OR IMMUNOLOGY.
<b>Coverage Duration</b>	INITIAL: ASTHMA: 12 MOS. CHRONIC IDIOPATHIC URTICARIA: 6 MOS. RENEWAL FOR ALL INDICATIONS: 12 MOS.
<b>Other Criteria</b>	FOR CHRONIC IDIOPATHIC URTICARIA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO A MAXIMALLY TOLERATED DOSE OF AN H1 ANTI-HISTAMINE (SUCH AS CLARINEX OR XYZAL) AND PATIENT STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK.

# OMBITASVIR-PARITAPREVIR-RITONAVIR

## Products Affected

- TECHNIVIE

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
<b>Exclusion Criteria</b>	DECOMPENSATED CIRRHOSIS, MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD-PUGH B OR C).
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. MUST BE USED CONCURRENTLY WITH RIBAVIRIN. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER): ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, RIFAMPIN, ERGOTAMINE, DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ (ATRIPLA, SUSTIVA), REVATIO (SILDENAFIL DOSE OF 20MG AND/OR DOSED THREE TIMES DAILY FOR PAH), TRIAZOLAM, ORAL MIDAZOLAM, LOPINAVIR/RITONAVIR, RILPIVIRINE, SALMETEROL.</p>

# OMBITASVIR-PARITAPREVIR-RITONAVIR-DASABUVIR

## Products Affected

- VIEKIRA PAK
- VIEKIRA XR

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
<b>Exclusion Criteria</b>	DECOMPENSATED CIRRHOSIS, MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD-PUGH B OR C).
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, GEMFIBROZIL, RIFAMPIN, ERGOTAMINE, DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), ST. JOHN'S WORT, LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ, REVATIO, TRIAZOLAM, ORAL MIDAZOLAM, DARUNAVIR/RITONAVIR, LOPINAVIR/RITONAVIR, RILPIVIRINE, SALMETEROL.</p>

# OSIMERTINIB

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## Products Affected

- TAGRISSO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	METASTATIC NSCLC WITH EGFR T790M MUTATION: CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# OXYMETHOLONE

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## Products Affected

- ANADROL-50

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	CARCINOMA OF THE PROSTATE OR BREAST IN MALE PATIENTS, CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, WOMEN WHO ARE OR MAY BECOME PREGNANT, NEPHROSIS OR THE NEPHROTIC PHASE OF NEPHRITIS, HYPERSENSITIVITY TO THE DRUG AND SEVERE HEPATIC DYSFUNCTION.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# PALBOCICLIB

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## Products Affected

- IBRANCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# PALIVIZUMAB

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## Products Affected

- SYNAGIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	GESTATIONAL AGE
<b>Age Restrictions</b>	LESS THAN 24 MONTHS OF AGE.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 MONTH TO 5 MONTHS. SEE OTHER CRITERIA FOR MORE INFORMATION.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT RECOMMENDATIONS FROM THE AMERICAN ACADEMY OF PEDIATRICS FOR PALIVIZUMAB PROPHYLAXIS FOR RESPIRATORY SYNCYTIAL VIRUS INFECTIONS. INITIAL: APPROVAL WILL BE FOR AT LEAST 1 MONTH AND NO GREATER THAN 5 MONTHS DEPENDENT UPON REMAINING LENGTH OF RESPIRATORY SYNCYTIAL VIRUS (RSV) SEASON. RENEWAL: ADDITIONAL 1 MONTH OF TREATMENT FOR CARDIOPULMONARY BYPASS SURGERY DURING RSV PROPHYLAXIS SEASON.

# PANITUMUMAB

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## Products Affected

- VECTIBIX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# PANOBINOSTAT

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## Products Affected

- FARYDAK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	RENEWAL: PATIENT HAS TOLERATED THE FIRST 8 CYCLES OF THERAPY WITHOUT UNRESOLVED SEVERE OR MEDICALLY SIGNIFICANT TOXICITY.

# PARATHYROID HORMONE

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## Products Affected

- NATPARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# PAZOPANIB

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## Products Affected

- VOTRIENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

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## Products Affected

- *alyq*
- *sildenafil (antihypertensive) oral tablet*
- *tadalafil (antihypertensive)*

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	PATIENT CANNOT CONCURRENTLY OR INTERMITTENTLY BE TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE (GC) STIMULATORS (ADEMPAS).
<b>Required Medical Information</b>	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. REQUEST FOR FORMULARY TADALAFIL 20MG TABLET REQUIRE TRIAL OR CONTRAINDICATION TO REVATIO (SILDENAFIL). RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</p>

# PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION - IV

## Products Affected

- *sildenafil (antihypertensive) intravenous*

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	PATIENT CANNOT CONCURRENTLY OR INTERMITTENTLY BE TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE (GC) STIMULATORS (ADEMPAS).
<b>Required Medical Information</b>	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.



# PEG-INTERFERON ALFA-2B-SYLATRON

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## Products Affected

- SYLATRON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	OVERALL DURATION OF THERAPY LIMITED TO 5 YEARS.

# PEGVALIASE-PQPZ

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## Products Affected

- PALYNZIQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: REDUCTION IN PHENYLALANINE LEVELS BY AT LEAST 20 PERCENT FROM BASELINE OR TO A LEVEL UNDER 600 MICROMOLES PER LITER.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	

# PEMBROLIZUMAB

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## Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# PENICILLAMINE

## Products Affected

- CUPRIMINE
- *penicillamine*

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	RHEUMATOID ARTHRITIS: HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	WILSON'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST. CYSTINURIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	WILSON'S DISEASE: CONFIRMED DIAGNOSIS OF WILSON'S DISEASE. CYSTINURIA: DIAGNOSIS REQUIRES THE PRESENCE OF NEPHROLITHIASIS AND 1 OR MORE OF THE FOLLOWING: STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN. REQUESTS FOR CUPRIMINE FOR THE TREATMENT OF WILSON'S DISEASE, CYSTINURIA, AND RHEUMATOID ARTHRITIS REQUIRE A PREVIOUS TRIAL OF OR CONTRAINDICATION TO DEPEN.

# PENICILLAMINE-DEPEN

## Products Affected

- DEPEN TITRATABS

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	RHEUMATOID ARTHRITIS: HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	WILSON'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST. CYSTINURIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	WILSON'S DISEASE: CONFIRMED DIAGNOSIS OF WILSON'S DISEASE. CYSTINURIA: DIAGNOSIS REQUIRES THE PRESENCE OF NEPHROLITHIASIS AND 1 OR MORE OF THE FOLLOWING: STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN.

# PERTUZUMAB

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## Products Affected

- PERJETA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# PIMAVANSERIN

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## Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG, 17 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 YEARS OR OLDER
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (SUCH AS A PSYCHIATRIST).
<b>Coverage Duration</b>	INITIAL 12 MONTHS. RENEWAL 12 MONTHS.
<b>Other Criteria</b>	RENEWAL REQUIRES THAT THE PATIENT HAS EXPERIENCED AN IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.

# PIRFENIDONE

## Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	PATIENTS WITH KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER). NOT APPROVED IF THE PATIENT HAS NOT OBTAINED LIVER FUNCTION TESTS.
<b>Required Medical Information</b>	PATIENT WITH USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PATIENT HAS A PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50%.



# POLATUZUMAB VEDOTIN

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## Products Affected

- POLIVY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# POMALIDOMIDE

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## Products Affected

- POMALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# PONATINIB

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## Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# PRAMLINTIDE

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## Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# PYRIMETHAMINE

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## Products Affected

- DARAPRIM

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D, ADDITIONAL CONSIDERATION FOR CHRONIC MAINTENANCE THERAPY FOR TOXOPLASMOSIS AND TOXOPLASMOSIS PROPHYLAXIS.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TOXOPLASMOSIS: INITIAL: 8 WEEKS. RENEWAL: 6 MOS. PROPHYLAXIS: 12 MOS. FOR INITIAL AND RENEWAL.
Other Criteria	INITIAL: PRIMARY PROPHYLAXIS OF TOXOPLASMOSIS IN PATIENTS WITH HIV REQUIRES PREVIOUS TRIAL OF OR CONTRAINDICATION TO BACTRIM (SMX/TMP). RENEWAL: CONTINUED TREATMENT OF TOXOPLASMOSIS REQUIRES ONE OF THE FOLLOWING: 1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING) OR 2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENT ANTI-RETROVIRAL THERAPY IF HIV POSITIVE. CONTINUATION OF PRIMARY PROPHYLAXIS FOR TOXOPLASMOSIS WITH HIV REQUIRES CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENT ANTI-RETROVIRAL THERAPY.

# QUININE SULFATE

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## Products Affected

- *quinine sulfate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# RAMUCIRUMAB

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## Products Affected

- CYRAMZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# REGORAFENIB

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## Products Affected

- STIVARGA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# RESLIZUMAB

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## Products Affected

- CINQAIR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	CONCURRENT USE OF XOLAIR.
<b>Required Medical Information</b>	BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 400 CELLS/MCL WITHIN THE LAST 6 MONTHS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE, AN ALLERGIST OR AN IMMUNOLOGIST.
<b>Coverage Duration</b>	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL THERAPY: PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS. RENEWAL REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED AT LEAST A 25 PERCENT REDUCTION IN ASTHMA EXACERBATIONS (FOR EXAMPLE: HOSPITALIZATIONS, URGENT OR EMERGENT CARE VISITS, USE OF RESCUE MEDICATIONS, ETC.) FROM BASELINE.

# RIBOCICLIB

## Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# RIFAXIMIN

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## Products Affected

- XIFAXAN ORAL TABLET 200 MG,  
550 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	TRAVELERS' DIARRHEA/HEPATIC ENCEPHALOPATHY: 12 MOS. IBS-D: 12 WKS.
<b>Other Criteria</b>	FOR RIFAXIMIN 550 MG TABLETS ONLY: HEPATIC ENCEPHALOPATHY (HE): PREVIOUS TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY.

# RIOCIQUAT

## Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	INITIAL FOR PAH: PATIENT IS NOT CONCURRENTLY TAKING NITRATES OR NITRIC OXIDE DONORS (E.G. AMYL NITRATE), PHOSPHODIESTERASE INHIBITORS (E.G. SILDENAFIL, TADALAFIL, OR VARDENAFIL), OR NON-SPECIFIC PDE INHIBITORS (E.G. DIPYRIDAMOLE, THEOPHYLLINE). INITIAL FOR CTEPH: PATIENT IS NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH. PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. PATIENT IS NOT CONCURRENTLY OR INTERMITTENTLY TAKING NITRATES, NITRIC OXIDE DONORS OR ANY PDE INHIBITORS (E.G. VIAGRA, CIALIS, DIPYRIDAMOLE).
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS. DIAGNOSIS OF PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) WHO GROUP 4. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL FOR PAH: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. PREVIOUS TRIAL OF OR CONTRAINDICATION TO A PHOSPHODIESTERASE-5 (PDE-5) INHIBITOR, SUCH AS REVATIO (SILDENAFIL) OR ADCIRCA (TADALAFIL). RENEWAL FOR PAH AND CTEPH: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.</p>

# RISANKIZUMAB-RZAA

## Products Affected

- SKYRIZI

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY, SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE

# RITUXIMAB

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## Products Affected

- RITUXAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL FOR RA: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: ONCOLOGIST.
<b>Coverage Duration</b>	RA: INITIAL: 6 MO, RENEWAL: 12 MONTHS. NHL, PV: 12 MONTHS. CLL: 6 MO. WG, MPA: 3 MONTHS.
<b>Other Criteria</b>	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# RITUXIMAB SQ

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## Products Affected

- RITUXAN HYCELA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THE PATIENT HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE.



# ROMIPLOSTIM

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## Products Affected

- NPLATE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.

# ROMOSOZUMAB

## Products Affected

- EVENITY 105 MG/1.17 ML SYRINGE
- EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	

# RUCAPARIB

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## Products Affected

- RUBRACA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# RUXOLITINIB

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## Products Affected

- JAKAFI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	MYELOFIBROSIS RENEWAL: IMPROVEMENT OR MAINTENANCE OF SYMPTOM IMPROVEMENT SUCH AS A 50% OR GREATER REDUCTION IN TOTAL SYMPTOM SCORE ON THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF) V2.0 OR 50% OR GREATER REDUCTION IN PALPABLE SPLEEN LENGTH, OR REDUCTION OF 35% OR GREATER FROM BASELINE SPLEEN VOLUME AFTER 6 MONTHS OF THERAPY.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	MYELOFIBROSIS INITIAL:6 MONTHS RENEWAL:12 MONTHS. OTHER INDICATIONS:12 MONTHS
<b>Other Criteria</b>	

# SAFINAMIDE MESYLATE

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## Products Affected

- XADAGO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# SARILUMAB

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## Products Affected

- KEVZARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE

# SEBELIPASE ALFA

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## Products Affected

- KANUMA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	BLOOD TEST OR DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT LYSOSOMAL ACID LIPASE DEFICIENCY (LAL) ENZYME ACTIVITY, OR A GENETIC TEST INDICATING THE PRESENCE OF ALTERED LIPA GENE(S).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, HEPATOLOGIST, GASTROENTEROLOGIST, MEDICAL GENETICIST, LIPIDOLOGIST, OR A METABOLIC SPECIALIST.
<b>Coverage Duration</b>	LAL INITIAL 6 OR 12 MONTHS, SEE OTHER CRITERIA. RENEWAL: 12 MONTHS



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY, AS CONFIRMED BY THE PRESENCE OF CLINICAL FEATURES (E.G., HEPATOMEGALY, ELEVATED SERUM TRANSAMINASES, DYSLIPIDEMIA, SPLENOMEGALY) PLUS ANY OF THE FOLLOWING: A BLOOD TEST INDICATING LOW OR ABSENT LEVELS OF LAL ENZYME ACTIVITY, A DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT LAL ENZYME ACTIVITY, OR A GENETIC TEST INDICATING THE BI-ALLELIC PRESENCE OF ALTERED LIPA GENE(S).</p> <p>RENEWAL:DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING AFTER THE FIRST 6 MONTHS OF LIFE AND NOT CONSIDERED RAPIDLY PROGRESSIVE REQUIRES DOCUMENTED IMPROVEMENT IN ANY ONE OF THE FOLLOWING CLINICAL PARAMETERS ASSOCIATED WITH LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY DURING THE PAST 6 MONTHS: A RELATIVE REDUCTION FROM BASELINE IN ANY ONE OF THE FOLLOWING LIPID LEVELS (LDL-C, NON-HDL-C, OR TRIGLYCERIDES), NORMALIZATION OF ASPARTATE AMINOTRANSFERASE (AST) BASED ON AGE- AND GENDER-SPECIFIC NORMAL RANGES, A DECREASE IN LIVER FAT CONTENT COMPARED TO BASELINE ASSESSED BY ABDOMINAL IMAGING (E.G., MULTI-ECHO GRADIENT ECHO [MEGE] MRI). DIAGNOSIS OF RAPIDLY PROGRESSIVE LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING WITHIN THE FIRST 6 MONTHS OF LIFE: 12 MONTHS. A DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING AFTER THE FIRST 6 MONTHS OF LIFE AND NOT CONSIDERED RAPIDLY PROGRESSIVE: INITIAL: 6 MONTHS</p>

# SECUKINUMAB

## Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL FOR PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION AT LEAST ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTI-RHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE</p>

# SELEXIPAG

## Products Affected

- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI ORAL TABLETS, DOSE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

# SELINEXOR

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## Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 160 MG/WEEK (20 MG X 8), 60 MG/WEEK (20 MG X 3), 80 MG/WEEK (20 MG X 4)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# SILTUXIMAB

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## Products Affected

- SYLVANT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# SIPONIMOD

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## Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 2 MG
- MAYZENT STARTER PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# SOFOSBUVIR

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## Products Affected

- SOVALDI

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
<b>Exclusion Criteria</b>	PATIENT WITH END STAGE RENAL DISEASE OR REQUIRES DIALYSIS.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE



<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. FOR PATIENTS ON SOVALDI PLUS DAKLINZA REGIMENS THERE WILL BE NO APPROVALS FOR CONCURRENT USE OF ANY OF THESE (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN. REQUESTS FOR SOVALDI IN COMBINATION WITH DAKLINZA WILL REQUIRE THAT THE PATIENT ALSO MEETS ALL CRITERIA FOR DAKLINZA.

# SOFOBUVIR/VELPATASVIR

## Products Affected

- EPCLUSA

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HCV RNA LEVEL.
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER.
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANA VIR/RITONAVIR OR TOPOTECAN. PATIENT MUST NOT HAVE SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS. RIBAVIRIN USE REQUIRED FOR PATIENTS WITH DECOMPENSATED CIRRHOSIS.

# SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

## Products Affected

- VOSEVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
<b>Exclusion Criteria</b>	SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS. MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR OR TIPRANAVIR/RITONAVIR.</p>

# SOFOSBUVIR/VELPATASVIR-GENERIC

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## Products Affected

- *sofosbuvir-velpatasvir*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HCV RNA LEVEL.
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER.
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR OR TOPOTECAN. PATIENT MUST NOT HAVE SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS. PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE. REQUESTS FOR GENERIC SOFOSBUVIR/VELPATASVIR REQUIRE TRIAL OF OR CONTRAINDICATION TO BRAND EPCLUSA.</p>

# SOMATROPIN - GROWTH HORMONE

## Products Affected

- HUMATROPE
- OMNITROPE
- SAIZEN
- SAIZEN SAIZENPREP
- ZOMACTON

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), AND SHOX DEFICIENCY
<b>Required Medical Information</b>	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, AND SHOX DEFICIENCY: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): PHYSICIAN ATTESTATION OF CONFIRMED GENETIC DIAGNOSIS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: ENDOCRINOLOGIST.
<b>Coverage Duration</b>	12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. FOR ALL DIAGNOSES EXCEPT SHOX DEFICIENCY: PREVIOUS TRIAL OF PREFERRED FORMULARY ALTERNATIVES NORDITROPIN AND GENOTROPIN. RENEWAL FOR PEDIATRIC GHD, ISS, SGA, TS, AND SHOX DEFICIENCY: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E, INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). PWS: PHYSICIAN ATTESTATION OF IMPROVEMENT IN BODY COMPOSITION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</p>



# SOMATROPIN - SEROSTIM

## Products Affected

- SEROSTIM SUBCUTANEOUS  
RECON SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
<b>Required Medical Information</b>	INITIAL: HIV/WASTING: MEETS ONE OF THE FOLLOWING CRITERIA FOR WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5% OVER 6 MONTHS, OR 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 18.5 KG PER METER SQUARED.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST
<b>Coverage Duration</b>	3 MONTHS
<b>Other Criteria</b>	INITIAL: HIV/WASTING: PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. RENEWAL: HIV/WASTING: PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT. INITIAL AND RENEWAL: HIV/WASTING: CURRENTLY ON HIV ANTIRETROVIRAL THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# SOMATROPIN - ZORBTIVE

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## Products Affected

- ZORBTIVE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST
<b>Coverage Duration</b>	SHORT BOWEL: 4 WEEKS ONCE.
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# SOMATROPIN-NORDITROPIN AND GENOTROPIN

## Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), AND NOONAN SYNDROME.
<b>Required Medical Information</b>	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, AND NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): PHYSICIAN ATTESTATION OF CONFIRMED GENETIC DIAGNOSIS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: ENDOCRINOLOGIST.
<b>Coverage Duration</b>	12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. RENEWAL: PEDIATRIC GHD, ISS, SGA, TS, AND NOONAN SYNDROME: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). PWS: PHYSICIAN ATTESTATION OF IMPROVEMENT IN BODY COMPOSITION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</p>

# SOMATROPIN-NUTROPIN AND NUTROPIN AQ

## Products Affected

- NUTROPIN AQ NUSPIN

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE DUE TO CKD IF PATIENT HAS HAD A RENAL TRANSPLANT, OR GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), AND TURNER SYNDROME (TS)
<b>Required Medical Information</b>	INITIAL FOR PEDIATRIC GHD, ISS, AND TS: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. INITIAL FOR CKD: HEIGHT OR GROWTH VELOCITY AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: ENDOCRINOLOGIST. FOR GROWTH HORMONE FAILURE DUE TO CKD: NEPHROLOGIST.
<b>Coverage Duration</b>	12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. FOR ALL DIAGNOSES EXCEPT CKD: PREVIOUS TRIAL OF PREFERRED FORMULARY ALTERNATIVES NORDITROPIN AND GENOTROPIN. RENEWAL FOR ALL INDICATIONS EXCEPT ADULT GHD: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E, INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.</p>

# SONIDEGIB

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## Products Affected

- ODOMZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# SORAFENIB TOSYLATE

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## Products Affected

- NEXAVAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# SUNITINIB MALATE

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## Products Affected

- SUTENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.

# TADALAFIL

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## Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TRIAL OF ONE FORMULARY ALPHA BLOCKER SUCH AS DOXAZOSIN, TERAZOSIN, TAMSULOSIN OR ALFUZOSIN) AND ONE FORMULARY 5-ALPHA-REDUCTASE (SUCH AS FINASTERIDE OR DUTASTERIDE). APPLIES TO 2.5MG AND 5MG STRENGTHS ONLY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# TAFAMIDIS

## Products Affected

- VYNDAQEL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT PROGRESSED TO NYHA CLASS IV HEART FAILURE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PATIENT HAS NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE. DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF 99MTCPPYP/DPD, OR 2) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN.

# TALAZOPARIB

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## Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# TALIMOGENE

## Products Affected

- IMLYGIC INJECTION SUSPENSION  
10EXP6 (1 MILLION) PFU/ML, 10EXP8  
(100 MILLION) PFU/ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	HISTORY OF PRIMARY OR ACQUIRED IMMUNODEFICIENT STATES, LEUKEMIA, LYMPHOMA, OR AIDS. PATIENT IS NOT CURRENTLY RECEIVING IMMUNOSUPPRESSIVE THERAPY.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	IMLYGIC TO BE INJECTED INTO CUTANEOUS, SUBCUTANEOUS, AND OR NODAL LESIONS THAT ARE VISIBLE, PALPABLE, OR DETECTABLE BY ULTRASOUND GUIDANCE. NO CONCURRENT USE WITH PEMBROLIZUMAB, NIVOLUMAB, IPILIMUMAB, DABRAFENIB, TRAMETINIB, VEMURAFENIB, INTERLEUKIN-2, INTERFERON, DACARBAZINE, TEMOZOLOMIDE, PACLITAXEL, CARBOPLATIN, IMATINIB, MELPHALAN, IMIQUIMOD, OR RADIATION THERAPY.

# TASIMELTEON

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## Products Affected

- HETLIOZ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# TEDUGLUTIDE

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## Products Affected

- GATTEX 30-VIAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PATIENT IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK.

# TELOTRISTAT

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## Products Affected

- XERMELO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# TEMOZOLOMIDE

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## Products Affected

- TEMODAR INTRAVENOUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# TERIFLUNOMIDE

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## Products Affected

- AUBAGIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# TERIPARATIDE

## Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., ALENDRONATE, RISEDRONATE, IBANDRONATE).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	

# TESTOSTERONE

## Products Affected

- *testosterone cypionate* (25 mg/2.5gram), 1 % (50 mg/5 gram),
- *testosterone enanthate* 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)
- *testosterone transdermal gel in metered-dose pump* 20.25 mg/1.25 gram (1.62 %) • XYOSTED
- *testosterone transdermal gel in packet* 1 %

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL CONSIDERATION FOR GENDER DYSPHORIA.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LAB CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 300 NG/DL OR 2) A LOW TOTAL SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB RESULT WITH A REFERENCE RANGE OBTAINED WITHIN 90 DAYS, OR 3) A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 PG/ML.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	LIFETIME OF MEMBERSHIP IN PLAN
<b>Other Criteria</b>	

# TETRABENAZINE

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## Products Affected

- *tetrabenazine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# TEZACAFTOR/IVACAFTOR

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## Products Affected

- SYMDEKO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
<b>Coverage Duration</b>	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
<b>Other Criteria</b>	RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.

# THALIDOMIDE

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## Products Affected

- THALOMID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# TILDRAKIZUMAB

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## Products Affected

- ILUMYA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, STELARA, ENBREL, SKYRIZI.

# TOCILIZUMAB IV

## Products Affected

- ACTEMRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RA, PJIA, OR SJIA: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	MODERATE TO SEVERE RHEUMATOID ARTHRITIS (RA)/POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA)/SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: RA, PJIA, OR SJIA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: 12 MONTHS FOR RA, PJIA, OR SJIA
Other Criteria	INITIAL: RA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PJIA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA

# TOCILIZUMAB SQ

## Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RA, PJIA AND SJIA RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA) AND SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	RA INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PJIA INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.

# TOFACITINIB

## Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL FOR RHEUMATOID ARTHRITIS (RA) AND PSORIATIC ARTHRITIS (PSA): PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.

# TOLVAPTAN

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## Products Affected

- JYNARQUE ORAL TABLET
- JYNARQUE ORAL TABLETS, SEQUENTIAL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION THAT PATIENT HAS NOT PROGRESSED TO ESRD/DIALYSIS OR TRANSPLANT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: THE PATIENT MEETS ALL OF THE FOLLOWING: (1) CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI IMAGING, OR ULTRASOUND (2) GENETIC TESTING FOR CAUSATIVE MUTATIONS OR FAMILY HISTORY OF CONFIRMED POLYCYSTIC KIDNEY DISEASE IN ONE OR BOTH PARENTS, AND (3) PATIENT DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS OR HAS UNDERGONE RENAL TRANSPLANT).

# TOPICAL TRETINOIN

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## Products Affected

- *tretinoin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	WRINKLES, PHOTOAGING, MELASMA.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# TOPICAL TRETINOIN LOTION

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## Products Affected

- ALTRENO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	WRINKLES, PHOTOAGING, MELASMA.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANOTHER FORMULARY VERSION OF TOPICAL TRETINOIN

# TRABECTEDIN

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## Products Affected

- YONDELIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# TRAMETINIB DIMETHYL SULFOXIDE

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## Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# TRASTUZUMAB

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## Products Affected

- HERCEPTIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	BREAST CANCER, METASTATIC BREAST CANCER, GASTRIC CANCER: HER2 POSITIVE
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	B VS D COVERAGE CONSIDERATION.

# TRASTUZUMAB HYALURONIDASE

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## Products Affected

- HERCEPTIN HYLECTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# TRASTUZUMAB-ANNS

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## Products Affected

- KANJINTI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# TREPROSTINIL DIOLAMINE

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## Products Affected

- ORENITRAM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	PATIENT DOES NOT HAVE SEVERE HEPATIC IMPAIRMENT.
<b>Required Medical Information</b>	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. PREVIOUS OR CURRENT TREATMENT WITH ONE OF THE FOLLOWING AGENTS: A FORMULARY PHOSPHODIESTERASE-5 INHIBITOR (E.G., SILDENAFIL [GENERIC FOR REVATIO] OR ADCIRCA [TADALAFIL]) OR AN ENDOTHELIN RECEPTOR ANTAGONIST (E.G., TRACLEER [BOSENTAN], LETAIRIS [AMBRISANTAN], OR OPSUMIT [MACITENTAN]). TRIAL OF A FORMULARY PHOSPHODIESTERASE-5 INHIBITOR OR ENDOTHELIN RECEPTOR ANTAGONIST IS NOT REQUIRED IF THE PATIENT WAS PREVIOUSLY STABLE ON ORENITRAM. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.</p>

# TREPROSTINIL INHALED

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## Products Affected

- TYVASO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>THIS DRUG MAYBE 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. NEBULIZER THERAPY IS COVERED UNDER PART B FOR PATIENTS WHO ARE USING THE MEDICATION VIA A NEBULIZER IN THEIR OWN HOME. THOSE WHO ARE NOT USING IT IN THEIR HOME WILL BE COVERED UNDER PART D. INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.</p>



# TREPROSTINIL SODIUM INJECTABLE

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## Products Affected

- *treprostinil sodium*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	COVERED UNDER LOCAL COVERAGE POLICY OF APPLICABLE MEDICARE DMERC.
<b>Required Medical Information</b>	FORMULARY DRUG ADMINISTERED IN A LONG TERM CARE FACILITY TO A PATIENT WHOSE PART A COVERAGE HAS EXPIRED OR FORMULARY DRUG NOT ADMINISTERED VIA AN IMPLANTABLE PUMP OR AN EXTERNAL PUMP OR DRUG ADMINISTERED VIA AN IMPLANTABLE PUMP/AN EXTERNAL PUMP. DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. CONTINUATION OF CURRENT REMODULIN THERAPY: PATIENT MUST HAVE NYHA/WHO FC II-IV SYMPTOMS. NEW REQUESTS FOR REMODULIN THERAPY: PATIENT MUST HAVE NYHA/WHO FC III-IV SYMPTOMS. NEW REQUESTS FOR REMODULIN THERAPY FOR PATIENTS WITH NYHA/WHO FC II SYMPTOMS REQUIRES A TRIAL OF OR CONTRAINDICATION TO A PHOSPHODIESTERASE-5 INHIBITOR (PDE-5) (E.G., REVATIO (SILDENAFIL), ADCIRCA (TADALAFIL)) OR AN ENDOTHELIN RECEPTOR ANTAGONIST (ERA) (E.G., LETAIRIS, OPSUMIT, TRACLEER). RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.</p>

# TRIENTINE

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## Products Affected

- *trientine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	KNOWN FAMILY HISTORY OF WILSON'S DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSON'S DISEASE. PLASMA COPPER-PROTEIN CERULOPLASMIN LESS THAN 20 MG/DL. LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250 MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PREVIOUS TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE (DEPEN).

# TRIFLURIDINE/TIPIRACIL

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## Products Affected

- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# URIDINE TRIACETATE

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## Products Affected

- XURIDEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: DIAGNOSIS CONFIRMED BY 1) GENETIC MUTATION OF URIDINE MONOPHOSPHATE SYNTHASE (UMPS) GENE AND 2) ELEVATED URINE OROTIC ACID PER AGE-SPECIFIC REFERENCE RANGE. RENEWAL: IMPROVEMENT FROM BASELINE OR STABILIZATION OF AGE DEPENDENT HEMATOLOGIC PARAMETERS (E.G., NEUTROPHIL COUNT, NEUTROPHIL PERCENT, WBC COUNT, MEAN CORPUSCULAR VOLUME)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	

# USTEKINUMAB

## Products Affected

- STELARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA OR FACE. RENEWAL FOR PSORIATIC ARTHRITIS OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: PSA, PSO, CD: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION AT LEAST ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS (I.E. BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE.</p>

# USTEKINUMAB IV

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## Products Affected

- STELARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	2 MONTHS
<b>Other Criteria</b>	PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS (I.E. BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.



# VALBENZAZINE TOSYLATE

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## Products Affected

- INGREZZA
- INGREZZA INITIATION PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	PATIENT HAS A PRIOR HISTORY OF USING ANTIPSYCHOTIC MEDICATIONS OR METOCLOPRAMIDE PER PHYSICIAN ATTESTATION.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# VANDETANIB

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## Products Affected

- CAPRELSA ORAL TABLET 100 MG,  
300 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# VEMURAFENIB

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## Products Affected

- ZELBORAF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# VENETOCLAX

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# VESTRONIDASE ALFA VJBK

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## Products Affected

- MEPSEVII

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS IMPROVED, MAINTAINED, OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY FROM BASELINE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN GENETIC OR METABOLIC DISORDERS.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: THE PATIENT MEETS ALL OF THE FOLLOWING CRITERIA: 1) THE PATIENT HAS NOT UNDERGONE SUCCESSFUL BONE MARROW OR STEM CELL TREATMENT FOR MPS VII, 2) THE PATIENT HAS LIMITATION IN MOBILITY, BUT REMAINS SUFFICIENTLY AMBUATLORY, AND 3) DIAGNOSIS OF MPS VII CONFIRMED BY ALL OF THE FOLLOWING CRITERIA: A) PHYSICIAN ATTESTATION OF URINARY GAG (GLYCOSAMINOGLYCAN) LEVEL OF GREATER THAN THREE TIMES THE UPPER LEVEL OF NORMAL BASED ON THE LABORATORY ASSAY, B) PHYSICIAN ATTESTATION OF BETA-GLUCURONIDASE ENZYME ACTIVITY DEFICIENCY OR GENETIC TESTING, AND C) PHYSICIAN ATTESTATION THAT THE PATIENT HAS AT LEAST ONE OF THE FOLLOWING CLINICAL SIGNS OF MPS VII: ENLARGED LIVER AND SPLEEN, JOINT LIMITATIONS, AIRWAY OBSTRUCTIONS OR PULMONARY DYSFUNCTION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.</p>

# VINCRIStINE SULFATE LIPOSOMAL

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## Products Affected

- MARQIBO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# VISMODEGIB

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## Products Affected

- ERIVEDGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	



# ZIV-AFLIBERCEPT

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## Products Affected

- ZALTRAP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
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