ACTIMMUNE

Products Affected

- Actimmune

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, atopic dermatitis.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ADAGEN

Products Affected

- Adagen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For pulmonary arterial hypertension (PAH) (WHO Group 1): PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangioleiomyomatosis, neuroendocrine tumor of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), osteosarcoma.
Exclusion Criteria	N/A
Required Medical Information	For breast cancer: 1) The patient has recurrent or metastatic hormone receptor positive, HER2 negative disease, 2) Afinitor will be used in combination with exemestane, and 3) The patient's disease either a) has progressed while on or within 12 months of nonsteroidal aromatase inhibitor therapy, OR b) was previously treated with tamoxifen. For renal cell carcinoma: 1) The disease is relapsed, metastatic or unresectable, and 2) For disease that is of predominantly clear cell histology, disease has progressed on prior antigiogenic therapy (e.g., sunitinib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALDURAZYME

Products Affected

- Aldurazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mucopolysaccharidosis I was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic testing. Patients with Scheie syndrome must have moderate to severe symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALPHA1-PROTEINASE INHIBITOR

Products Affected

- Aralast Np INJ 1000MG, 500MG
- Prolastin-c
- Zemaira

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patients must have clinically evident emphysema. Patients must have a pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dl by radial immunodiffusion or 50 mg/dl by nephelometry). Patients must have a pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) greater than or equal to 25 percent and less than or equal to 80 percent of predicted.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AMPYRA

Products Affected

- Ampyra
- Dalfampridine Er

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment. For continuation of therapy: Patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting the requested medication.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ANABOLIC STEROIDS

Products Affected

- Oxandrolone TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting) or to enhance growth in patients with Turner's Syndrome.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

ANADROL

Products Affected

- Anadrol-50

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting), Fanconi's anemia.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

ANALGESICS-AGE EDIT

Products Affected

- Indomethacin CAPS
- Indomethacin Er
- Ketorolac Tromethamine INJ 15MG/ML, 30MG/ML
- Ketorolac Tromethamine TABS
- Meperidine Hcl INJ 100MG/ML, 10MG/ML, 25MG/ML, 50MG/ML
- Meperidine Hcl ORAL SOLN
- Meperidine Hcl TABS
- Pentazocine/naloxone Hcl

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For acute gout: Member must have tried and failed, or has a contraindication or intolerance to two of the following covered formulary drugs: generic colchicine, Colcrys (colchicine), celecoxib, diclofenac, naproxen, piroxicam, or sulindac.

ANTIDEPRESSANTS-AGE EDIT

Products Affected

- Amitriptyline Hcl TABS 100MG, 150MG, 25MG, 75MG
- Amitriptyline Hydrochloride TABS 10MG, 50MG
- Chlordiazepoxide/amitriptyline
- Clomipramine Hcl CAPS
- Doxepin Hcl CAPS 100MG, 10MG, 150MG, 50MG, 75MG
- Doxepin Hcl CONC
- Doxepin Hydrochloride CAPS 25MG
- Imipramine Hcl TABS 25MG, 50MG
- Imipramine Hydrochloride TABS 10MG
- Imipramine Pamoate
- Perphenazine/amitriptyline
- Trimipramine Maleate CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to two formulary Selective serotonin reuptake inhibitors (SSRI), Serotonin–norepinephrine reuptake inhibitors (SNRI), or trazodone. If using target medication for a medically-accepted indication not shared by the required alternatives listed, then no trial of alternatives is required for that target high-risk medication. Applies to new starts only.

ANTIEMETICS-AGE EDIT

Products Affected

- Trimethobenzamide Hydrochloride

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to ondansetron or granisetron. If using target medication for a medically-accepted indication not shared by the required alternatives listed, then no trial of alternatives is required for that target high-risk medication.

ANTIHISTAMINES-AGE EDIT

Products Affected

- Carbinoxamine Maleate SOLN
- Carbinoxamine Maleate TABS
- Clemastine Fumarate TABS 2.68MG
- Cyproheptadine Hcl SYRP
- Cyproheptadine Hcl TABS
- Cyproheptadine Hydrochloride SYRP
- Diphenhydramine Hcl INJ 50MG/ML
- Phenadoz
- Phenergan SUPP
- Promethazine Hcl INJ
- Promethazine Hcl SUPP
- Promethazine Hcl SYRP
- Promethazine Hcl TABS 12.5MG
- Promethazine Hcl Plain
- Promethazine Hydrochloride TABS 25MG, 50MG
- Promethazine Vc Plain SOLN
- Promethazine/phenylephrine
- Promethegan

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For Perennial Allergic Rhinitis or Chronic Idiopathic Urticaria: Member must have tried and failed, or has a contraindication or intolerance to levocetirizine.

ANTIPARKINSON AGENTS-AGE EDIT

Products Affected

- Benztropine Mesylate INJ
- Benztropine Mesylate TABS
- Trihexyphenidyl Hcl SOLN
- Trihexyphenidyl Hydrochloride

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For Parkinson's disease: Member must have tried and failed, or has a contraindication or intolerance to one of the following: amantadine, pramipexole, or ropinirole.

ANXIOLYTICS-AGE EDIT

Products Affected

- Meprobamate

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to two of the following: buspirone, SSRIs, SNRIs

APOKYN

Products Affected

- Apokyn INJ 30MG/3ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ARANESP

Products Affected

- Aranesp Albumin Free INJ 100MCG/0.5ML, 100MCG/ML, 10MCG/0.4ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 25MCG/0.42ML, 25MCG/ML, 300MCG/0.6ML, 300MCG/ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled hypertension
Required Medical Information	For initiation of therapy: adequate iron stores have been demonstrated by means of bone marrow iron or serum ferritin levels or serum iron saturation studies within the prior 12 months (Note: for persons with iron deficiency, erythropoietin analog therapy may be initiated simultaneous with iron replacement), and the following criteria is met: hemoglobin (Hgb) is approaching or has fallen below 10 g/dl (CKD not on dialysis-adult, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD) or hematocrit of 30% OR patient will be starting myelosuppressive therapy and will have an anticipated hemoglobin drop associated with their therapy. For continuation of therapy: documentation of the below: for persons with anemia due to myelosuppressive anticancer chemotherapy: Hgb target of 12 g/dl For persons with chronic renal failure and end-stage renal disease (ESRD): Hgb target 10-11 g/dl. Continued use of the therapy is not covered if the hemoglobin rises less than 1 g/dl (hematocrit rise less than 3%) compared to pretreatment baseline by 12 weeks of treatment and whose hemoglobin level remains less than 10 g/dL (or the hematocrit is less than 30%).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks

Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to Procrit (erythropoietin injection). Excluded from members with Hgb at or above 10 g/dL (CKD not on dialysis-adult, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD).

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, prevention of gout flares in patients initiating or continuing urate-lowering therapy.
Exclusion Criteria	N/A
Required Medical Information	For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., oral allopurinol or febuxostat) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, AND 3) concurrent use with urate-lowering therapy (i.e., oral allopurinol or febuxostat). For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., oral allopurinol or febuxostat) (continuation): 1) member must have achieved or maintained a clinical benefit (i.e., fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For prevention of gout flares: 4 months. Other: Plan Year
Other Criteria	N/A

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AUSTEDO

Products Affected

- Austedo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

AVASTIN

Products Affected

- Avastin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BANZEL

Products Affected

- Banzel

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BELEODAQ

Products Affected

- Beleodaq

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe active lupus nephritis. Severe active central nervous system lupus.
Required Medical Information	Patient has been diagnosed with active, autoantibody-positive systemic lupus erythematosus (SLE). Patient is currently receiving standard therapy for SLE (e.g., corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) OR patient is not currently receiving standard therapy for SLE because patient tried and had an inadequate response or intolerance to standard therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BERINERT

Products Affected

- Berinert

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

BETASERON

Products Affected

- Betaseron

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BEXAROTENE

Products Affected

- Bexarotene
- Targretin GEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), chronic or smoldering adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BOSENTAN

Products Affected

- Bosentan
- Tracleer TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, relapsed/refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL).
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of CML was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) Patient has chronic phase CML, OR 2) Patient has accelerated or blast phase CML, OR 3) Patient received a hematopoietic stem cell transplant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BRAFTOVI

Products Affected

- Braftovi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

BRIVIACT

Products Affected

- Briviact

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	4 years of age or older (tablets and oral solution).
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BUPHENYL

Products Affected

- Sodium Phenylbutyrate POWD 3GM/TSP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated for acute hyperammonemia emergency management.
Required Medical Information	Urea Cycle Disorders (UCD): Confirmed by enzymatic, biochemical or genetic testing. Will be used for chronic management of UCD.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

BUPRENORPHINE

Products Affected

- Buprenorphine Hcl SUBL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is being prescribed for the treatment of opioid dependence AND 2) If the patient is pregnant or breastfeeding and being prescribed the requested drug for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) If the requested drug is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) If the requested drug is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Induction 3 months, Maintenance Plan Year, Pregnancy/Breastfeeding Plan Year
Other Criteria	N/A

BUTALBITAL-AGE EDIT

Products Affected

- Ascomp/codeine
- Bupap TABS 300MG; 50MG
- Butalbital/acetaminophen/caffeine CAPS
- Butalbital/acetaminophen/caffeine TABS 325MG; 50MG; 40MG
- Butalbital/acetaminophen/caffeine/codeine
- Butalbital/aspirin/caffeine
- Butalbital/aspirin/caffeine/codeine
- Esgic CAPS
- Phrenilin Forte CAPS 300MG; 50MG; 40MG
- Zebutal CAPS 325MG; 50MG; 40MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For tension headache: Patient has a documented trial and failure of or intolerance or contraindication to rizatriptan and ibuprofen.

BUTRANS

Products Affected

- Buprenorphine PTWK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Significant respiratory depression, Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment, Known or suspected gastrointestinal obstruction, including paralytic ileus. As an as-needed (prn) analgesic.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer.
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CALCIPOTRIENE

Products Affected

- Calcipotriene CREA
- Calcipotriene OINT
- Calcipotriene SOLN
- Calcipotriene/betamethasone Dipropionate
- Calcitrene
- Enstilar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members with demonstrated hypercalcemia or evidence of vitamin D toxicity.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use.

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CAMBIA

Products Affected

- Cambia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in patients who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. Contraindicated for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to 2 of the following: ibuprofen, formulary generic triptan drugs (such as sumatriptan, eletriptan, naratriptan, rizatriptan)

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small lung cancer and differentiated thyroid carcinoma: papillary, follicular, Hurthle cell.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): the requested drug is used for NSCLC with RET gene rearrangements.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CARAC

Products Affected

- Carac
- Fluorouracil CREA 0.5%

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members who are pregnant or may become pregnant. Members with dihydropyrimidine dehydrogenase (DPD) enzyme deficiency.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use.

CARBAGLU

Products Affected

- Carbaglu

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, methylmalonic acidemia, propionic acidemia.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CARDIOVASCULAR-AGE EDIT

Products Affected

- Dipyridamole TABS
- Disopyramide Phosphate CAPS
- Guanfacine Hcl
- Methyldopa TABS 250MG, 500MG
- Nifedipine CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pseudomonas aeruginosa is present in the patient's airway cultures OR the patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CERDELGA

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CEREZYME

Products Affected

- Cerezyme

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

CHANTIX

Products Affected

- Chantix TABS 0.5MG, 1MG
- Chantix Continuing Month Pak
- Chantix Starting Month Pak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

COLY-MYCIN

Products Affected

- Colistimethate Sodium INJ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Administration via nebulizer.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease specialist
Coverage Duration	Initial approval: 3 months, Renewal: Through end of plan contract year.
Other Criteria	Allow intravenous (IV) or intramuscularly (IM) use only. CMS endorsed compendia do not support inhalation/nebulization of colistimethate.

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small lung cancer and differentiated thyroid carcinoma: papillary, follicular, Hurthle cell.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC): The requested drug is used for NSCLC with RET gene rearrangements.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CYSTAGON

Products Affected

- Cystagon

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CYSTARAN

Products Affected

- Cystaran

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by DNA testing. The patient has corneal cystine crystal accumulation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

DEFERASIROX

Products Affected

- Deferasirox
- Jadenu
- Jadenu Sprinkle

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DEMSER

Products Affected

- Demser

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DIABETES-AGE EDIT

Products Affected

- Glyburide TABS 1.25MG, 2.5MG, 5MG
- Glyburide Micronized
- Glyburide/metformin Hydrochloride

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For Type 2 diabetes mellitus: Member must have tried and failed, or has a contraindication or intolerance to glipizide and glimepiride.

DIHYDROERGOT

Products Affected

- Dihydroergotamine Mesylate INJ
- Dihydroergotamine Mesylate SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Hypersensitivity to dihydroergotamine or any component of the formulation, uncontrolled hypertension, ischemic heart disease, angina pectoris, history of MI, silent ischemia, coronary artery vasospasm including Prinzmetal angina, hemiplegic or basilar migraine, peripheral vascular disease, sepsis, severe hepatic or renal dysfunction, avoid use within 24 hours of 5-hydroxytryptamine-1 (5HT1) receptor agonists (triptans) or other serotonin agonists or ergot-like agents, concurrent use of peripheral and central vasoconstrictors, concurrent use of potent inhibitors of CYP3A4 (ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin, ketoconazole, itraconazole), pregnancy, breastfeeding.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DRIZALMA

Products Affected

- Drizalma Sprinkle

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that the patient requires administration of the requested drug via nasogastric tube OR documentation that the patient is unable to swallow an intact capsule.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DRONABINOL

Products Affected

- Dronabinol

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV:6 months, PONV:1 month, Other medically accepted indications: Through end of plan contract year
Other Criteria	For chemotherapy-induced nausea and vomiting (CINV): The member is receiving cancer chemotherapy AND has failed one oral generic 5HT-3 receptor antagonist such as ondansetron or granisetron. There are no additional requirements for anorexia associated with weight loss in patients with AIDS. PONV = Postoperative nausea and vomiting. Drug is also subject to a Part B versus Part D coverage determination.

EMSAM

Products Affected

- Emsam

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (e.g., venlafaxine), selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline), tricyclic or tetracyclic antidepressants (e.g., amitriptyline, nortriptyline) OR 2) Patient is unable to swallow oral formulations.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ENDARI

Products Affected

- Endari

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	5 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

EPO

Products Affected

- Procrit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa), anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis.
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	For all uses except surgery: Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL (less than 9 g/dL for anemia in CHF only). Additional requirements for primary myelofibrosis (MF), post-polycythemia vera MF, post-essential thrombocythemia MF: 1) Patient has symptomatic anemia and 2) For initial therapy, pretreatment serum erythropoietin level is less than 500mU/mL. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery and 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	16 weeks

Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion. For reauthorizations (patient received erythropoietin in previous month): 1) For all uses except surgery, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy, 2) For anemia in CKD, MDS, CHF, RA, HIV, hepatitis C treatment, primary MF, post-polycythemia vera MF, post-essential thrombocythemia MF, or patients whose religious beliefs forbid blood transfusions: current Hgb is less than or equal to 12 g/dL, and 3) For anemia due to myelosuppressive cancer chemotherapy: current Hgb is less than 11 g/dL.

ERGOLOID-AGE EDIT

Products Affected

- Ergoloid Mesylates TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For treatment of Alzheimer's/Dementia: Member must have tried and failed, or has a contraindication or intolerance to two of the following: galantamine, rivastigmine, or donepezil.

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	Non-metastatic, castration-resistant prostate cancer (NM-CRPC): member will be receiving a gonadotropin-releasing hormone (GnRH) analog concurrently or had a bilateral orchiectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial Review Only: The patient does not have a known etiology for interstitial lung disease and meets one of the following: 1) a high-resolution computed tomography (HRCT) study of the chest or surgical lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, or 2) HRCT study of the chest reveals a possible UIP pattern and the diagnosis is supported either by surgical lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if surgical lung biopsy has not been conducted. For continuation: The patient does not have a known etiology for interstitial lung disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ESTROGEN-AGE EDIT

Products Affected

- Amabelz
- Dotti
- Duavee
- Estradiol ORAL TABS 0.5MG, 1MG, 2MG
- Estradiol PTTW
- Estradiol PTWK
- Estradiol/norethindrone Acetate
- Estropipate TABS
- Fyavolv
- Jinteli
- Lopreeza
- Mimvey
- Mimvey Lo
- Norethindrone Acetate/ethinyl Estradiol TABS 2.5MCG; 0.5MG, 5MCG; 1MG
- Premarin INJ
- Premarin TABS 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG
- Prempro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

EXJADE

Products Affected

- Exjade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to Jadenu (deferasirox).

FABRAZYME

Products Affected

- Fabrazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is an obligate female carrier with a first degree male relative diagnosed with Fabry disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FENTANYL ORAL

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The drug is not indicated in the management of acute or post-operative pain. This medication must not be used in opioid non-tolerant patients. The patient must not have any of the following contraindications: patients with pain not associated with cancer OR that are opioid naïve.
Required Medical Information	For the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying cancer pain. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine daily, at least 25 mcg of transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8 mg of oral hydromorphone daily, at least 25 mg oral oxymorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	Covered for patients 16 years of age and older.
Prescriber Restrictions	Oncologists and pain specialists who are experienced in the use of Schedule II opioids to treat cancer pain.
Coverage Duration	Through end of plan contract year.
Other Criteria	Diagnosis of breakthrough cancer pain in opioid-tolerant patients AND concomitant use of long acting opioid therapy, such as ONE of these: controlled-release morphine or extended-release morphine or controlled-release oxycodone or fentanyl transdermal. Member must have tried and failed, or has a contraindication or intolerance to a short acting opiate, such as oxycodone, oxycodone/APAP, hydrocodone/APAP, hydromorphone, morphine sulfate, tramadol.

FETZIMA

Products Affected

- Fetzima
- Fetzima Titration Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FIRAZYR

Products Affected

- Firazyr
- Icatibant Acetate

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The requested drug is being used for the treatment of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FLECTOR

Products Affected

- Flector

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. For treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to two generic oral nonsteroidal anti-inflammatories (NSAIDs).

FLUOROURACIL

Products Affected

- Fluorouracil CREA 5%

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members who are pregnant or may become pregnant. Members with dihydropyrimidine dehydrogenase (DPD) enzyme deficiency.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Applies to new starts only. If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use.

FORTEO

Products Affected

- Forteo INJ 600MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following (1. or 2.): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or osteopenia with a high pre-treatment FRAX fracture probability and patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous osteoporosis therapy (i.e., oral bisphosphonates or injectable antiresorptive agents). For primary or hypogonadal osteoporosis in men: patient has a) a history of osteoporotic vertebral or hip fracture OR b) a pre-treatment T-score of less than or equal to -2.5 OR c) osteopenia with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: Patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND Patient has a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) osteopenia with a high pre-treatment FRAX fracture probability.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 months (lifetime)
Other Criteria	Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20% for any major osteoporotic fracture or greater than or equal to 3% for hip fracture

FYCOMPA

Products Affected

- Fycompa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Partial-onset seizures - 4 years of age or older. Primary generalized tonic-clonic seizures - 12 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial therapy: Patient was dependent on parenteral support for at least 12 months. For continuation: Requirement for parenteral support has decreased from baseline while on teduglutide therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GILENYA

Products Affected

- Gilenya CAPS 0.5MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC), patient meets either of the following: 1) patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) patient has a known sensitizing epidermal growth factor receptor (EGFR) mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GLATIRAMER

Products Affected

- Glatiramer Acetate
- Glatopa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, first clinical episode of MS.
Exclusion Criteria	N/A
Required Medical Information	Have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GRANIX

Products Affected

- Granix

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

GROWTH HORMONE

Products Affected

- Genotropin
- Genotropin Miniquick

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pediatric patients with closed epiphyses (except in patients with PWS).
Required Medical Information	Pediatric GHD: 1) Younger than 2.5 yrs old, when applicable: a) Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2) 2.5 yrs old or older: a) Pre-tx 1-year ht velocity more than 2 SD below mean OR b) Pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) Patient is a neonate or was diagnosed with GHD as a neonate. TS: 1) Confirmed by karyotyping AND 2) Pre-treatment height is less than the 5th percentile for age. SGA: 1) Birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) Did not manifest catch-up growth by age 2. Adult GHD: 1) Failed 2 stimulation tests (peak below 5 ng/mL) or test with Macrilen (peak below 2.8 ng/ml) prior to starting tx, OR 2) Structural abnormality of the hypothalamus/pituitary AND 3 or more pituitary hormone deficiencies, OR 3) Childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS, OR 4) Low pre-tx IGF-1 and failed 1 stimulation test prior to starting tx.
Age Restrictions	SGA: 2 years of age or older
Prescriber Restrictions	Endocrinologist, pediatric endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, geneticist.
Coverage Duration	Plan Year
Other Criteria	Renewal for pediatric GHD, TS, SGA, and adult GHD: patient is experiencing improvement.

HAEGARDA

Products Affected

- Haegarda

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

HARVONI

Products Affected

- Harvoni TABS 90MG; 400MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria applied consistent with current AASLD-IDSA guidance.Reminder for 8wk option if appropriate.
Other Criteria	Harvoni will not be used with other drugs containing sofosbuvir, including Sovaldi.

HERCEPTIN

Products Affected

- Herceptin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, neoadjuvant treatment for HER2-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction cancer.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
Other Criteria	N/A

HERCEPTIN HYLECTA

Products Affected

- Herceptin Hylecta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial therapy and continuation of Hetlioz therapy: 1) diagnosis of Non-24 Hour Sleep-Wake Disorder and 2) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and 3) unable to perceive light in both eyes. For patients currently on therapy with the requested medication, must meet at least one of the following: 1) increased total nighttime sleep or 2) decreased daytime nap duration.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initiation: 6 Months, Renewal: Plan Year
Other Criteria	N/A

HIGH RISK MEDICATION

Products Affected

- Scopolamine
- Transderm-scop

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

HUMIRA

Products Affected

- Humira
- Humira Pediatric Crohns Disease Starter Pack
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-ps/uv Starter

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD (e.g., tofacitinib). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): Patient meets ANY of the following: 1) Inadequate response, intolerance or contraindication to MTX, OR 2) Inadequate response or intolerance to a prior biologic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial at maximum recommended or tolerated dose OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate or cyclosporine b) Pharmacologic treatment with methotrexate or cyclosporine is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one immunosuppressant therapy (e.g., corticosteroids, azathioprine, mercaptopurine), OR 2) Intolerance or contraindication to immunosuppressant therapy.

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

HYDROXYPROGESTERONE CAPROATE

Products Affected

- Hydroxyprogesterone Caproate INJ 1.25GM/5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindications per FDA labeling.
Required Medical Information	Member is not pregnant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Testing of Endogenous Estrogen Production: 2 months. All Others: Through end of plan contract year
Other Criteria	Applies to new starts only.

HYDROXYZINE-AGE EDIT

Products Affected

- Hydroxyzine Hcl INJ 25MG/ML
- Hydroxyzine Hcl SYRP
- Hydroxyzine Hcl TABS 25MG
- Hydroxyzine Hydrochloride INJ
- Hydroxyzine Hydrochloride TABS 10MG, 50MG
- Hydroxyzine Pamoate CAPS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

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

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, well-differentiated/dedifferentiated liposarcoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IMATINIB

Products Affected

- Imatinib Mesylate

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new Starts Only.

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, hairy cell leukemia, and lymphoplasmacytic lymphoma.
Exclusion Criteria	N/A
Required Medical Information	For mantle cell lymphoma: 1) the requested medication will be used in a patient who has received at least one prior therapy, OR 2) the requested medication will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen. For gastric MALT lymphoma and non-gastric MALT lymphoma: 1) disease is recurrent, refractory, or progressive, AND 2) the requested medication will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested medication will be used as a single agent for disease progression.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Must meet all of the following prior to beginning therapy with the requested medication (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. For renewal, patient is experiencing improvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, papillary, Hurthle cell, or follicular thyroid carcinoma.
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

INSOMNIA AGENTS-AGE EDIT

Products Affected

- Eszopiclone
- Zaleplon
- Zolpidem Tartrate

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

IR BEFORE ER

Products Affected

- Fentanyl
- Hysingla Er
- Methadone Hcl CONC
- Methadone Hcl INJ
- Methadone Hcl ORAL SOLN
- Methadone Hcl TABS
- Morphine Sulfate Er CP24 100MG, 10MG, 120MG, 20MG, 30MG, 45MG, 50MG, 60MG, 75MG, 80MG, 90MG
- Morphine Sulfate Er TBCR
- Nucynta Er
- Tramadol Hcl Er CP24 100MG, 200MG, 300MG
- Tramadol Hcl Er TB24

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient can safely take the requested dose based on their history of opioid use AND 4) The patient has been evaluated and will be monitored for the development of opioid use disorder AND 5) The request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR 6) The patient has severe continuous pain and has received an immediate-release opioid for at least one week
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer, patient has a known sensitizing EGFR mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ITRACONAZOLE

Products Affected

- Itraconazole CAPS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Coccidioidomycosis, Cryptococcosis, Microsporidiosis, Penicilliosis, Sporotrichosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea manuum/Tinea pedis.
Exclusion Criteria	N/A
Required Medical Information	If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed by a fungal diagnostic test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

IVIG

Products Affected

- Bivigam
- Carimune Nanofiltered INJ 12GM, 6GM
- Flebogamma Dif
- Gammagard Liquid
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 20GM/400ML, 5GM/100ML, 5GM/50ML
- Gamunex-c
- Octagam
- Privigen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, primary immunodeficiency, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, idiopathic thrombocytopenic purpura, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, Stiff-person syndrome, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
Exclusion Criteria	N/A
Required Medical Information	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections. For dermatomyositis and polymyositis: at least one standard first-line treatment (corticosteroids or immunosuppressants) has been tried but was unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. PRCA is secondary to parvovirus B19 infection.
Age Restrictions	For pediatric HIV infection: age 12 years or younger.
Prescriber Restrictions	N/A

Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, low-risk, intermediate-risk, accelerated phase, or blast phase myelofibrosis, polycythemia vera in patients with inadequate response or intolerance to interferon therapy (interferon alfa-2b, peginterferon alfa-2a, or peginterferon alfa-2b).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin), covered formulary fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated LDL-C greater than 100 mg/dl (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points.

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient has one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation.
Age Restrictions	6 months of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	The requested drug will not be used in combination with lumacaftor/ivacaftor or tezacaftor/ivacaftor.

KEYTRUDA

Products Affected

- Keytruda

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, malignant pleural mesothelioma, Merkel cell carcinoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KHAPZORY

Products Affected

- Khapzory

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

KISQALI

Products Affected

- Kisqali
- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KUVAN

Products Affected

- Kuvan

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

KYNAMRO

Products Affected

- Kynamro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin), covered formulary fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen, as demonstrated by treated LDL-C greater than 100 mg/dl (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy, 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points.

LENVIMA

Products Affected

- Lenvima 10 Mg Daily Dose
- Lenvima 12mg Daily Dose
- Lenvima 14 Mg Daily Dose
- Lenvima 18 Mg Daily Dose
- Lenvima 20 Mg Daily Dose
- Lenvima 24 Mg Daily Dose
- Lenvima 4 Mg Daily Dose
- Lenvima 8 Mg Daily Dose

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LETAIRIS

Products Affected

- Ambrisentan
- Letairis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LEUPROLIDE

Products Affected

- Leuprolide Acetate INJ
- Lupron Depot (1-month) INJ 3.75MG
- Lupron Depot (3-month) INJ 11.25MG
- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in pregnancy.
Required Medical Information	For central precocious puberty (CPP), patiensts not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP confirmed by: a) A pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay AND b) Assessment of bone age versus chronological age, and 2) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. For endometriosis retreatment patient must meet all of the following: 1) Patient has had a recurrence of symptoms, and 2) Patient will be receiving add-back therapy (eg, norethindrone). For uterine fibroids patient must meet one of the following: 1) Diagnosis of anemia (eg, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) medication will be used in the preoperative setting to facilitate surgery. For epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: medication will be used as a single agent AND disease is persistent or recurrent. For breast cancer, patient must be premenopausal with hormone receptor positive disease.
Age Restrictions	CPP: Less than 12 years old if female and less than 13 years old if male. Endometriosis, fibroids, breast cancer, stromal tumors, epithelial ovarian/fallopian tube/primary peritoneal cancer: 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year
Other Criteria	N/A

LIBTAYO

Products Affected

- Libtayo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

LIDODERM

Products Affected

- Lidocaine PTCH

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer: The disease is unresectable advanced or metastatic. Patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

LUMIZYME

Products Affected

- Lumizyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LUMOXITI

Products Affected

- Lumoxiti

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

LYNPARZA

Products Affected

- Lynparza

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

LYRICA CR

Products Affected

- Lyrica Cr

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A

MEGESTROL-AGE EDIT

Products Affected

- Megestrol Acetate SUSP
- Megestrol Acetate TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For melanoma, tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

MEMANTINE

Products Affected

- Memantine Hcl
- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN
- Memantine Hydrochloride Er

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	This edit only applies to patients less than 30 years of age.

MEPRON

Products Affected

- Atovaquone SUSP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Mild-to-moderate Pneumocystis jiroveci pneumonia/Prevention of Pneumocystis jiroveci pneumonia: Member must have tried and failed, or has a contraindication or intolerance to sulfamethoxazole/trimethoprim (SMZ/TMP).

METFORMIN ER

Products Affected

- Metformin Hydrochloride Er TB24 500MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute or chronic metabolic acidosis, including diabetic ketoacidosis.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to generic metformin extended release (generic for Glucophage XR).

MODAFINIL

Products Affected

- Modafinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of narcolepsy: Documented by multiple sleep latency test (MSLT) less than 10 minutes or other appropriate testing. For treatment of excessive daytime sleepiness associated with obstructive sleep apnea (OSA) when the member meets the following criteria: (1) A Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSA and meets ICSD or DSM diagnostic criteria AND (2) that the daytime fatigue is significantly impacting, impairing, or compromising the member's ability to function normally. For shift work sleep disorder (SWSD): Require confirmed diagnosis and the member must have a job that requires them to frequently rotate shifts or work at night, and be unable to adjust to their schedule.
Age Restrictions	N/A
Prescriber Restrictions	Board certified as a sleep specialist, ear, nose and throat, neurologist or pulmonologist, or has obtained a consult from a board certified sleep specialist.
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

MUSCLE RELAXANTS-AGE EDIT

Products Affected

- Chlorzoxazone TABS 250MG, 500MG
- Cyclobenzaprine Hydrochloride TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

MYLOTARG

Products Affected

- Mylotarg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, acute promyelocytic leukemia (APL).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

NAGLAZYME

Products Affected

- Naglazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mucopolysaccharidosis VI disease was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute postsurgical hypoparathyroidism (within 6 months of surgery) and expected to recover from the hypoparathyroidism.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The requested medication is initiated within two years after completing adjuvant trastuzumab based therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NEUPOGEN

Products Affected

- Neupogen

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

NEXAVAR

Products Affected

- Nexavar

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

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used in combination with lenalidomide and dexamethasone, pomalidomide and dexamethasone, or dexamethasone therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prior to initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing. The requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) Dopamine beta hydroxylase deficiency, OR 3) Non-diabetic autonomic neuropathy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Patients currently on Northera must experience a sustained decrease in dizziness.

NP MULTIPLE SCLEROSIS

Products Affected

- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Relapsing or primary progressive forms of multiple sclerosis (MS): Documentation that other therapies used for treating MS will be discontinued (Note: This does NOT require having to discontinue Ampyra (dalfampridine)).The member has a diagnosis of a relapsing form of MS, a primary progressive form of MS OR has experienced a first clinical episode and has MRI features consistent with MS.
Age Restrictions	N/A
Prescriber Restrictions	MS: Neurologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Relapsing MS: Member must have tried and failed, or has a contraindication or intolerance to two of the following: Ampyra (dalfampridine), Betaseron (interferon beta-1b), Gilenya (fingolimod), glatiramer, Glatopa (glatiramer).

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NUVIGIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography OR 3) Diagnosis is Shift Work Disorder (SWD).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OCTREOTIDE

Products Affected

- Octreotide Acetate

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, meningiomas, thymomas and thymic carcinomas, and neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, pancreas and adrenal gland.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For NETs of the GI tract, thymus, and lung: patient has metastatic or unresectable disease. For meningiomas: patient has unresectable disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For idiopathic pulmonary fibrosis: Initial Review Only: The patient does not have a known etiology for interstitial lung disease and meets one of the following: 1) a high-resolution computed tomography (HRCT) study of the chest or surgical lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, or 2) HRCT study of the chest reveals a possible UIP pattern and the diagnosis is supported either by surgical lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if surgical lung biopsy has not been conducted. For idiopathic pulmonary fibrosis continuation: The patient does not have a known etiology for interstitial lung disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ONFI

Products Affected

- Clobazam
- Onfi SUSP
- Onfi TABS 10MG, 20MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORACEA

Products Affected

- Doxycycline CPDR
- Oracea

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to formulary generic topical metronidazole.

ORAL-INTRANASAL FENTANYL

Products Affected

- Fentanyl Citrate TABS 200MCG, 400MCG, 600MCG, 800MCG
- Fentora TABS 100MCG, 200MCG, 400MCG, 600MCG, 800MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is indicated for the treatment of breakthrough CANCER related pain only. The requested drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain AND 2) The ICD diagnosis code provided supports the CANCER RELATED diagnosis [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER RELATED diagnosis.]
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORFADIN

Products Affected

- Orfadin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	The requested drug will not be used in combination with ivacaftor or tezacaftor/ivacaftor.

PEGASYS

Products Affected

- Pegasys
- Pegasys Proclick INJ 180MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocythemia myelofibrosis).
Exclusion Criteria	N/A
Required Medical Information	For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HCV=Criteria will be applied consistent with current AASLD-IDSA guidance. HBV=48 wks. Other=Plan Yr
Other Criteria	N/A

PHENOBARBITAL-AGE EDIT

Products Affected

- Phenobarbital ELIX 20MG/5ML
- Phenobarbital TABS 100MG, 15MG, 16.2MG, 30MG, 32.4MG, 60MG, 64.8MG, 97.2MG
- Phenobarbital Sodium INJ 130MG/ML, 65MG/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Seizures: Member must have tried and failed, or has a contraindication or intolerance to one non-High Risk Medication (HRM) alternative formulary drug (such as carbamazepine, lamotrigine, or topiramate).

PHENYLBUTYRATE

Products Affected

- Sodium Phenylbutyrate TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PIQRAY

Products Affected

- Piqray 200mg Daily Dose
- Piqray 250mg Daily Dose
- Piqray 300mg Daily Dose

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POLIVY

Products Affected

- Polivy

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis.
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent (ie, thalidomide, lenalidomide) AND a proteasome inhibitor (ie, bortezomib, ixazomib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POTELIGEO

Products Affected

- Poteligeo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) patient has had an inadequate response or is intolerant to corticosteroids, immunoglobulins or splenectomy, AND b) untransfused platelet count at any point prior to the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, platelet (plt) count response to the requested drug: a) current plt count is less than or equal to 200,000/mcL OR b) current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): 1) For continuation of therapy, plt count response to the requested drug: a) current plt count is 50,000-200,000/mcL, OR b) current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR c) current plt count is less than 50,000/mcL and patient is transfusion-independent, OR d) current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HCV:6mo, INITIAL: ITP/AA-6mo, REAUTH: 1) ITP/AA APR-Plan Yr, 2) AA IPR-16wks
Other Criteria	APR: adequate platelet response (greater than 50k/mcL), IPR: inadequate platelet response (less than 50k/mcL)

PULMONARY HYPERTENSION-OTHER

Products Affected

- Epoprostenol Sodium

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	PAH: Pulmonary Arterial Hypertension (PAH) (WHO Group 1) member has mean pulmonary artery pressure greater than or equal to 25 mm Hg at rest or greater than 30 mm Hg with exertion, documented by right-heart catheterization or echocardiography. Renewal: Member's condition is stable or showing clinical improvement.
Age Restrictions	N/A
Prescriber Restrictions	PAH: Pulmonologist or cardiologist
Coverage Duration	Initial: 6 months. Renewal: Through end of plan contract year.
Other Criteria	Drug is also subject to a Part B versus Part D coverage determination.

PULMOZYME

Products Affected

- Pulmozyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

QUININE SULFATE

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Babesiosis, uncomplicated Plasmodium vivax malaria.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month
Other Criteria	N/A

REGRANEX

Products Affected

- Regranex

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

RELISTOR INJ

Products Affected

- Relistor INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The requested drug is being prescribed for opioid-induced constipation in an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care OR 2) The requested drug is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried. (Note: Examples are Amitiza or Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: Examples are Amitiza or Movantik) OR 6) The patient has a contraindication to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: Examples are Amitiza or Movantik).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 months
Other Criteria	N/A

REMICADE

Products Affected

- Remicade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis, Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab). For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, covered formulary mesalamine) OR 2) intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab) or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR 2) intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab). For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab). For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis (e.g., methotrexate, azathioprine, or mycophenolate mofetil).
Age Restrictions	N/A

Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, classical Hodgkin lymphoma, myelofibrosis-associated anemia, non-Hodgkin's lymphoma with the following subtypes: chronic lymphocytic leukemia/small lymphocytic lymphoma, AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, lymphoma associated with Castleman's disease, diffuse large B-cell lymphoma, follicular lymphoma, nongastric/gastric MALT lymphoma, primary cutaneous B-cell lymphoma, splenic/nodal marginal zone lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, mycosis fungoides/Sezary syndrome, angioimmunoblastic T-cell lymphoma, peripheral T-cell lymphoma not otherwise specified, enteropathy-associated T-cell lymphoma and primary cutaneous anaplastic large cell lymphoma.
Exclusion Criteria	N/A
Required Medical Information	Myelodysplastic syndrome (MDS): Low- to intermediate-1 risk MDS with symptomatic anemia
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RITUXAN

Products Affected

- Rituxan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, Castleman's disease, AIDS-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary CNS lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) The requested medication is used in combination with methotrexate (MTX) unless MTX is contraindicated or not tolerated AND 2) Patient has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab) or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). Hematologic malignancies must be CD20-positive. For Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): The requested medication will be used in combination with glucocorticoids. For multiple sclerosis: 1) Patient has a diagnosis of relapsing remitting multiple sclerosis and 2) Patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year

Other Criteria	N/A

RITUXAN HYCELA

Products Affected

- Rituxan Hycela

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

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For newly diagnosed FLT3 mutation-positive acute myeloid leukemia (AML), the requested medication is/was used in combination with standard cytarabine with daunorubicin or idarubicin induction followed by cytarabine consolidation chemotherapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has had pituitary surgery that was not curative or the patient is not a candidate for surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SILDENAFIL

Products Affected

- Sildenafil INJ
- Sildenafil Citrate TABS 20MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The requested drug is being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis, or infection caused by the non-tuberculous mycobacteria
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

SOMATULINE DEPOT

Products Affected

- Somatuline Depot

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, pancreas, and adrenal gland.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For NETs of the GI tract, thymus, and lung: patient has metastatic or unresectable disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient meets both of the following criteria: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

SORIATANE

Products Affected

- Acitretin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered in pregnant females.
Required Medical Information	Indicated for the treatment of severe psoriasis in adults as monotherapy or in combination with phototherapy.
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist or Dermatologist
Coverage Duration	6 months
Other Criteria	Psoriasis: Member must have tried and failed, or has a contraindication or intolerance to methotrexate or cyclosporine.

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, gastrointestinal stromal tumor (GIST).
Exclusion Criteria	N/A
Required Medical Information	For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) patient is 21 years of age or younger, or b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have PDGFRA D842V mutation and disease progression on imatinib, sunitinib, or regorafenib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, progressive GIST.
Exclusion Criteria	N/A
Required Medical Information	For colorectal cancer: The disease is unresectable advanced or metastatic. The patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), angiosarcoma, solitary fibrous tumor, hemangiopericytoma, chordoma (bone cancer), thymic carcinoma.
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: Either 1) The disease is relapsed, metastatic, or unresectable, OR 2) The patient is at high risk of disease recurrence following nephrectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYLATRON

Products Affected

- Sylatron

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myelofibrosis, polycythemia vera, essential thrombocythemia.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYMLIN

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The patient has a diagnosis of type 1 or type 2 diabetes mellitus AND 2) The patient is currently receiving optimal mealtime insulin therapy AND 3) The patient has experienced an inadequate treatment response to insulin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

SYMPAZAN

Products Affected

- Sympazan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

SYNRIBO

Products Affected

- Synribo

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

TADALAFIL (PAH)

Products Affected

- Alyq
- Tadalafil TABS 20MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, brain metastases from melanoma.
Exclusion Criteria	N/A
Required Medical Information	For melanoma (including brain metastases), tumor is positive for a BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation). For NSCLC, tumor is positive for a BRAF V600 activating mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, EGFR mutation-positive recurrent or metastatic non-small cell lung cancer, brain metastases if active against primary tumor (EGFR T790M mutation-positive non-small cell lung cancer).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

TARCEVA

Products Affected

- Erlotinib Hydrochloride
- Tarceva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chordoma, renal cell carcinoma (RCC).
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer, patient has a known sensitizing EGFR mutation. For pancreatic cancer, the disease is locally advanced, unresectable, or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST).
Exclusion Criteria	N/A
Required Medical Information	For CML or ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, the patient has one of the following: a) patient is 18 years of age or younger, b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAZAROTENE

Products Affected

- Tazarotene CREA
- Tazorac CREA 0.05%

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For plaque psoriasis, the requested drug is being prescribed to treat less than 20 percent of the patient's body surface area.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TECENTRIQ

Products Affected

- Tecentriq

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myelofibrosis-related anemia, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, HIV-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease.
Exclusion Criteria	N/A
Required Medical Information	Cachexia: Cachexia must be due to cancer or HIV infection. Kaposi's sarcoma: The patient has HIV infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

THIORIDAZINE-AGE EDIT

Products Affected

- Thioridazine Hcl TABS 100MG, 10MG, 25MG, 50MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Member must have tried and failed, or has a contraindication or intolerance to two formulary alternative non-High Risk Medication (HRM) drugs (such as aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, ziprasidone).

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

TOPICAL DOXEPIN

Products Affected

- Doxepin Hydrochloride CREA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members with untreated narrow angle glaucoma or a tendency to urinary retention.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use.

TOPICAL LIDOCAINE

Products Affected

- Lidocaine OINT
- Lidocaine/prilocaine CREA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	1) If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use. 2) Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TOPICAL NSAIDS

Products Affected

- Diclofenac Sodium GEL
- Diclofenac Sodium TRANSDERMAL SOLN 1.5%
- Klofensaid II
- Pennsaid SOLN 2%

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For Osteoarthritis: Member must have tried and failed, or has a contraindication or intolerance to two formulary generic oral Nonsteroidal Anti-inflammatory Drugs (NSAIDs).

TOPICAL TESTOSTERONES

Products Affected

- Androderm PT24 2MG/24HR, 4MG/24HR
- Testosterone SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TOPICAL TRETINOIN

Products Affected

- Avita
- Tretinoin CREA
- Tretinoin GEL
- Tretinoin Microsphere
- Tretinoin Microsphere Pump

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TREATMENT OF ATTENTION DEFICIT DISORDER - AGE EDIT

Products Affected

- Amphetamine/dextroamphetamine
- Dexmethylphenidate Hcl
- Dexmethylphenidate Hcl Er
- Dexmethylphenidate Hydrochloride TABS 2.5MG, 5MG
- Dextroamphetamine Sulfate SOLN
- Dextroamphetamine Sulfate TABS
- Dextroamphetamine Sulfate Er
- Metadate Er TBCR 20MG
- Methylphenidate Hydrochloride
- Methylphenidate Hydrochloride CD CPCR 10MG, 20MG, 30MG, 50MG, 60MG
- Methylphenidate Hydrochloride Er CP24
- Methylphenidate Hydrochloride Er CPCR 40MG
- Methylphenidate Hydrochloride Er TB24
- Methylphenidate Hydrochloride Er TBCR
- Methylphenidate Hydrochloride Er (la)
- Vyvanse
- Zenzedi TABS 10MG, 5MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

TRELSTAR

Products Affected

- Trelstar Mixject INJ 11.25MG, 3.75MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Use as neoadjuvant therapy prior to radical prostatectomy is not approvable.

TREPROSTINIL INJ

Products Affected

- Remodulin
- Treprostinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TRIENTINE

Products Affected

- Trientine Hydrochloride

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TURALIO

Products Affected

- Turalio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, metastatic CNS lesions from HER2-positive breast cancer.
Exclusion Criteria	N/A
Required Medical Information	For HER2-positive breast cancer, the requested drug will be used in combination with: 1) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane), or 2) capecitabine, or 3) trastuzumab.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic or smoldering adult T-cell leukemia/lymphoma, mycosis fungoides, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VELCADE

Products Affected

- Bortezomib
- Velcade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, small lymphocytic lymphoma, mantle cell lymphoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VENTAVIS

Products Affected

- Ventavis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VERSACLOZ

Products Affected

- Versacloz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VIDAZA

Products Affected

- Azacitidine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members with advanced malignant hepatic tumors.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

VIGABATRIN

Products Affected

- Sabril TABS
- Vigabatrin
- Vigadrone

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For complex partial seizures (CPS): patient had an inadequate response to at least 2 covered formulary alternatives therapies for CPS (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma, ovarian cancer (epithelial ovarian, fallopian tube, or primary peritoneal).
Exclusion Criteria	N/A
Required Medical Information	For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma, AND 2) The patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk, head/neck sarcoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VRAYLAR

Products Affected

- Vraylar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer (NSCLC) with high-level MET amplification or MET exon 14 skipping mutation, inflammatory myofibroblastic tumors (IMT).
Exclusion Criteria	N/A
Required Medical Information	For IMT, the tumor is ALK-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XELJANZ

Products Affected

- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab). For active psoriatic arthritis (new starts only): Patient meets BOTH of the following criteria: 1) Inadequate response to methotrexate (MTX) or other nonbiologic disease-modifying antirheumatic drugs (DMARDs) (e.g., leflunomide, sulfasalazine, etc.) OR a prior biologic DMARD (e.g., adalimumab), AND 2) The requested drug is used in combination with a nonbiologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, etc.). For moderately to severely active ulcerative colitis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to at least one conventional therapy option (e.g., oral aminosalicylates, corticosteroids), or 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XENAZINE

Products Affected

- Tetrabenazine
- Xenazine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members who are actively suicidal, or with untreated or inadequately treated depression. Impaired hepatic function. Currently taking monoamine oxidase inhibitors.
Required Medical Information	Huntington's Disease (initial): Diagnosis of chorea in members with Huntington's disease. Tardive dyskinesia and Tourette's syndrome (initial): Member has stereotypes associated with tardive dyskinesia or patient has tics associated with Tourette's syndrome. Renewal (all diagnoses): Member's condition is stable or showing clinical improvement.
Age Restrictions	Tardive dyskinesia: Covered for members 18 years of age and older.
Prescriber Restrictions	Huntington: Prescribed by a neurologist. Tardive dyskinesia, Tourette: Prescribed by neurologist or psychiatrist.
Coverage Duration	Initial: 3 months, Renewal: Through end of plan contract year
Other Criteria	Tics associated with Tourette's syndrome: Member must have tried and failed, or has a contraindication or intolerance to haloperidol.

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy (eg, zoledronic acid, pamidronate) or there is a clinical reason to avoid IV bisphosphonate therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Applies to new starts only.

XIFAXAN

Products Affected

- Xifaxan TABS 550MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Reduction in risk of overt HE recurrence - 6 Months, IBS-D and all other indications - Plan Year
Other Criteria	N/A

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For allergic asthma initial therapy: 1)Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid, b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on the requested drug since initiation of therapy. Chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.
Age Restrictions	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Allergic asthma: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year.
Other Criteria	N/A

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

XPOVIO

Products Affected

- Xpovio 100 Mg Once Weekly
- Xpovio 60 Mg Once Weekly
- Xpovio 80 Mg Once Weekly
- Xpovio 80 Mg Twice Weekly

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The requested drug will be used to treat prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1) The drug is being prescribed for the treatment of excessive daytime sleepiness in a patient with narcolepsy AND 2) The patient experienced an inadequate treatment response or intolerance to at least one CNS stimulant drug and one CNS promoting wakefulness drug OR 3) the patient has a contraindication to at least one CNS stimulant drug and one CNS wakefulness promoting drug (NOTE: Examples of a CNS stimulant drug are amphetamine, dextroamphetamine, or methylphenidate. Example of a CNS wakefulness promoting drug is armodafinil. Coverage of armodafinil or amphetamines or methylphenidates may require prior authorization). OR 4) The drug is being prescribed for the treatment of cataplexy in a patient with narcolepsy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	If the request is for the continuation of Xyrem (sodium oxybate), then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

YERVOY

Products Affected

- Yervoy

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, CNS metastases from primary tumor (melanoma), small cell lung cancer
Exclusion Criteria	N/A
Required Medical Information	For CNS metastases from primary tumor (melanoma), member must meet all of the following: 1) Yervoy was active against the primary tumor (melanoma) AND 2) the disease is recurrent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZAVESCA

Products Affected

- Miglustat

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Treatment is being started or was started no later than 8 weeks after the most recent platinum-based chemotherapy.

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, brain metastases from melanoma, non-small cell lung cancer, hairy cell leukemia, and thyroid carcinoma (papillary, follicular, and Hurthle).
Exclusion Criteria	N/A
Required Medical Information	For melanoma (including brain metastases), tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation). For non-small cell lung cancer, tumor is positive for the BRAF V600E mutation. For thyroid carcinoma the tumor is positive for BRAF mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZEPATIER

Products Affected

- Zepatier

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions (eg, NS5A polymorphisms) where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	N/A

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), refractory, relapsed or progressive follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor.
Exclusion Criteria	N/A
Required Medical Information	For non-small cell lung cancer (NSCLC), the requested medication is used for the treatment of recurrent or metastatic ALK-positive NSCLC. For inflammatory myofibroblastic tumor, the tumor is ALK-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYPREXA RELPREVV

Products Affected

- Zyprexa Relprevv

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Tolerability with oral olanzapine has been established.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYTIGA

Products Affected

- Abiraterone Acetate
- Zytiga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D and newly diagnosed metastatic or high-risk locally advanced prostate cancer.
Exclusion Criteria	N/A
Required Medical Information	For metastatic castration-resistant prostate cancer: The requested drug will be used in combination with prednisone. For castration-sensitive metastatic or locally advanced prostate cancer: 1) The requested drug will be used in combination with prednisone and concurrent androgen-deprivation therapy. Androgen deprivation therapy is not required in patients who have had bilateral orchiectomy, 2) Disease is newly diagnosed and metastatic, node-positive, high-risk locally advanced, or was previously treated with radical surgery or radiotherapy and is now relapsing with high risk features.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYVOX

Products Affected

- Linezolid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered with concomitant use of MAOI therapy.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	28 days
Other Criteria	Confirmed diagnosis of Vancomycin-resistant Enterococcus faecium Infections OR a trial of three days each of two preferred antibiotics indicated for the members condition such as amoxicillin, moxifloxacin, azithromycin, cephalosporin, clindamycin or dicloxicillin OR Discharge from hospital or medical facility due to a documented diagnosis/covered use AND Documented initial treatment with vancomycin OR intravenous (IV) linezolid while in the hospital/medical facility. For all IV linezolid uses: confirmation member is unable to take oral linezolid.

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adrucil INJ 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Albuterol Sulfate NEBU
- Ambisome
- Aminosyn INJ 148MEQ/L; 1280MG/100ML; 980MG/100ML; 1280MG/100ML; 300MG/100ML; 720MG/100ML; 940MG/100ML; 720MG/100ML; 400MG/100ML; 440MG/100ML; 860MG/100ML; 420MG/100ML; 520MG/100ML; 160MG/100ML; 44MG/100ML; 800MG/100ML, 90MEQ/L; 1100MG/100ML; 850MG/100ML; 35MEQ/L; 1100MG/100ML; 260MG/100ML; 620MG/100ML; 810MG/100ML; 624MG/100ML; 340MG/100ML; 380MG/100ML; 750MG/100ML; 370MG/100ML; 460MG/100ML; 150MG/100ML; 44MG/100ML; 680MG/100ML
- Aminosyn 7%/electrolytes INJ 124MEQ/L; 900MG/100ML; 690MG/100ML; 96MEQ/L; 900MG/100ML; 210MG/100ML; 510MG/100ML; 660MG/100ML; 510MG/100ML; 10MEQ/L; 280MG/100ML; 310MG/100ML; 30MMOLE/L; 65MEQ/L; 610MG/100ML; 300MG/100ML; 65MEQ/L; 370MG/100ML; 120MG/100ML; 44MG/100ML; 560MG/100ML
- Aminosyn 8.5%/electrolytes INJ 142MEQ/L; 1100MG/100ML; 850MG/100ML; 98MEQ/L; 1100MG/100ML; 260MG/100ML; 620MG/100ML; 810MG/100ML; 624MG/100ML; 10MEQ/L; 340MG/100ML; 380MG/100ML; 30MEQ/L; 65MEQ/L; 750MG/100ML; 370MG/100ML; 65MEQ/L; 460MG/100ML; 150MG/100ML; 44MG/100ML; 680MG/100ML
- Aminosyn II INJ 61.1MEQ/L; 844MG/100ML; 865MG/100ML; 595MG/100ML; 627MG/100ML; 425MG/100ML; 255MG/100ML; 561MG/100ML; 850MG/100ML; 893MG/100ML; 146MG/100ML; 253MG/100ML; 614MG/100ML; 450MG/100ML; 33.3MEQ/L; 340MG/100ML; 170MG/100ML; 230MG/100ML; 425MG/100ML, 71.8MEQ/L; 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 38MEQ/L; 400MG/100ML; 200MG/100ML; 270MG/100ML; 500MG/100ML
- Aminosyn II 8.5%/electrolytes
- Aminosyn M INJ 65MEQ/L; 448MG/100ML; 343MG/100ML; 40MEQ/L; 448MG/100ML; 105MG/100ML; 252MG/100ML; 329MG/100ML; 252MG/100ML; 3MEQ/L; 140MG/100ML; 154MG/100ML; 3.5MMOLE/L; 13MEQ/L; 300MG/100ML; 147MG/100ML; 40MEQ/L; 182MG/100ML; 56MG/100ML; 31MG/100ML; 280MG/100ML

- Aminosyn-hbc INJ 7.1MEQ/100ML; 660MG/100ML; 507MG/100ML; 660MG/100ML; 154MG/100ML; 789MG/100ML; 1576MG/100ML; 265MG/100ML; 206MG/100ML; 1.12GM/100ML; 228MG/100ML; 448MG/100ML; 221MG/100ML; 272MG/100ML; 88MG/100ML; 33MG/100ML; 789MG/100ML
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 3.4MEQ/L; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML
- Aminosyn-pf 7%
- Aminosyn-rf INJ 113MEQ/L; 600MG/100ML; 429MG/100ML; 462MG/100ML; 726MG/100ML; 535MG/100ML; 726MG/100ML; 726MG/100ML; 330MG/100ML; 165MG/100ML; 528MG/100ML
- Amphotericin B INJ
- Aprepitant
- Azathioprine INJ
- Azathioprine TABS
- Bleomycin Sulfate INJ
- Budesonide SUSP
- Cladribine
- Clinimix 2.75%/dextrose 5%
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 20%
- Clinimix 4.25%/dextrose 25%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 5%/dextrose 25%
- Clinisol Sf 15%
- Clinolipid
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclosporine CAPS
- Cyclosporine INJ
- Cyclosporine Modified
- Cytarabine Aqueous
- Dextrose 50%
- Dextrose 70%
- Diphtheria/tetanus Toxoids Adsorbed Pediatric
- Doxorubicin Hcl INJ 10MG, 2MG/ML, 50MG
- Emend SUSR
- Engerix-b
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Freamine Hbc 6.9%
- Freamine III INJ 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML
- Gamastan
- Gamastan S/d
- Ganciclovir INJ 500MG, 500MG/10ML
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hcl TABS
- Hepatamine
- Humulin R U-500 (concentrated)
- Hydromorphone Hcl INJ 10MG/ML, 1MG/ML, 2MG/ML, 4MG/ML, 50MG/5ML
- Hydromorphone Hydrochloride INJ 1MG/ML, 2MG/ML, 4MG/ML
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML, 30GM/100ML

- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU
- Levalbuterol Hydrochloride NEBU 0.31MG/3ML
- Melphalan
- Morphine Sulfate INJ 0.5MG/ML, 10MG/ML, 150MG/30ML, 1MG/ML, 25MG/ML, 2MG/ML, 4MG/ML, 50MG/ML, 5MG/ML, 8MG/ML
- Mycophenolate Mofetil
- Mycophenolic Acid Dr
- Nebupent
- Nephramine
- Nulojix
- Nutrilipid
- Ondansetron Hcl ORAL SOLN
- Ondansetron Hcl TABS 24MG
- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- Plenamine
- Prednisone Intensol
- Premasol
- Procalamine
- Prograf PACK
- Prosol
- Rabavert
- Rapamune SOLN
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tdvax
- Tenivac
- Tobramycin NEBU
- Tpn Electrolytes
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trophamine INJ 97MEQ/L; 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML
- Vinblastine Sulfate INJ 1MG/ML
- Vincasar Pfs
- Vincristine Sulfate INJ
- Zortress

Details

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

INDEX

A

Abelcet 262
Abiraterone Acetate..... 260
Acetylcysteine 262
Acitretin..... 198
Actimmune 1
Acyclovir Sodium 262
Adagen 2
Adempas..... 3
Adrucil..... 262
Afinitor 4
Afinitor Disperz..... 4
Albuterol Sulfate 262
Aldurazyme 5
Alecensa 6
Alpha1-proteinase Inhibitor 7
Alunbrig 8
Alyq..... 206
Amabelz 75
Ambisome 262
Ambrisentan 129
Aminosyn 262
Aminosyn 7%/electrolytes 262
Aminosyn 8.5%/electrolytes 262
Aminosyn II..... 262
Aminosyn II 8.5%/electrolytes..... 262
Aminosyn M..... 262
Aminosyn-hbc 263
Aminosyn-pf..... 263
Aminosyn-pf 7% 263
Aminosyn-rf 263
Amitriptyline Hcl 13
Amitriptyline Hydrochloride..... 13
Amphetamine/dextroamphetamine 222
Amphotericin B 263
Ampyra..... 9
Anabolic Steroids 10
Anadrol 11
Anadrol-50 11
Analgesics-age Edit 12
Androderm 220
Antidepressants-age Edit 13
Antiemetics-age Edit.....14
Antihistamines-age Edit.....15
Antiparkinson Agents-age Edit.....16
Anxiolytics-age Edit 17
Apokyn.....18
Aprepitant 263
Aralast Np 7
Aranesp 19
Aranesp Albumin Free.....19
Arcalyst 21
Armodafinil.....160
Ascomp/codeine.....38
Atovaquone 144
Auryxia 22
Austedo 23
Avastin 24
Avita.....221
Azacitidine 234
Azathioprine.....263

B

Balversa.....25
Banzel 26
Beleodaq 27
Benlysta.....28
Benztropine Mesylate 16
Berinert 29
Betaseron.....30
Bexarotene 31
Bivigam.....115
Bleomycin Sulfate.....263
Bortezomib.....229
Bosentan.....32

Bosulif 33
Braftovi 34
Briviact 35
Budesonide 263
Bupap 38
Buphenyl 36
Buprenorphine 37, 39
Buprenorphine Hcl 37
Butalbital/acetaminophen/caffeine 38
Butalbital/acetaminophen/caffeine/codeine 38
Butalbital/aspirin/caffeine 38
Butalbital/aspirin/caffeine/codeine 38
Butalbital-age Edit 38
Butrans 39

C

Cabometyx 40
Calcipotriene 41
Calcipotriene/betamethasone Dipropionate 41
Calcitrene 41
Calquence 42
Cambia 43
Caprelsa 44
Carac 45
Carbaglu 46
Carbinoxamine Maleate 15
Cardiovascular-age Edit 47
Carimune Nanofiltered 115
Cayston 48
Cerdelga 49
Cerezyme 50
Chantix 51
Chantix Continuing Month Pak 51
Chantix Starting Month Pak 51
Chlordiazepoxide/amitriptyline 13
Chlorzoxazone 147
Cladribine 263
Clemastine Fumarate 15
Clinimix 2.75%/dextrose 5% 263
Clinimix 4.25%/dextrose 10% 263
Clinimix 4.25%/dextrose 20% 263
Clinimix 4.25%/dextrose 25% 263
Clinimix 4.25%/dextrose 5% 263
Clinimix 5%/dextrose 15% 263
Clinimix 5%/dextrose 20% 263
Clinimix 5%/dextrose 25% 263
Clinisol Sf 15% 263
Clinolipid 263
Clobazam 164
Clomipramine Hcl 13
Colistimethate Sodium 52
Coly-mycin 52
Cometriq 53
Copiktra 54
Cotellic 55
Cromolyn Sodium 263
Cyclobenzaprine Hydrochloride 147
Cyclophosphamide 263
Cyclosporine 263
Cyclosporine Modified 263
Cyproheptadine Hcl 15
Cyproheptadine Hydrochloride 15
Cystagon 56
Cystaran 57
Cytarabine Aqueous 263

D

Dalfampridine Er 9
Daurismo 58
Deferasirox 59
Demser 60
Dexmethylphenidate Hcl 222
Dexmethylphenidate Hcl Er 222
Dexmethylphenidate Hydrochloride 222
Dextroamphetamine Sulfate 222
Dextroamphetamine Sulfate Er 222
Dextrose 50% 263
Dextrose 70% 263
Diabetes-age Edit 61
Diclofenac Sodium 219
Dihydroergot 62
Dihydroergotamine Mesylate 62
Diphenhydramine Hcl 15
Diphtheria/tetanus Toxoids Adsorbed Pediatric 263
Dipyridamole 47
Disopyramide Phosphate 47
Dotti 75
Doxepin Hcl 13
Doxepin Hydrochloride 13, 217
Doxorubicin Hcl 263

Doxycycline 166
Drizalma 63
Drizalma Sprinkle 63
Dronabinol 64
Duavee 75

E

Emend 263
Emsam 65
Endari 66
Engerix-b 263
Enstilar 41
Epclusa 67
Epidiolex 68
Epo 69
Epoprostenol Sodium 179
Ergoloid Mesylates 71
Ergoloid-age Edit 71
Erivedge 72
Erleada 73
Erlotinib Hydrochloride 210
Esbriet 74
Esgic 38
Estradiol 75
Estradiol/norethindrone Acetate 75
Estrogen-age Edit 75
Estropipate 75
Eszopiclone 111
Exjade 76

F

Fabrazyme 77
Farydak 78
Fentanyl 112
Fentanyl Citrate 167
Fentanyl Citrate Oral Transmucosal 79
Fentanyl Oral 79
Fentora 167
Fetzima 80
Fetzima Titration Pack 80
Firazyr 81
Flebogamma Dif 115
Flector 82
Fluorouracil 45, 83, 263
Forteo 84
Freamine Hbc 6.9% 263
Freamine III 263
Fyavolv 75
Fycompa 85

G

Gamastan 263
Gamastan S/d 263
Gammagard Liquid 115
Gammagard S/d Iga Less Than 1mcg/ml 115
Gammaked 115
Gammaplex 115
Gamunex-c 115
Ganciclovir 263
Gattex 86
Gengraf 263
Genotropin 91
Genotropin Miniquick 91
Gilenya 87
Gilotrif 88
Glatiramer 89
Glatiramer Acetate 89
Glatopa 89
Glyburide 61
Glyburide Micronized 61
Glyburide/metformin Hydrochloride 61
Granisetron Hcl 263
Granix 90
Growth Hormone 91
Guanfacine Hcl 47

H

Haegarda 92
Harvoni 93
Hepatamine 263
Herceptin 94
Herceptin Hylecta 95
Hetlioz 96
High Risk Medication 97
Humira 98
Humira Pediatric Crohns Disease Starter Pack 98
Humira Pen 98
Humira Pen-cd/uc/hs Starter 98
Humira Pen-ps/uv Starter 98
Humulin R U-500 (concentrated) 263

Hydromorphone Hcl 263
Hydromorphone Hydrochloride 263
Hydroxyprogesterone Caproate 100
Hydroxyzine Hcl 101
Hydroxyzine Hydrochloride 101
Hydroxyzine Pamoate 101
Hydroxyzine-age Edit 101
Hysingla Er 112

I

Ibrance 103
Icatibant Acetate 81
Iclusig 104
Idhifa 105
Imatinib 106
Imatinib Mesylate 106
Imbruvica 107
Imipramine Hcl 13
Imipramine Hydrochloride 13
Imipramine Pamoate 13
Imovax Rabies (h.d.c.v.) 263
Increlex 108
Indomethacin 12
Indomethacin Er 12
Inlyta 109
Inrebic 110
Insomnia Agents-age Edit 111
Intralipid 263
Ipratropium Bromide 264
Ipratropium Bromide/albuterol Sulfate 264
Ir Before Er 112
Iressa 113
Itraconazole 114
Ivig 115

J

Jadenu 59
Jadenu Sprinkle 59
Jakafi 117
Jinteli 75
Juxtapid 118

K

Kalydeco 120
Ketorolac Tromethamine 12
Keytruda 121
Khapzory 122
Kisqali 123
Kisqali Femara 200 Dose 123
Kisqali Femara 400 Dose 123
Kisqali Femara 600 Dose 123
Klofensaid II 219
Korlym 124
Kuvan 125
Kynamro 126

L

Lenvima 128
Lenvima 10 Mg Daily Dose 128
Lenvima 12mg Daily Dose 128
Lenvima 14 Mg Daily Dose 128
Lenvima 18 Mg Daily Dose 128
Lenvima 20 Mg Daily Dose 128
Lenvima 24 Mg Daily Dose 128
Lenvima 4 Mg Daily Dose 128
Lenvima 8 Mg Daily Dose 128
Letairis 129
Leuprolide 130
Leuprolide Acetate 130
Levalbuterol 264
Levalbuterol Hcl 264
Levalbuterol Hydrochloride 264
Libtayo 131
Lidocaine 132, 218
Lidocaine/prilocaine 218
Lidoderm 132
Linezolid 261
Lonsurf 133
Lopreeza 75
Lorbrena 134
Lumizyme 135
Lumoxiti 136
Lupron Depot (1-month) 130
Lupron Depot (3-month) 130
Lupron Depot-ped (1-month) 130
Lupron Depot-ped (3-month) 130
Lynparza 137
Lyrica Cr 138

M

Mavyret 139
Megestrol Acetate 140
Megestrol-age Edit 140
Mekinist 141
Mektovi 142
Melphalan 264
Memantine 143
Memantine Hcl 143
Memantine Hcl Titration Pak 143
Memantine Hydrochloride 143
Memantine Hydrochloride Er 143
Meperidine Hcl 12
Meprobamate 17
Mepron 144
Metadate Er 222
Metformin Er 145
Metformin Hydrochloride Er 145
Methadone Hcl 112
Methyldopa 47
Methylphenidate Hydrochloride 222
Methylphenidate Hydrochloride CD 222
Methylphenidate Hydrochloride Er 222
Methylphenidate Hydrochloride Er (la) 222
Miglustat 252
Mimvey 75
Mimvey Lo 75
Modafinil 146
Morphine Sulfate 264
Morphine Sulfate Er 112
Muscle Relaxants-age Edit 147
Mycophenolate Mofetil 264
Mycophenolic Acid Dr 264
Mylotarg 148

N

Naglazyme 149
Natpara 150
Nebupent 264
Nephramine 264
Nerlynx 151
Neupogen 152
Nexavar 153
Nifedipine 47
Ninlaro 154
Norethindrone Acetate/ethinyl Estradiol 75
Northera 155
Np Multiple Sclerosis 156
Nubeqa 157
Nucynta Er 112
Nuedexta 158
Nulojix 264
Nuplazid 159
Nutrilipid 264
Nuvigil 160

O

Octagam 115
Octreotide 161
Octreotide Acetate 161
Odomzo 162
Ofev 163
Ondansetron Hcl 264
Ondansetron Hydrochloride 264
Ondansetron Odt 264
Onfi 164
Opsumit 165
Oracea 166
Oral-intranasal Fentanyl 167
Orfadin 168
Orkambi 169
Oxandrolone 10

P

Part B Versus Part D 262
Pegasys 170
Pegasys Proclick 170
Pennsaid 219
Pentazocine/naloxone Hcl 12
Perphenazine/amitriptyline 13
Phenadoz 15
Phenergan 15
Phenobarbital 171
Phenobarbital Sodium 171
Phenobarbital-age Edit 171
Phenylbutyrate 172
Phrenilin Forte 38
Piqray 173
Piqray 200mg Daily Dose 173

Piqray 250mg Daily Dose 173
Piqray 300mg Daily Dose 173
Plenamine 264
Polivy 174
Pomalyst 175
Poteligeo 176
Praluent 177
Prednisone Intensol 264
Premarin 75
Premasol 264
Prempro 75
Privigen 115
Procalamine 264
Procrit 69
Prograf 264
Prolastin-c 7
Promacta 178
Promethazine Hcl 15
Promethazine Hcl Plain 15
Promethazine Hydrochloride 15
Promethazine Vc Plain 15
Promethazine/phenylephrine 15
Promethegan 15
Prosol 264
Pulmonary Hypertension-other 179
Pulmozyme 180

Q

Quinine Sulfate 181

R

Rabavert 264
Rapamune 264
Rebif 156
Rebif Rebidose 156
Rebif Rebidose Titration Pack 156
Rebif Titration Pack 156
Recombivax Hb 264
Regranex 182
Relistor 183
Relistor Inj 183
Remicade 184
Remodulin 224
Revlimid 186
Rituxan 187
Rituxan Hycela 189
Rozlytrek 190
Rubraca 191
Rydapt 192

S

Sabril 235
Sandimmune 264
Scopolamine 97
Signifor 193
Sildenafil 194
Sildenafil Citrate 194
Sirolimus 264
Sirturo 195
Sodium Phenylbutyrate 36, 172
Somatuline Depot 196
Somavert 197
Soriatane 198
Sprycel 199
Stivarga 200
Sutent 201
Sylatron 202
Symlin 203
Symlinpen 120 203
Symlinpen 60 203
Sympazan 204
Synribo 205

T

Tacrolimus 264
Tadalafil 206
Tadalafil (pah) 206
Tafinlar 207
Tagrisso 208
Talzenna 209
Tarceva 210
Targretin 31
Tasigna 211
Tazarotene 212
Tazorac 212
Tdvax 264
Tecentriq 213
Tenivac 264
Testosterone 220
Tetrabenazine 243

Thalomid 214
Thioridazine Hcl 215
Thioridazine-age Edit 215
Tibsovo 216
Tobramycin 264
Topical Doxepin 217
Topical Lidocaine 218
Topical Nsaids 219
Topical Testosterones 220
Topical Tretinoin 221
Tpn Electrolytes 264
Tracleer 32
Tramadol Hcl Er 112
Transderm-scop 97
Travasol 264
Treatment Of Attention Deficit Disorder - Age Edit 222
Trelstar 223
Trelstar Mixject 223
Treprostinil 224
Treprostinil Inj 224
Tretinoin 221
Tretinoin Microsphere 221
Tretinoin Microsphere Pump 221
Trientine 225
Trientine Hydrochloride 225
Trihexyphenidyl Hcl 16
Trihexyphenidyl Hydrochloride 16
Trimethobenzamide Hydrochloride 14
Trimipramine Maleate 13
Trophamine 264
Turalio 226
Tykerb 227

V

Valchlor 228
Velcade 229
Venclexta 230
Venclexta Starting Pack 230
Ventavis 231
Versacloz 232
Verzenio 233
Vidaza 234
Vigabatrin 235
Vigadrone 235
Vinblastine Sulfate 264
Vincasar Pfs 264
Vincristine Sulfate 264
Vitrakvi 236
Vizimpro 237
Vosevi 238
Votrient 239
Vraylar 240
Vyvanse 222

X

Xalkori 241
Xeljanz 242
Xeljanz Xr 242
Xenazine 243
Xgeva 244
Xifaxan 245
Xolair 246
Xospata 247
Xpovio 248
Xpovio 100 Mg Once Weekly 248
Xpovio 60 Mg Once Weekly 248
Xpovio 80 Mg Once Weekly 248
Xpovio 80 Mg Twice Weekly 248
Xtandi 249
Xyrem 250

Y

Yervoy 251

Z

Zaleplon 111
Zavesca 252
Zebutal 38
Zejula 253
Zelboraf 254
Zemaira 7
Zenzedi 222
Zepatier 255
Zolinza 256
Zolpidem Tartrate 111
Zortress 264
Zydelig 257
Zykadia 258
Zyprexa Relprevv 259

Zytiga 260
Zyvox 261