

# **Medicare Prior Authorization Requirements**

**Effective: 12/01/2017**

# ABALOPARATIDE

## Products Affected

- Tymlos

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

# ABATACEPT IV

---

## Products Affected

- Orencia (with maltose)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS. JIA: 4 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. JUVENILE IDIOPATHIC ARTHRITIS (JIA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

# ABATACEPT SQ

---

## Products Affected

- Orencia
- Orencia ClickJect

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

# ABEMACICLIB

---

## Products Affected

- Verzenio

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

# ABIRATERONE

---

## Products Affected

- Zytiga

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

# ADALIMUMAB

## Products Affected

- Humira
- Humira Pediatric Crohn's Start
- Humira Pen
- Humira Pen Crohn's-UC-HS Start
- Humira Pen Psoriasis-Uveitis

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: CURRENT WEIGHT. PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: RA: 6 MO. PSA/AS: 4 MO. PJIA: 5 MO. PSO/CD/UC/HS: 3 MO. UVEITIS: 6 MO. RENEW: 12 MO FOR ALL

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



# AFATINIB DIMALEATE

---

## Products Affected

- Gilotrif

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

# ALECTINIB

---

## Products Affected

- Alecensa

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

# ALEMTUZUMAB - LEMTRADA

---

## Products Affected

- Lemtrada

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 1 MONTH. RENEWAL: 12 MONTHS.
Other Criteria	TRIAL WITH TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, OR GLATIRAMER. RENEWAL REQUESTS FOR ALEMTUZUMAB REQUIRE THAT AT LEAST 12 MONTHS HAVE ELAPSED SINCE RECEIVING THE FIRST COURSE OF LEMTRADA. PATIENTS ARE LIMITED TO TWO COURSES OF THERAPY WITH LEMTRADA WITHIN A LIFETIME.

# ALIROCUMAB

---

## Products Affected

- Praluent Pen
- Praluent Syringe

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER.
<b>Prescriber Restrictions</b>	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>MUST HAVE A LDL CHOLESTEROL LEVEL GREATER THAN 100MG/DL WHILE ON MAXIMAL DRUG TREATMENT FOR THE PAST 2 MONTHS AND ONE OF THE FOLLOWING DIAGNOSES: (1) HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) DETERMINED BY SIMON BROOME DIAGNOSTIC CRITERIA FOR HEFH OR A SCORE OF 6 OR GREATER ON THE DUTCH LIPID NETWORK CRITERIA FOR HEFH OR (2) HISTORY OF ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) AS DOCUMENTED BY PHYSICIAN ATTESTATION. PATIENT MUST NOT HAVE CONCURRENT USE OF REPATHA OR OTHER PCSK9 AGENT. INITIAL THERAPY: FOR STATIN TOLERANT PATIENTS: MUST HAVE TAKEN ATORVASTATIN OR ROSUVASTATIN FOR THE PAST 2 MONTHS. FOR STATIN INTOLERANT PATIENTS: DOCUMENTATION OF STATIN INTOLERANCE BY ONE OF THE FOLLOWING: (1) PHYSICIAN ATTESTATION, (2) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY). PATIENTS WITH CONTRAINDICATIONS TO STATINS INCLUDING ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT OR HYPERSENSITIVITY REACTIONS WILL BE APPROVED FOR PRALUENT THERAPY WITHOUT REQUIREMENT OF DOCUMENTATION OF STATIN INTOLERANCE. RENEWAL CRITERIA: RECEIVING PRIOR PRALUENT THERAPY FOR THE PAST 6 MONTHS AND NO CLAIMS FOR REPATHA, JUXTAPID, OR KYNAMRO SINCE PRALUENT APPROVAL.</p>

# AMANTADINE

---

## Products Affected

- Gocovri oral capsule, extended release 24hr  
137 mg, 68.5 mg

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

# ANAKINRA

---

## Products Affected

- Kineret

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: RA: 6 MONTHS. NOMID/CAPS: 12 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA, OR ACTEMRA.

# APREMILAST

## Products Affected

- Otezla
- Otezla Starter

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST
<b>Coverage Duration</b>	INITIAL: PSORIATIC ARTHRITIS: 4 MONTHS. PSORIASIS: 5 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH HUMIRA AND ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE.



# ASFOTASE

## Products Affected

- Strensiq

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

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

PA Criteria	Criteria Details
	<p>BOWED LEGS, KNOCK-KNEES),PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, OR HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. STRENSIQ WILL NOT BE APPROVED FOR THE FOLLOWING PATIENTS: PATIENTS CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE (E.G., BONIVA (IBANDRONATE), FOSAMAX (ALENDRONATE), ACTONEL (RISEDRONATE)), PATIENTS WITH SERUM CALCIUM OR PHOSPHATE LEVELS BELOW THE NORMAL RANGE, PATIENTS WITH A TREATABLE FORM OF RICKETS. RENEWAL: PATIENT HAS EXPERIENCED AN IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HYPOPHOSPHATASIA (HPP) (E.G., IMPROVEMENT OF THE IRREGULARITY OF THE PROVISIONAL ZONE OF CALCIFICATION, PHYSEAL WIDENING, METAPHYSEAL FLARING, RADIOLUCENCIES, PATCHY OSTEOSCLEROSIS, RATIO OF MID-DIAPHYSEAL CORTEX TO BONE THICKNESS, GRACILE BONES, BONE FORMATION AND FRACTURES.</p>

# ASPARAGINASE

---

## Products Affected

- Oncaspar

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

# ATEZOLIZUMAB

---

## Products Affected

- Tecentriq

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

# AVELUMAB

---

## Products Affected

- Bavencio

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

# AXITINIB

---

## Products Affected

- Inlyta oral tablet 1 mg, 5 mg

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

# BEDAQUILINE FUMARATE

---

## Products Affected

- Sirturo

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



# BELIMUMAB

## Products Affected

- Benlysta intravenous
- Benlysta subcutaneous

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

# BELINOSTAT

---

## Products Affected

- Beleodaq

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

# BENDAMUSTINE

---

## Products Affected

- Bendeka

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

# BEVACIZUMAB

---

## Products Affected

- Avastin

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

# BEXAROTENE

---

## Products Affected

- bexarotene
- Targretin oral
- Targretin topical

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

# BLINATUMOMAB

---

## Products Affected

- Blincyto intravenous kit

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF PHILADELPHIA CHROMOSOME-NEGATIVE (PH-) B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA IN A PATIENT WHO HAS PREVIOUSLY TRIED CHEMOTHERAPY BUT HAS RELAPSED OR IS REFRACTORY TO TREATMENT. INITIAL APPROVAL IS FOR 2 CYCLES, MAY APPROVE FOR 1 ADDITIONAL CYCLE DUE TO TREATMENT INTERRUPTION FOR DOSE MODIFICATION. RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED COMPLETE REMISSION WITH OR WITHOUT PARTIAL HEMATOLOGICAL RECOVERY OF PERIPHERAL BLOOD COUNTS AFTER 2 CYCLES OF TREATMENT. RENEWAL IS NOT APPROVED FOR PATIENTS WHO RECEIVED AN ALLOGENEIC HEMATOPOIETIC STEM-CELL TRANSPLANT.

# BORTEZOMIB

---

## Products Affected

- Velcade

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

# BOSUTINIB

---

## Products Affected

- Bosulif oral tablet 100 mg, 500 mg

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



# BRENTUXIMAB

---

## Products Affected

- Adcetris

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

# BRIGATINIB

---

## Products Affected

- Alunbrig

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

# BRODALUMAB

## Products Affected

- Siliq

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

# C1 ESTERASE INHIBITOR

---

## Products Affected

- Cinryze
- Haegarda

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

# CABOZANTINIB

---

## Products Affected

- Cometriq

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

# CABOZANTINIB S-MALATE - CABOMETYX

---

## Products Affected

- Cabometyx oral tablet 20 mg, 40 mg, 60 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PATIENT HAS RECEIVED PRIOR ANTIANGIOGENIC THERAPY (E.G., SUTENT [SUNITINIB], VOTRIENT [PAZOPANIB], INLYTA [AXITINIB], NEXAVAR [SORAFENIB])

# CANAKINUMAB

---

## Products Affected

- Ilaris (PF)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	CAPS: 4 YEARS AND OLDER. SJIA: 2 YEARS AND OLDER.
<b>Prescriber Restrictions</b>	PRESCRIBED OR SUPERVISED BY RHEUMATOLOGIST, DERMATOLOGIST, OR AN IMMUNOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# CANNABINOIDS

---

## Products Affected

- dronabinol

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



# CARFILZOMIB

---

## Products Affected

- Kyprolis intravenous recon soln 30 mg, 60 mg

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

# CERITINIB

---

## Products Affected

- Zykadia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	POSITIVE FOR ANAPLASTIC LYMPHOMA KINASE (ALK) FUSION ONCOGENE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# CERTOLIZUMAB PEGOL

## Products Affected

- Cimzia
- Cimzia Powder for Reconst

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH DERMATOLOGIST OR RHEUMATOLOGIST. CROHN'S DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS. PSA/AS: 4 MONTHS. CD: 12 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL OF HUMIRA. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF HUMIRA AND ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE.

# CLOBAZAM

---

## Products Affected

- Onfi oral suspension
- Onfi oral tablet 10 mg, 20 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	2 YEARS OF AGE OR OLDER
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TRIAL OF LAMOTRIGINE OR TOPIRAMATE. REQUESTS FOR ORAL SUSPENSION APPROVABLE IF PATIENT IS UNABLE TO SWALLOW OR IS UNDER THE AGE OF 5 YEARS.

# COBIMETINIB FUMARATE

---

## Products Affected

- Cotellic

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

# COPANLISIB DI-HCL

---

## Products Affected

- Aliqopa

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

# CRIZOTINIB

---

## Products Affected

- Xalkori

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	LOCALLY ADVANCED OR METASTATIC NON SMALL CELL LUNG CANCER IS ANAPLASTIC LYMPHOMA KINASE POSITIVE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# DABRAFENIB MESYLATE

---

## Products Affected

- Tafinlar

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



# DACLATASVIR

---

## Products Affected

- Daklinza

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI, SOVALDI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO APPROVALS FOR CONCURRENT USE WITH ANY OF THESE (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN. APPROVAL FOR INTERFERON INELIGIBLE PATIENTS - INTERFERON INELIGIBILITY INCLUDES CONCURRENT DIAGNOSIS OF AUTOIMMUNE HEPATITIS OR OTHER AUTOIMMUNE DISORDER, A KNOWN HYPERSENSITIVITY REACTION (SUCH AS URTICARIA, ANGIOEDEMA, BRONCHOCONSTRICTION AND ANAPHYLAXIS TO ALPHA INTERFERONS, PEG, OR ANY COMPONENT OF PEGINTERFERON), DOCUMENTED DEPRESSION, DECOMPENSATED HEPATIC DISEASE: A BASELINE NEUTROPHIL COUNT BELOW 1,500 PER MICROLITER, A BASELINE PLATELET COUNT BELOW 90,000, OR A BASELINE HEMOGLOBIN BELOW 10G/DL THAT HAS NOT RESPONDED TO TREATMENT.</p>

# DACLIZUMAB

---

## Products Affected

- Zinbryta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	PRE-EXISTING HEPATIC DISEASE OR IMPAIRMENT, INCLUDING: ACTIVE HEPATITIS B AND C, AUTOIMMUNE HEPATITIS OR OTHER AUTOIMMUNE CONDITIONS INVOLVING THE LIVER, BASELINE ALT AND AST GREATER THAN OR EQUAL TO 2 TIMES UPPER LIMIT OF NORMAL (ULN).
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
<b>Other Criteria</b>	PREVIOUS TRIAL OF TWO OF THE FOLLOWING PREFERRED AGENTS FOR MULTIPLE SCLEROSIS, SUCH AS AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, OR FORMULARY GLATIRAMER ACETATE. RENEWAL: REQUESTS FOR DACLIZUMAB WILL NOT BE APPROVED FOR THE FOLLOWING PATIENTS: PATIENT WITH AUTOIMMUNE HEPATITIS OR HEPATIC INJURY.

# DALFAMPRIDINE

---

## Products Affected

- Ampyra

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

# DARATUMUMAB

---

## Products Affected

- Darzalex

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

# DASATINIB

---

## Products Affected

- Sprycel oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg

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

# DEFLAZACORT

---

## Products Affected

- Emflaza oral suspension mg
- Emflaza oral tablet 18 mg, 30 mg, 36 mg, 6

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST SPECIALIZING IN THE TREATMENT OF DUCHENNE MUSCULAR DYSTROPHY (DMD).
Coverage Duration	12 MONTHS
Other Criteria	

# DESIRUDIN

---

## Products Affected

- Iprivask

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



# DEUTETRABENAZINE

---

## Products Affected

- Austedo oral tablet 12 mg, 6 mg, 9 mg

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

# DICHLORPHENAMIDE

---

## Products Affected

- Keveyis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	HEPATIC INSUFFICIENCY, PULMONARY OBSTRUCTION, OR A HEALTH CONDITION THAT WARRANTS CONCURRENT USE OF HIGH-DOSE ASPIRIN
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 YEARS AND OLDER
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	INITIAL: 2 MONTHS RENEWAL: 12 MONTHS
<b>Other Criteria</b>	RENEWAL REQUIRES THE PATIENT EXPERIENCED AT LEAST TWO FEWER ATTACKS PER WEEK FROM THEIR BASELINE

# DICLOFENAC EPOLAMINE

---

## Products Affected

- Flector

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

# DIMETHYL FUMARATE

---

## Products Affected

- Tecfidera oral capsule, delayed release(DR/EC) 120 mg, 120 mg (14)- 240 mg (46), 240 mg

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

# DINUTUXIMAB

---

## Products Affected

- Unituxin

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

# DROXIDOPA

## Products Affected

- Northera

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE (LYING FACE UP) POSITION AT BASELINE AND RENEWAL.
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST
<b>Coverage Duration</b>	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: DIAGNOSIS OF ORTHOSTATIC HYPOTENSION AS DOCUMENTED BY A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION. RENEWAL: PATIENT HAD AN INCREASE IN SYSTOLIC BLOOD PRESSURE FROM BASELINE OF AT LEAST 10 MMHG UPON STANDING FROM A SUPINE (LAYING FACE UP) POSITION.

# DUPILUMAB

## Products Affected

- Dupixent

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PATIENT HAS MINIMUM BODY SURFACE AREA (BSA) INVOLVEMENT OF AT LEAST 10%, ECZEMA AREA AND SEVERITY INDEX (EASI) SCORE OF AT LEAST 16, OR PHYSICIAN GLOBAL ASSESSMENT (PGA) SCORE OF AT LEAST 3. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL:12 MONTHS
<b>Other Criteria</b>	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: TOPICAL CORTICOSTEROIDS, TOPICAL CALCINEURIN INHIBITORS [E.G., ELIDEL (PIMECROLIMUS), GENERIC TACROLIMUS OINTMENT], OR TOPICAL PDE4 INHIBITOR [E.G., EUCRISA (CRISABOROLE)].

# DURVALUMAB

---

## Products Affected

- Imfinzi

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



# EDARAVONE

---

## Products Affected

- Radicava

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

# ELBASVIR/GRAZOPREVIR

## Products Affected

- Zepatier

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

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

# ELIGLUSTAT TARTRATE

---

## Products Affected

- Cerdelga

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

# ELOSULFASE ALFA

---

## Products Affected

- Vimizim

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

# ELOTUZUMAB

---

## Products Affected

- Empliciti

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

# ELTROMBOPAG

## Products Affected

- Promacta

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ITP: INITIAL: 2 MONTHS. RENEWAL: AFTER RESPONSE: 12 MONTHS. AFTER INADEQUATE DOSE:2 MOS. HCV:12 MOS.
Other Criteria	CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ITP: RENEWAL: PATIENT HAS A CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10 <sup>9</sup> /L (GREATER THAN OR EQUAL TO 50,000 PER UL) AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS. HEPATITIS C: CONCURRENT INTERFERON THERAPY.

# ENASIDENIB

---

## Products Affected

- Idhifa

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



# ENDOTHELIN RECEPTOR ANTAGONISTS

## Products Affected

- Letairis
- Opsumit
- Tracleer

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

# ENZALUTAMIDE

---

## Products Affected

- Xtandi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	TRIAL OF OR CONTRAINDICATION TO ZYTIGA (ABIRATERONE ACETATE) IS ALSO REQUIRED IN PATIENTS WHO DO NOT HAVE A CONTRAINDICATION OR INTOLERANCE TO PREDNISONE.

# ERLOTINIB

---

## Products Affected

- Tarceva oral tablet 100 mg, 150 mg, 25 mg

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

# ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA

---

**Products Affected**

- EPOGEN 10,000 UNITS/ML VIAL SDV, P/F, OUTER
- Epogen injection solution 2,000 unit/mL, 20,000 unit/2 mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL
- Procrit injection solution 10,000 unit/mL, 2,000 unit/mL, 20,000 unit/2 mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL, 40,000 unit/mL

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

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

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

# ERYTHROPOIESIS STIMULATING AGENTS - MIRCERA

## Products Affected

- Mircera

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: CHRONIC RENAL FAILURE REQUIRES HEMOGLOBIN LEVELS LESS THAN 10G/DL RENEWAL: CHRONIC RENAL FAILURE REQUIRES THAT THE PATIENT MEETS ONE OF THE FOLLOWING: IF THE PATIENT IS CURRENTLY RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 11G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 11G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. IF THE PATIENT IS NOT RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	ANEMIA DUE TO CKD WITH OR WITHOUT DIALYSIS: 12 MONTHS.
<b>Other Criteria</b>	TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

# ETANERCEPT

## Products Affected

- Enbrel subcutaneous recon soln
- Enbrel SureClick
- Enbrel subcutaneous syringe

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
<b>Age Restrictions</b>	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, PSORIATIC ARTHRITIS: 18 YEARS OR OLDER
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: RA: 6 MONTHS. PJIA: 3 MONTHS. PSA/AS/PSO: 4 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA, OR ACTEMRA. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA OR ACTEMRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA, OTEZLA, OR COSENTYX. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA OR COSENTYX. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: COSENTYX OR OTEZLA.</p>

# ETEPLIRSEN

## Products Affected

- Exondys 51

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING THAT MUTATION IN DUCHENNE MUSCULAR DYSTROPHY (DMD) GENE IS AMENABLE TO EXON 51 SKIPPING.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST SPECIALIZING IN THE TREATMENT OF DMD AT A DMD TREATMENT CENTER.
<b>Coverage Duration</b>	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL CRITERIA: PATIENT IS AMBULATORY AND IS CONCURRENTLY RECEIVING TREATMENT WITH GLUCOCORTICIDS. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION) DURING THE PAST 24 WEEKS.

# EVEROLIMUS

---

## Products Affected

- Afinitor Disperz 7.5 mg
- Afinitor oral tablet 10 mg, 2.5 mg, 5 mg,

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

# EVOLOCUMAB

---

## Products Affected

- Repatha Pushtronex
- Repatha SureClick
- Repatha Syringe

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	HEFH OR ASCVD: 18 YEARS OF AGE AND OLDER.
<b>Prescriber Restrictions</b>	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
<b>Coverage Duration</b>	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>FOR HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) OR ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD): MUST HAVE LDL LEVEL GREATER THAN 100MG/DL ON MAXIMAL DRUG TREATMENT (MDT) FOR AT LEAST 2 MONTHS WITHIN THE PAST 2 MONTHS AND ONE OF THE FOLLOWING: (1) HEFH DETERMINED BY SIMON BROOME DIAGNOSTIC (SBD) CRITERIA OR A SCORE OF 6 OR GREATER ON THE DUTCH LIPID NETWORK (DLN) CRITERIA OR (2) ASCVD AS SUBSTANTIATED BY PHYSICIAN ATTESTATION.</p> <p>HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): LDL LEVEL GREATER THAN 100MG/DL ON MDT FOR AT LEAST 2 MONTHS WITHIN THE PAST 2 MONTHS AND HOFH DETERMINED BY ONE OF THE FOLLOWING: 1) SBD CRITERIA, 2) A SCORE OF 8 OR GREATER ON THE DLN CRITERIA, OR 3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. NO CONCURRENT USE OF OTHER PCSK9 INHIBITORS. INITIAL THERAPY: FOR STATIN TOLERANT PATIENTS: MUST HAVE TRIED MAXIMALLY TOLERATED DOSE OF HIGH INTENSITY STATIN SUCH AS ATORVASTATIN OR ROSUVASTATIN. FOR STATIN INTOLERANT PATIENTS WITH HEFH OR ASCVD: ONE OF THE FOLLOWING MUST BE MET: PHYSICIAN ATTESTATION OF STATIN INTOLERANCE (INCLUDING BUT NOT LIMITED TO MYOPATHY), OR PATIENT HAS TRIED ROSUVASTATIN OR ATORVASTATIN AT ANY DOSE. PATIENTS WITH CONTRAINDICATIONS TO STATINS INCLUDING ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT OR HYPERSENSITIVITY REACTIONS WILL BE APPROVED FOR REPATHA THERAPY WITHOUT DOCUMENTED STATIN INTOLERANCE. FOR STATIN INTOLERANT PATIENTS WITH HOFH: MUST BE ON MAX LIPID-LOWERING THERAPY INCLUDING ONE OF THE FOLLOWING: NIACIN, BILE ACID SEQUESTRANT, LOMITAPIDE OR MIPOMERSEN. QUALIFIERS MUST PROVIDE DOCUMENTATION OF STATIN INTOLERANCE TO ONE OF THE FOLLOWING: A HIGH INTENSITY STATIN (ROSUVASTATIN OR ATORVASTATIN) OR OTHER STATIN THERAPY AT ANY DOSE. STATIN INTOLERANT PATIENTS</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>MUST BE ON MAXIMAL LIPID-LOWERING MEDICATION (NON-STATIN THERAPY) FOR AT LEAST 2 MONTHS WITHIN THE PAST 2 MONTHS WITH DOCUMENTATION OF STATIN INTOLERANCE TO ATORVASTATIN OR ROSUVASTATIN OR STATIN THERAPY AT ANY DOSE. DOCUMENTATION OF STATIN INTOLERANCE INCLUDES: (1) PHYSICIAN ATTESTATION, OR (2) PATIENT HAS TRIED ROSUVASTATIN OR ATORVASTATIN AND HAS EXPERIENCED SKELETAL MUSCLE RELATED EVENTS (E.G. MYOPATHY). RENEWAL CRITERIA: RECEIVING PRIOR REPATHA THERAPY FOR AT LEAST 6 MONTHS AND NOT ON CONCURRENT THERAPY WITH OTHER PCSK9 INHIBITORS, MIPOMERSEN, OR LOMITAPIDE.</p>

# FENTANYL NASAL SPRAY

---

## Products Affected

- Lazanda

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	<p>CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE SR, OXYCODONE SR, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES AND TRIAL OR CONTRAINDICATION TO GENERIC FENTANYL CITRATE LOZENGE.</p>

# FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

## Products Affected

- fentanyl citrate

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE SR, OXYCODONE SR, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES.



# FINGOLIMOD

---

## Products Affected

- Gilenya

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

# GEFITINIB

---

## Products Affected

- Iressa

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

# GEMTUZUMAB OZOGAMICIN

---

## Products Affected

- Mylotarg

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

# GLATIRAMER ACETATE

---

## Products Affected

- Copaxone subcutaneous syringe
- Glatopa
- glatiramer

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

# GLECAPREVIR/PIBRENTASVIR

## Products Affected

- Mavyret

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

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

# GLYCEROL PHENYL BUTYRATE

---

## Products Affected

- Ravicti

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

# GOLIMUMAB IV

---

## Products Affected

- Simponi ARIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST
<b>Coverage Duration</b>	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PREVIOUS TRIAL HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA, OR ACTEMRA.



# GOLIMUMAB SQ

## Products Affected

- Simponi

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS. PSA/AS: 4 MONTHS. UC: 12 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA OR ACTEMRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING REFERRED AGENTS: CIMZIA, OTEZLA, OR COSENTYX. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA OR COSENTYX. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING CONVENTIONAL AGENTS SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDINSONE), AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE.

# GUSELKUMAB

## Products Affected

- Tremfya

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

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

## Products Affected

- benztropine oral
- trihexyphenidyl

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

# HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE

## Products Affected

- Phenadoz
- promethazine oral
- promethazine rectal
- Promethegan

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OF OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. NAUSEA AND VOMITING: PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE REQUESTED MEDICATION IS LABELED AS A HIGH-RISK MEDICATION FOR PATIENTS 65 YEARS AND OLDER. MOTION SICKNESS: TRIAL OF OR CONTRAINDICATION TO MECLIZINE. HOSPICE PATIENTS WILL BE APPROVED WITHOUT TRIAL OF FORMULARY ALTERNATIVES NOR REQUIRING PRESCRIBER ACKNOWLEDGEMENT.

# HIGH RISK DRUGS IN THE ELDERLY - ANTI- INFECTIVE

## Products Affected

- nitrofurantoin macrocrystal
- nitrofurantoin monohyd/m-cryst

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF (UNLESS CONTRAINDICATED TO) SULFAMETHOXAZOLE/TRIMETHOPRIM (TMP-SMX) OR TRIMETHOPRIM. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING A TRIAL OF SULFAMETHOXAZOLE/TRIMETHOPRIM (TMP-SMX) OR TRIMETHOPRIM.

# HIGH RISK DRUGS IN THE ELDERLY - BARBITURATE COMBINATIONS

## Products Affected

- Allzital
- Ascomp with Codeine
- Butalbital Compound W/Codeine
- butalbital-acetaminop-caf-cod
- butalbital-acetaminophen oral tablet 50-325 mg
- butalbital-acetaminophen-caff oral capsule 50-325-40 mg
- butalbital-acetaminophen-caff oral tablet 50-325-40 mg
- butalbital-aspirin-caffeine
- Capacet
- Margesic
- Tencon oral tablet 50-325 mg
- Zebutal oral capsule 50-325-40 mg

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

# HIGH RISK DRUGS IN THE ELDERLY - CARDIOVASCULAR

---

## Products Affected

- guanfacine oral tablet

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>HYPERTENSION: TRIAL OR CONTRAINDICATION TO TWO (2) OF THE FOLLOWING - BENAZEPRIL, BENAZEPRIL/HYDROCHLOROTHIAZIDE, CAPTOPRIL, CAPTOPRIL/HYDROCHLOROTHIAZIDE, ENALAPRIL, ENALAPRIL/HYDROCHLOROTHIAZIDE, FOSINOPRIL, FOSINOPRIL/HYDROCHLOROTHIAZIDE, LISINOPRIL, LISINOPRIL/HYDROCHLOROTHIAZIDE, QUINAPRIL, QUINAPRIL/HYDROCHLOROTHIAZIDE, RAMIPRIL, MOEXIPRIL, MOEXIPRIL/HYDROCHLOROTHIAZIDE, PERINDOPRIL ERBUMINE, TRANDOLAPRIL, TRANDOLAPRIL/VERAPAMIL, LOSARTAN, LOSARTAN/HYDROCHLOROTHIAZIDE, IRBESARTAN, IRBESARTAN/HYDROCHLOROTHIAZIDE, OLMESARTAN, OLMESARTAN/HYDROCHLOROTHIAZIDE, OLMESARTAN/AMLODIPINE/HYDROCHLOROTHIAZIDE, VALSARTAN, VALSARTAN/HYDROCHLOROTHIAZIDE, DILTIAZEM HCL, DILTIAZEM SUSTAINED RELEASE, VERAPAMIL, VERAPAMIL SUSTAINED RELEASE, ATENOLOL, ATENOLOL/CHLORTHALIDONE, BISOPROLOL, BISOPROLOL/HYDROCHLOROTHIAZIDE, CARVEDILOL, METOPROLOL TARTRATE, NADOLOL, ACEBUTOLOL, BETAXOLOL, LABETALOL, METOPROLOL SUCCINATE, METOPROLOL/HYDROCHLOROTHIAZIDE, PINDOLOL, PROPRANOLOL, PROPRANOLOL/HYDROCHLOROTHIAZIDE, SOTALOL, TIMOLOL MALEATE. HOSPICE PATIENTS ARE APPROVED WITHOUT A TRIAL OF FORMULARY ALTERNATIVES.</p>



# HIGH RISK DRUGS IN THE ELDERLY - CENTRAL NERVOUS SYSTEM - THIORIDAZINE

## Products Affected

- thioridazine

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

# HIGH RISK DRUGS IN THE ELDERLY - DIGOXIN

## Products Affected

- Digitek
- Digox
- DIGOXIN 0.25 MG/ML SYRINGE
- digoxin injection solution
- digoxin oral solution 50 mcg/mL
- digoxin oral tablet
- Lanoxin oral tablet 187.5 mcg, 62.5 mcg

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

# HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - ESTROGEN

## Products Affected

- CombiPatch
- Duavee
- estradiol oral
- estradiol transdermal patch semiweekly
- estradiol transdermal patch weekly
- estradiol-norethindrone acet
- estropipate
- Menest
- Mimvey
- Mimvey Lo
- Premarin oral
- Premphase
- Prempro

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

# HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - SULFONYLUREAS

## Products Affected

- glyburide
- glyburide-metformin
- glyburide micronized

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

# HIGH RISK DRUGS IN THE ELDERLY - NON-BENZODIAZEPINE

## Products Affected

- eszopiclone
- zolpidem oral
- zaleplon

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

# HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

## Products Affected

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

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

# HYDROXYPROGESTERONE CAPROATE- DELALUTIN GENERIC

---

## Products Affected

- hydroxyprogesterone caproate

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

# IBRUTINIB

---

## Products Affected

- Imbruvica

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



# IDELALISIB

---

## Products Affected

- Zydelig

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

# IMATINIB MESYLATE

## Products Affected

- imatinib oral tablet 100 mg, 400 mg

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ALL DIAGNOSES:12 MOS.ADJUVANT GASTROINTESTINAL STROMAL TUMOR(GIST)TREATMENT(TWICE DAILY DOSE):36 MOS
Other Criteria	GASTROINTESTINAL STROMAL TUMOR (GIST) KIT (CD117) POSITIVE USE IMATINIB 400MG TWICE DAILY: TRIAL OF IMATINIB 400MG ONCE DAILY OR GIST TUMOR EXPRESSING A KIT EXON 9 MUTATION. PREVIOUSLY TREATED CML REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, F317L/V/I/C, Y253H, E255K/V, F359V/C/I.

# IMIQUIMOD - ALDARA

---

## Products Affected

- imiquimod

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

# INFLIXIMAB

## Products Affected

- Remicade

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: CD/UC: 8 MO. RA: 6 MO. PSA/AS/PSO: 4 MO. RENEWAL FOR ALL INDICATIONS: 12 MO.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: ORENCIA, XELJANZ, CIMZIA, OR ACTEMRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: CIMZIA, OTEZLA, OR COSENTYX. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY CIMZIA OR COSENTYX. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: COSENTYX OR OTEZLA. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY CIMZIA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: SIMPONI OR ENTYVIO.</p>

# INFLIXIMAB-ABDA

---

## Products Affected

- Renflexis

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

# INFLIXIMAB-DYYB

## Products Affected

- Inflectra

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: CD/UC: 8 MOS. RA: 6 MOS. PSA/AS/PSO: 4 MOS. RENEWAL FOR ALL INDICATIONS: 12 MOS.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: ORENCIA, XELJANZ, CIMZIA, OR ACTEMRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: CIMZIA, OTEZLA, OR COSENTYX. ANKYLOSING SPONDYLITIS (AS): HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: CIMZIA OR COSENTYX. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: COSENTYX OR OTEZLA. CROHN'S DISEASE (CD): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY CIMZIA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: SIMPONI OR ENTYVIO.</p>



# INOTUZUMAB OZOGAMICIN

---

## Products Affected

- Besponsa

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

# INTERFERON ALFA-2B

---

## Products Affected

- Intron A injection

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

# INTERFERONS FOR MS-AVONEX, PLEGRIDY, REBIF

---

## Products Affected

- Avonex (with albumin)
- Avonex intramuscular pen injector kit
- Avonex intramuscular syringe kit
- Plegridy
- Rebif (with albumin)
- Rebif Rebidose
- Rebif Titration Pack

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

# INTERFERONS FOR MS-BETASERON, EXTAVIA

## Products Affected

- Betaseron subcutaneous kit
- Extavia subcutaneous kit

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

# IPILIMUMAB

---

## Products Affected

- Yervoy

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

# IVACAFTOR

---

## Products Affected

- Kalydeco

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE.
<b>Required Medical Information</b>	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
<b>Age Restrictions</b>	6 YEARS OF AGE OR OLDER.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# IVACAFTOR - GRANULE PACKETS

---

## Products Affected

- Kalydeco

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	F508DEL MUTATION IN CFTR GENE.
<b>Required Medical Information</b>	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS. PATIENT WEIGHT.
<b>Age Restrictions</b>	2 YEARS OF AGE TO 5 YEARS OF AGE
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# IXAZOMIB

---

## Products Affected

- Ninlaro

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



# IXEKIZUMAB

## Products Affected

- TALTZ 80 MG/ML AUTOINJECTOR P/F,L/F,SDV,OUTER
- Taltz Autoinjector (3 Pack)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST
Coverage Duration	PLAQUE PSORIASIS (PSO): INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	PSORIASIS (PSO): INITIAL PLAQUE : PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: COSENTYX OR OTEZLA.

# LEDIPASVIR-SOFOSBUVIR

## Products Affected

- Harvoni

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

# LENALIDOMIDE

---

## Products Affected

- Revlimid

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

# LENVATINIB MESYLATE

---

## Products Affected

- Lenvima

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

# LIDOCAINE

---

## Products Affected

- lidocaine topical adhesive patch,medicated

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

# LIDOCAINE OINTMENT TIRF

---

## Products Affected

- lidocaine topical ointment

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

# LOMITAPIDE

---

## Products Affected

- Juxtapid oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 5 mg, 60 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	MODERATE OR SEVERE HEPATIC IMPAIRMENT OR ACTIVE LIVER DISEASE
<b>Required Medical Information</b>	LDL CHOLESTEROL LEVEL, LDL RECEPTOR STATUS
<b>Age Restrictions</b>	AT LEAST 18 YEARS OF AGE OR OLDER
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST.
<b>Coverage Duration</b>	INITIAL: 7 MONTHS RENEWAL: 6 MONTHS

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: SIMON BROOME DIAGNOSTIC CRITERIA (DEFINITE), (E.G. GENETIC TESTING CONSISTENT WITH HOFH AND PRETREATMENT BASELINE LDL CHOLESTEROL IS GREATER THAN 190 MG/DL), CASCADE SCREENING, DUTCH LIPID NETWORK CRITERIA WITH A SCORE OF AT LEAST 6, OR HISTORY OF UNTREATED CHOLESTEROL GREATER THAN 500MG/DL (OR TREATED CHOLESTEROL GREATER THAN 300MG/DL) AND CUTANEOUS XANTHOMA BEFORE 10 YEARS OF AGE. LOMITAPIDE WILL NOT BE APPROVED FOR PATIENTS CONCURRENTLY USING ANY OF THE FOLLOWING STRONG OR MODERATE CYP3A4 MEDICATIONS: CLARITHROMYCIN, CONIVAPTAN, INDINAVIR, ITRACONAZOLE, KETOCONAZOLE, LOPINAVIR/RITONAVIR, MIBEFRADIL, NEFAZODONE, NELFINAVIR, POSACONAZOLE, RITONAVIR, SAQUINAVIR, TELITHROMYCIN, TIPRANAVIR/RITONAVIR, VORICONAZOLE, AMPRENAVIR, APREPITANT, ATAZANAVIR, CIPROFLOXACIN, CRIZOTINIB, DARUNAVIR/RITONAVIR, DILTIAZEM, ERYTHROMYCIN, FLUCONAZOLE, FOSAMPRENAVIR, IMATINIB, OR VERAPAMIL. INITIAL: LDL CHOLESTEROL LEVEL OF AT LEAST 160MG/DL WHILE ON LIPID-LOWERING THERAPY PRIOR TO INITIATING LOMITAPIDE. PREVIOUS TRIAL OF A PCSK9 INHIBITOR (E.G. ALIROCUMAB OR EVOLOCUMAB), UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. PREVIOUS TRIAL OF ROSUVASTATIN OR ATORVASTATIN, UNLESS THE PATIENT HAS AN ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G. ACTIVE, DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTION). STATIN-TOLERANT PATIENTS MUST BE TAKING ATORVASTATIN OR ROSUVASTATIN FOR THE PAST 2 MONTHS PRIOR TO STARTING LOMITAPIDE. LOMITAPIDE MUST BE USED IN COMBINATION WITH ATORVASTATIN OR ROSUVASTATIN. IF THE PATIENT HAS PREVIOUSLY TRIED ATORVASTATIN OR ROSUVASTATIN, LOMITAPIDE MUST BE USED IN COMBINATION WITH ANOTHER STATIN OR LDL-LOWERING AGENT (E.G. BILE ACID SEQUESTRANT, GEMFIBROZIL OR OTHER FIBRATE, EZETIMIBE, OR NIACIN). STATIN-INTOLERANT PATIENTS REQUIRE EITHER PHYSICIAN ATTESTATION OF STATIN</p>



PA Criteria	Criteria Details
	<p>INTOLERANCE OR HISTORY OF SKELETAL-MUSCLE RELATED SYMPTOMS (E.G. MYOPATHY) DUE TO A PREVIOUS TRIAL OF STATINS (E.G. ROSUVASTATIN OR ATORVASTATIN). FOR STATIN-INTOLERANT PATIENTS, LOMITAPIDE MUST BE USED IN COMBINATION WITH ONE OF THE FOLLOWING LIPID-LOWERING TREATMENTS: EZETIMIBE, FENOFIBRATE, NIACIN, OR A BILE ACID SEQUESTRANT (E.G. CHOLESTYRAMINE, COLESTIPOL, COLESEVELAM). RENEWAL: PATIENT HAS RECEIVED AT LEAST 6 MONTHS OF THERAPY WITH LOMITAPIDE IN COMBINATION WITH ANOTHER LIPID-LOWERING AGENT.</p>

# LUMACAFITOR-IVACAFITOR

---

## Products Affected

- Orkambi

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

# MEPOLIZUMAB

## Products Affected

- Nucala

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
<b>Exclusion Criteria</b>	CONCURRENT USE OF XOLAIR
<b>Required Medical Information</b>	BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE LAST 6 WEEKS OR GREATER THAN OR EQUAL TO 300 CELLS/MCL WITHIN THE LAST 12 MONTHS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE, AN ALLERGIST OR AN IMMUNOLOGIST.
<b>Coverage Duration</b>	INITIAL 24 WEEKS. RENEWAL 12 MONTHS
<b>Other Criteria</b>	INITIAL THERAPY: PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION WHICH INCLUDES ANY OF THE FOLLOWING: LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, OR ORAL CORTICOSTEROID. RENEWAL REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED IMPROVEMENT IN ASTHMA EXACERBATIONS FROM BASELINE (PHYSICIAN ATTESTATION) AND A REDUCTION IN ORAL CORTICOSTEROID DOSE (IF THE PATIENT WAS ON A MAINTENANCE REGIMEN OF ORAL CORTICOSTEROIDS AT THE INITIATION OF TREATMENT).

# METHYLNALTREXONE

## Products Affected

- Relistor subcutaneous solution
- Relistor subcutaneous syringe

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

# METHYLNALTREXONE ORAL

---

## Products Affected

- Relistor oral

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

# MIDOSTAURIN

---

## Products Affected

- Rydapt

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

# MIFEPRISTONE

---

## Products Affected

- Korlym

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

# MIPOMERSEN

---

## Products Affected

- Kynamro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	LDL CHOLESTEROL LEVEL, LDL RECEPTOR STATUS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
<b>Coverage Duration</b>	INITIAL: 7 MONTHS RENEWAL 12 MONTHS



PA Criteria	Criteria Details
Other Criteria	<p>DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA AS DETERMINED BY ONE OF THE FOLLOWING CRITERIA: SIMON BROOME DIAGNOSTIC CRITERIA (DEFINITE) [EXAMPLE: GENETIC TESTING CONSISTENT WITH HOFH AND PRETREATMENT BASELINE LDL CHOLESTEROL IS GREATER THAN 190 MG/DL], CASCADE SCREENING, DUTCH LIPID NETWORK CRITERIA WITH A SCORE AT LEAST 6, OR HISTORY OF UNTREATED CHOLESTEROL GREATER THAN 500MG/DL (OR TREATED GREATER THAN 300MG/DL) AND CUTANEOUS XANTHOMA BEFORE AGE 10 INITIAL CRITERIA: CURRENT LDL CHOLESTEROL LEVEL IS AT LEAST 160MG/DL. PATIENT DOES NOT HAVE ANY OF THE FOLLOWING CONTRAINDICATIONS TO KYNAMRO (MIPOMERSEN): MODERATE OR SEVERE HEPATIC IMPAIRMENT OR ACTIVE LIVER DISEASE, INCLUDING UNEXPLAINED PERSISTENT ELEVATIONS OF SERUM TRANSAMINASES. PREVIOUS TRIAL OF A PCSK9 INHIBITOR (SUCH AS ALIROCUMAB OR EVOLOCUMAB) UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. PREVIOUS TRIAL WITH ONE OF THE FOLLOWING STATINS: ROSUVASTATIN OR ATORVASTATIN. PATIENTS WITH ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (ACTIVE, DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTION) WILL BE APPROVED FOR THERAPY WITHOUT REQUIREMENT OF A TRIAL WITH A STATIN. STATIN-TOLERANT PATIENTS: PRIOR TO (KYNAMRO), PATIENT MUST HAVE BEEN TAKING ONE OF THE FOLLOWING: ATORVASTATIN OR ROSUVASTATIN, FOR AT LEAST 2 MONTHS WITHIN THE PAST 2 MONTHS. FOR STATIN-INTOLERANT PATIENTS: DOCUMENTATION OF STATIN INTOLERANCE WHICH INCLUDES THE FOLLOWING: PHYSICIAN ATTESTATION OR PATIENT HAS TRIED ROSUVASTATIN OR ATORVASTATIN AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY). UNLESS CONTRAINDICATED, PATIENT MUST BE ON CONCURRENT THERAPY WITH ONE OF THE FOLLOWING LIPID-LOWERING TREATMENTS (SUCH AS A STATIN [SIMVASTATIN, ATORVASTATIN], EZETIMIBE, FENOFIBRATE, NIACIN, OR BILE ACID SEQUESTRANT [CHOLESTYRAMINE, COLESTIPOL, COLESEVELAM]). RENEWAL CRITERIA:</p>

<b>PA Criteria</b>	<b>Criteria Details</b>
	PATIENT HAS RECEIVED THERAPY FOR AT LEAST 6 MONTHS AND MUST ALSO BE TAKING KYNAMRO IN COMBINATION WITH ANOTHER LIPID-LOWERING AGENT.

# NATALIZUMAB

## Products Affected

- Tysabri

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHN'S DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH GASTROENTEROLOGIST.
Coverage Duration	MULTIPLE SCLEROSIS: 12 MONTHS. CROHN'S DISEASE: INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	MULTIPLE SCLEROSIS: PREVIOUS TRIAL OF TWO OF THE FOLLOWING PREFERRED AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, OR GLATIRAMER. CROHN'S DISEASE: PREVIOUS TRIAL OF HUMIRA FOLLOWED BY CIMZIA. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH A TNF (TUMOR NECROSIS FACTOR) INHIBITOR: ENBREL, CIMZIA, REMICADE, SIMPONI OR SIMPONI ARIA

# NECITUMUMAB

---

## Products Affected

- Portrazza

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

# NERATINIB MALEATE

---

## Products Affected

- Nerlynx

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

# NILOTINIB

---

## Products Affected

- Tasigna

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

# NINTEDANIB ESYLATE

## Products Affected

- Ofev

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

# NIRAPARIB TOSYLATE

---

## Products Affected

- Zejula

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



# NIVOLUMAB

---

## Products Affected

- Opdivo

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

# OBETICHOLIC ACID

---

## Products Affected

- Ocaliva

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	PATIENTS WITH COMPLETE BILIARY OBSTRUCTION.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# OBINUTUZUMAB

---

## Products Affected

- Gazyva

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

# OCRELIZUMAB

## Products Affected

- Ocrevus

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS: TRIAL OF TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, OR GLATIRAMER. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# OLAPARIB

---

## Products Affected

- Lynparza oral capsule
- Lynparza oral tablet

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

# OLARATUMAB

---

## Products Affected

- Lartruvo

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

# OMACETAXINE

## Products Affected

- Synribo

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

# OMALIZUMAB

## Products Affected

- Xolair

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL CRITERIA FOR ASTHMA: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, FEV1 LESS THAN 80%, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30IU/ML. RENEWAL CRITERIA FOR ASTHMA: PHYSICIAN ATTESTATION OF IMPROVEMENT IN ASTHMA EXCERBATIONS FROM BASELINE AND A REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A SPECIALIST IN ALLERGY, PULMONARY MEDICINE, DERMATOLOGY OR IMMUNOLOGY.
<b>Coverage Duration</b>	ASTHMA: 12 MONTHS. CHRONIC IDIOPATHIC URTICARIA: 6 MONTHS.
<b>Other Criteria</b>	FOR CHRONIC IDIOPATHIC URTICARIA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO A HIGH DOSE H1 ANTI-HISTAMINE (SUCH AS CLARINEX OR XYZAL) FOR AT LEAST 2 WEEKS AND STILL EXPERIENCE HIVES ON MOST DAYS OF THE WEEK.



# OMBITASVIR-PARITAPREVIR-RITONAVIR

## Products Affected

- Technivie

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

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

# OMBITASVIR-PARITAPREVIR-RITONAVIR-DASABUVIR

## Products Affected

- Viekira Pak
- Viekira XR

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

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

# OPIOID DEPENDENCY AGENTS

## Products Affected

- buprenorphine HCl sublingual

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	BUPRENORPHINE: 2 DAYS UNLESS PREGNANT (12 MO.) OR SERIOUS NALOXONE ALLERGY (12 MO.).
Other Criteria	BUPRENORPHINE MONOTHERAPY WILL BE APPROVED FOR THE FOLLOWING PATIENTS: PREGNANCY OR DOCUMENTATION OF SERIOUS NALOXONE ALLERGY DEFINED AS NALOXONE-INDUCED ANAPHYLAXIS, BRONCHOSPASM, OR ANGIONEUROTIC EDEMA, AND FOR PATIENTS BEING TRANSITIONED DIRECTLY FROM A LONG ACTING OPIOID (I.E. METHADONE, FENTANYL PATCH, OR OTHER ER OPIOIDS). FOR PATIENTS BEING TRANSITIONED DIRECTLY FROM A LONG-ACTING OPIOID APPROVAL FOR BUPRENORPHINE MONOTHERAPY WILL BE LIMITED TO USE DURING INDUCTION THERAPY ONLY (2 DAYS). FOR NEW STARTS: ADDITIONAL CONSIDERATION WILL BE PROVIDED FOR A QUANTITY EXCEPTION FOR INDUCTION DOSING FOR 2 DAYS OF THERAPY.

# OSIMERTINIB MESYLATE

---

## Products Affected

- Tagrisso

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

# OXYMETHOLONE

---

## Products Affected

- Anadrol-50

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

# PALBOCICLIB

---

## Products Affected

- Ibrance

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



# PALIVIZUMAB

---

## Products Affected

- Synagis

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

# PANOBINOSTAT

---

## Products Affected

- Farydak

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

# PARATHYROID HORMONE

---

## Products Affected

- Natpara

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

# PAZOPANIB

---

## Products Affected

- Votrient

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

# PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

## Products Affected

- Adcirca
- sildenafil (antihypertensive) oral

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

# PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION - IV

## Products Affected

- sildenafil (antihypertensive) intravenous

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

# PEG-INTERFERON ALFA-2B-SYLATRON

---

## Products Affected

- Sylatron

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

# PEMBROLIZUMAB

---

## Products Affected

- Keytruda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PATIENTS WITH UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT REQUESTS FOR YERVOY, TAFINLAR, OR ZELBORAF



# PIMAVANSERIN

---

## Products Affected

- Nuplazid

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

# PIRFENIDONE

## Products Affected

- Esbriet oral capsule
- Esbriet oral tablet 267 mg, 801 mg

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

# POMALIDOMIDE

---

## Products Affected

- Pomalyst

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

# PONATINIB

---

## Products Affected

- Iclusig oral tablet 15 mg, 45 mg

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

# PRAMLINTIDE

---

## Products Affected

- SymlinPen 120
- SymlinPen 60

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

# PYRIMETHAMINE

---

## Products Affected

- Daraprim

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D, ADDITIONAL CONSIDERATION FOR CHRONIC MAINTENANCE THERAPY FOR TOXOPLASMOSIS AND TOXOPLASMOSIS PROPHYLAXIS.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	MALARIA: PLASMODIA SUSCEPTIBLE TESTING. TOXOPLASMOSIS:CD4 LEVEL
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	ACUTE MALARIA AND CHEMOPROPHYLAXIS: INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS. SEE OTHER CRITERIA FIELD

PA Criteria	Criteria Details
Other Criteria	<p>INITIAL: ACUTE MALARIA TREATMENT AND MALARIA CHEMOPROPHYLAXIS REQUIRES THAT THE PATIENT HAS MALARIA SUSCEPTIBLE TO PYRIMETHAMINE AND A PREVIOUS TRIAL OF PLAQUENIL (HYDROXYCHLOROQUINE SULFATE) AND MALARONE (ATOVAQUONE/PROGUANIL) (UNLESS THESE REGIMENS ARE RESISTANT IN THE SPECIFIC REGION AS INDICATED BY REGIONAL PLASMODIA SUSCEPTIBILITY). PRIMARY PROPHYLAXIS OF TOXOPLASMOSIS IN PATIENTS WITH HIV REQUIRES PREVIOUS TRIAL OF OR CONTRAINDICATION TO BACTRIM (SMX/TMP). RENEWAL: CONTINUATION OF TREATMENT FOLLOWING ACUTE MALARIA REQUIRES PREVIOUS INFECTION WITH MALARIA SUSCEPTIBLE TO PYRIMETHAMINE WITH SUBSEQUENT CLINICAL CURE (ELIMINATION OF MALARIA SYMPTOMS DEFINED AS CHILLS, FEVER, SWEATS, GENERAL MALAISE) FOLLOWED BY SYMPTOMS OF RELAPSE. CONTINUATION OF MALARIA CHEMOPROPHYLAXIS REQUIRES THE PATIENT WILL BE TRAVELING TO OR RESIDING IN AN AREA WHERE PLASMODIA SUSCEPTIBLE TO PYRIMETHAMINE EXISTS (MALARIA MUST BE SENSITIVE TO PYRIMETHAMINE).CONTINUED TREATMENT OF TOXOPLASMOSIS REQUIRES ONE OF THE FOLLOWING: 1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING) OR 2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENT ANTI-RETROVIRAL THERAPY IF HIV POSITIVE. CONTINUATION OF PRIMARY PROPHYLAXIS FOR TOXOPLASMOSIS WITH HIV REQUIRES CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENT ANTI RETROVIRAL THERAPY. TOXOPLASMOSIS: INITIAL: 8 WEEKS. RENEWAL: 6 MONTHS. PRIMARY PROPHYLAXIS OF TOXOPLASMOSIS: INITIAL AND RENEWAL IS 12 MONTHS.</p>

# QUININE SULFATE

---

## Products Affected

- quinine sulfate

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



# RAMUCIRUMAB

---

## Products Affected

- Cyramza

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

# REGORAFENIB

## Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR COLORECTAL CANCER: TRIAL OF OR CONTRAINDICATION TO AN ANTI-VEGF THERAPY SUCH AS AVASTIN OR ZALTRAP AND A FLUOROPYRIMIDINE-, OXALIPLATIN- AND IRINOTECAN-BASED CHEMOTHERAPY SUCH AS FOLFOX, FOLFOXIRI, FOLFIRI, CAPEOX, INFUSIONAL 5-FU/LV OR CAPECITABINE. IF APPLICABLE, A TRIAL OF OR CONTRAINDICATION TO AN ANTI-EGFR THERAPY SUCH AS ERBITUX OR VECTIBIX IS ALSO REQUIRED FOR KRAS WILD TYPE COLORECTAL CANCER. FOR GIST, A TRIAL OF OR CONTRAINDICATION TO GLEEVEC AND SUTENT IS REQUIRED.

# RESLIZUMAB

---

## Products Affected

- Cinqair

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

# RIBOCICLIB

## Products Affected

- Kisqali mg/day(200 mg x 2)-2.5 mg, 600
- Kisqali Femara Co-Pack oral tablet 200 mg/day(200 mg x 3)-2.5 mg  
mg/day(200 mg x 1)-2.5 mg, 400

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

# RIFAXIMIN

---

## Products Affected

- Xifaxan oral tablet 200 mg

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

# RIFAXIMIN-HEPATIC ENCEPHALOPATHY

## Products Affected

- Xifaxan oral tablet 550 mg

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HEPATIC ENCEPHALOPATHY: 12 MO IRRITABLE BOWEL SYNDROME WITH DIARRHEA: INITIAL: 12 WKS. RENEWAL:12 MO
Other Criteria	INITIAL: HEPATIC ENCEPHALOPATHY (HE): TRIAL OF LACTULOSE OR CONCURRENT LACTULOSE THERAPY. IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D): TRIAL WITH DICYCLOMINE (UNLESS CONTRAINDICATED) RENEWAL: ISB-D: ALL OF THE FOLLOWING CRITERIA MUST HAVE BEEN MET: AT LEAST 10 WEEKS HAVE PASSED SINCE THE LAST TREATMENT COURSE OF RIFAXIMIN, AND PATIENT HAS EXPERIENCED AT LEAST 30% DECREASE IN ABDOMINAL PAIN (ON A 0-10 POINT PAIN SCALE), AND PATIENT HAS EXPERIENCED AT LEAST 50% REDUCTION IN THE NUMBER OF DAYS PER WEEK WITH A STOOL CONSISTENCY OF MUSHY STOOL (BRISTOL STOOL SCALE TYPE 6) OR ENTIRELY LIQUID STOOL (BRISTOL STOOL SCALE TYPE 7).

# RIOCIGUAT

## Products Affected

- Adempas

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

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



# RITUXIMAB

---

## Products Affected

- Rituxan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: ONCOLOGIST.
<b>Coverage Duration</b>	RA: INITIAL: 6 MO. RENEWAL: 12 MONTHS. NHL: 1 YEAR. CLL: 6 MO. WG, MPA: 3 MONTH.
<b>Other Criteria</b>	INITIAL: RHEUMATOID ARTHRITIS: PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA OR ACTEMRA.

# RITUXIMAB SQ

---

## Products Affected

- Rituxan Hycela

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

# RUCAPARIB

---

## Products Affected

- Rubraca

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

# RUXOLITINIB

## Products Affected

- Jakafi

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

# SAFINAMIDE MESYLATE

---

## Products Affected

- Xadago

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

# SARILUMAB

---

## Products Affected

- Kevzara

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
<b>Coverage Duration</b>	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
<b>Other Criteria</b>	INITIAL: PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: ACTEMRA, CIMZIA, ORENCIA, OR XELJANZ.

# SEBELIPASE ALFA

---

## Products Affected

- Kanuma

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

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



# SECUKINUMAB

## Products Affected

- Cosentyx
- COSENTYX (150 MG/ML) 300 MG DOSE-2 PENS
- COSENTYX (150 MG/ML) 300 MG DOSE-2 SYRINGES
- Cosentyx Pen

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH HUMIRA AND ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL WITH HUMIRA

# SELEXIPAG

## Products Affected

- Upravi oral tablet 1,000 mcg, 1,200 mcg, 1,400 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg
- Upravi oral tablets, dose pack

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

# SILTUXIMAB

---

## Products Affected

- Sylvant

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

# SIMEPREVIR

---

## Products Affected

- Olysio

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS. FOR ALL GENOTYPE 1A: NS3 80K POLYMORPHISM LAB TEST AT BASELINE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (FOR EXAMPLE HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. PATIENT MUST NOT BE TAKING ANY OF THE FOLLOWING INTERACTING MEDICATIONS: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ERYTHROMYCIN (DOES NOT INCLUDE TOPICAL FORMULATIONS), CLARITHROMYCIN, TELITHROMYCIN, ITRACONAZOLE, KETOCONAZOLE, POSACONAZOLE, FLUCONAZOLE (DOES NOT INCLUDE TOPICAL FORMULATIONS), VORICONAZOLE, DEXAMETHASONE, CISAPRIDE, CYCLOSPORINE, ROSUVASTATIN DOSE ABOVE 10MG, ATORVASTATIN DOSE ABOVE 40MG, OR ANY OF THE FOLLOWING HIV MEDICATIONS: COBICISTAT-CONTAINING MEDS (E.G., STRIBILD), ANY HIV PROTEASE INHIBITOR (ATAZANAVIR, FOSAMPRENAVIR, LOPINAVIR, INDINAVIR, NELFINAVIR, SAQUINAVIR, OR TIPRANAVIR) RITONAVIR, DARUNAVIR/RITONAVIR, DELAVIRIDINE, ETRAVIRINE, NEVIRAPINE, EFAVIRENZ). PATIENT MUST ALSO NOT BE TAKING AMIODARONE IF ON COMBINATION REGIMEN OF SOVALDI AND OLYSIO.</p>

# SOFOSBUVIR

## Products Affected

- Sovaldi

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSa GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS. FOR ALL GENOTYPE 1 PATIENTS USING OLYSIO AND SOVALDI AND HAVE GENOTYPE 1A: NS3 80K POLYMORPHISM LAB TEST AT BASELINE.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATIONS WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSa GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSa GUIDANCE. FOR PATIENTS ON SOVALDI PLUS DAKLINZA REGIMENS THERE WILL BE NO APPROVALS FOR CONCURRENT USE OF ANY OF THESE (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN. REQUESTS FOR SOVALDI IN COMBINATION WITH DAKLINZA OR OLYSIO WILL REQUIRE THAT THE PATIENT ALSO MEETS ALL CRITERIA FOR THE RESPECTIVE AGENT USED (DAKLINZA OR OLYSIO).

# SOFOSBUVIR/VELPATASVIR

## Products Affected

- Epclusa

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

# SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

## Products Affected

- Vosevi

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
<b>Exclusion Criteria</b>	SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS. MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).
<b>Required Medical Information</b>	HCV RNA LEVEL WITHIN PAST 6 MONTHS
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
<b>Coverage Duration</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
<b>Other Criteria</b>	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR OR TIPRANAVIR/RITONAVIR.



# SOMATROPIN - GROWTH HORMONE

## Products Affected

- Humatrope
- Omnitrope
- Saizen
- Saizen click.easy
- Zomacton

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES, GROWTH FAILURE WITH CLOSED EPIPHYSES.
<b>Required Medical Information</b>	INDUCTION - PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. RENEWAL: GROWTH VELOCITY AND/OR TARGET HEIGHT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH: ENDOCRINOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	INITIAL: PREVIOUS TRIAL OF PREFERRED FORMULARY ALTERNATIVES NORDITROPIN AND GENOTROPIN PER FDA INDICATION. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.

# SOMATROPIN - SEROSTIM

## Products Affected

- Serostim subcutaneous recon soln 4 mg, 5 mg, 6 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
<b>Required Medical Information</b>	HIV/WASTING: MEETS CRITERIA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5 % OVER 6 MONTHS, OR 5PERCENT BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 20 KG PER METER SQUARED.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST (SBS), OR INFECTIOUS DISEASE SPECIALIST
<b>Coverage Duration</b>	3 MONTHS
<b>Other Criteria</b>	HIV/WASTING: CURRENTLY ON ANTIRETROVIRAL THERAPY. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. (I.E. EXERCISE TRAINING, NUTRITIONAL SUPPLEMENTS, APPETITE STIMULANTS, OR ANABOLIC STEROIDS).

# SOMATROPIN - ZORBTIVE

---

## Products Affected

- Zorbtive

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

# SOMATROPIN-NORDITROPIN AND GENOTROPIN

## Products Affected

- Genotropin
- Genotropin MiniQuick
- Norditropin FlexPro

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES, GROWTH FAILURE WITH CLOSED EPIPHYSES.
<b>Required Medical Information</b>	INDUCTION - PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. RENEWAL: GROWTH VELOCITY AND/OR TARGET HEIGHT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH: ENDOCRINOLOGIST.
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E. INCREASED HEIGHT OR INCREASED GROWTH VELOCITY).

# SOMATROPIN-NUTROPIN AND NUTROPIN AQ

## Products Affected

- Nutropin AQ
- Nutropin AQ Nuspin

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES, GROWTH FAILURE DUE TO CKD IF PATIENT HAS HAD A RENAL TRANSPLANT, OR GROWTH FAILURE WITH CLOSED EPIPHYSES.
<b>Required Medical Information</b>	INDUCTION - PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. RENEWAL: GROWTH VELOCITY AND/OR TARGET HEIGHT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR IN CONSULTATION WITH: ENDOCRINOLOGIST. FOR GROWTH HORMONE FAILURE DUE TO CRI: NEPHROLOGIST.
<b>Coverage Duration</b>	INITIAL AND RENEWAL: 12 MONTHS
<b>Other Criteria</b>	ALL DIAGNOSES EXCEPT FOR CHRONIC KIDNEY DISEASE (CKD): INITIAL: PREVIOUS TRIAL OF PREFERRED FORMULARY ALTERNATIVES NORDITROPIN AND GENOTROPIN PER FDA INDICATION. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E. INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). FOR GROWTH FAILURE SECONDARY TO CKD: PATIENT HAS NOT RECEIVED A RENAL TRANSPLANT.

# SONIDEGIB

---

## Products Affected

- Odomzo

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

# SORAFENIB TOSYLATE

---

## Products Affected

- Nexavar

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

# SUNITINIB MALATE

---

## Products Affected

- Sutent

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



# TALIMOGENE

## Products Affected

- Imlygic injection suspension 10exp6 (1 million) PFU/mL, 10exp8 (100 million) PFU/mL

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

# TASIMELTEON

---

## Products Affected

- Hetlioz

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

# TEDUGLUTIDE

---

## Products Affected

- GATTEX 5 MG 30-VIAL KIT
- Gattex One-Vial

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	18 YEARS OF AGE AND OLDER
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	PATIENT IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK.

# TELOTRISTAT

---

## Products Affected

- Xermelo

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

# TEMOZOLOMIDE

---

## Products Affected

- Temodar intravenous

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

# TERIFLUNOMIDE

---

## Products Affected

- Aubagio

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

# TERIPARATIDE

---

## Products Affected

- Forteo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	GREATER THAN 24 MONTHS OF THERAPY.
<b>Required Medical Information</b>	A PATIENT WITH EITHER A DIAGNOSIS OF SEVERE OSTEOPOROSIS (T-SCORE LESS THAN -2.5 WITH FRAGILITY FRACTURE) OR A T SCORE EQUAL TO OR LESS THAN -2.5 AND MULTIPLE RISK FACTORS FOR FRACTURE (E.G. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR FAILED AN ADEQUATE TRIAL OF BISPHOSPHONATES, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BISPHOSPHONATES.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# TESTOSTERONE

## Products Affected

- Androderm
- AndroGel transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)
- AndroGel transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)
- testosterone cypionate
- testosterone enanthate
- testosterone transdermal gel
- testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)
- testosterone transdermal gel in packet

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



# TETRABENAZINE

---

## Products Affected

- tetrabenazine

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

# THALIDOMIDE

---

## Products Affected

- Thalomid

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

# TOCILIZUMAB IV

## Products Affected

- Actemra

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RA, PJIA, OR SJIA: PHYSICIAN ATTESTATION OF IMPROVEMENT
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA)/POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: RA: 7 MOS. PJIA: 5 MOS. SJIA: 12 MOS. CRS: 1 MO. RENEWAL: 12 MOS FOR RA, PJIA, OR SJIA
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PREVIOUS TRIAL WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH KINERET (ANAKINRA), ORENCIA (ABATACEPT), OR ANOTHER TNF (TUMOR NECROSIS FACTOR) INHIBITOR: HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.

# TOCILIZUMAB SQ

## Products Affected

- Actemra

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 7 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH KINERET (ANAKINRA), ORENCIA (ABATACEPT) OR ANOTHER TNF (TUMOR NECROSIS FACTOR) INHIBITOR: HUMIRA, ENBREL, CIMZIA, REMICADE, SIMPONI OR SIMPONI ARIA.

# TOFACITINIB

## Products Affected

- Xeljanz
- Xeljanz XR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	RA: INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS: PREVIOUS TRIAL WITH HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

# TOPICAL TRETINOIN

---

## Products Affected

- tretinoin
- TRETINOIN GEL MICRO 0.04% TUBE
- TRETINOIN GEL MICRO 0.1% TUBE
- tretinoin microspheres topical gel with pump

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

# TRABECTEDIN

---

## Products Affected

- Yondelis

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

# TRAMETINIB DIMETHYL SULFOXIDE

---

## Products Affected

- Mekinist oral tablet 0.5 mg, 2 mg

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



# TRASTUZUMAB

---

## Products Affected

- Herceptin

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

# TREPROSTINIL DIOLAMINE

---

## Products Affected

- Orenitram

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

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. PATIENT DOES NOT HAVE SEVERE HEPATIC IMPAIRMENT. PREVIOUS TREATMENT WITH UPTRAVI AND PREVIOUS OR CURRENT TREATMENT WITH ONE OF THE FOLLOWING: A PHOSPHODIESTERASE-5 INHIBITOR (E.G., REVATIO [SILDENAFIL] OR ADCIRCA [TADALAFIL]) OR AN ENDOTHELIN RECEPTOR ANTAGONIST (E.G., TRACLEER [BOSENTAN], LETAIRIS [AMBRISENTAN]), OR OPSUMIT [MACITENTAN]). TRIAL OF 2 FORMULARY AGENTS (UPTRAVI AND A PHOSPHODIESTERASE-5 INHIBITOR OR ENDOTHELIN RECEPTOR ANTAGONIST) IS NOT REQUIRED IF THE PATIENT WAS PREVIOUSLY STABLE ON ORENITRAM. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.</p>

# TREPROSTINIL INHALED

## Products Affected

- Tyvaso

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	THIS DRUG MAYBE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. NEBULIZER THERAPY IS COVERED UNDER PART B FOR PATIENTS WHO ARE USING THE MEDICATION VIA A NEBULIZER IN THEIR OWN HOME. THOSE WHO ARE NOT USING IT IN THEIR HOME WILL BE COVERED UNDER PART D. INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

# TREPROSTINIL SODIUM INJECTABLE

---

## Products Affected

- Remodulin

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

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

# TRIFLURIDINE/TIPIRACIL

---

## Products Affected

- Lonsurf oral tablet 15-6.14 mg, 20-8.19 mg

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

# USTEKINUMAB

## Products Affected

- Stelara subcutaneous syringe

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL FOR PSORIATIC ARTHRITIS OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION OF IMPROVEMENT.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: DERMATOLOGIST. CROHN'S DISEASE: GASTROENTEROLOGIST.
<b>Coverage Duration</b>	INITIAL: PSA, PSO, CD: 4 MONTHS. CD WITH PREVIOUS DOSE IV: 2 MONTHS. RENEW ALL: 12 MO
<b>Other Criteria</b>	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA, OTEZLA, OR COSENTYX. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: COSENTYX OR OTEZLA. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO PREFERRED TNF INHIBITORS: HUMIRA FOLLOWED BY CIMZIA.



# USTEKINUMAB IV

---

## Products Affected

- Stelara intravenous

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
<b>Coverage Duration</b>	2 MONTHS
<b>Other Criteria</b>	PREVIOUS TRIAL OF OR CONTRAINDICATION TO THE PREFERRED TNF INHIBITORS: HUMIRA FOLLOWED BY CIMZIA. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# VALBENZAZINE TOSYLATE

---

## Products Affected

- Ingrezza oral capsule 40 mg, 80 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	PATIENT HAS BEEN USING ANTIPSYCHOTIC MEDICATIONS OR METOCLOPRAMIDE FOR AT LEAST 3 MONTHS (OR AT LEAST 1 MONTH IF PATIENT IS 60 YEARS OF AGE OR OLDER) PER PHYSICIAN ATTESTATION
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	MODERATE TO SEVERE TARDIVE DYSKINESIA HAS BEEN PRESENT FOR AT LEAST 3 MONTHS

# VANDETANIB

---

## Products Affected

- Caprelsa oral tablet 100 mg, 300 mg

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

# VEMURAFENIB

---

## Products Affected

- Zelboraf

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	BRAFV600E MUTATION
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	

# VENETOCLAX

---

## Products Affected

- Venclexta oral tablet 10 mg, 100 mg, 50 mg
- Venclexta Starting Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
<b>Exclusion Criteria</b>	NONE
<b>Required Medical Information</b>	NONE
<b>Age Restrictions</b>	NONE
<b>Prescriber Restrictions</b>	NONE
<b>Coverage Duration</b>	12 MONTHS
<b>Other Criteria</b>	NONE

# VISMODEGIB

---

## Products Affected

- Erivedge

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



## INDEX

Actemra.....	226, 227	butalbital-acetaminophen-caff oral capsule 50-325-40 mg.....	101
Adcetris.....	32	butalbital-acetaminophen-caff oral tablet 50-325-40 mg.....	101
Adcirca.....	172	butalbital-aspirin-caffeine.....	101
Adempas.....	190	Cabometyx oral tablet 20 mg, 40 mg, 60 mg.....	37
Afinitor Disperz.....	82	Capacet.....	101
Afinitor oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg.....	82	Caprelsa oral tablet 100 mg, 300 mg.....	242
Alecensa.....	9	carisoprodol.....	109
Aliqopa.....	45	Cerdelga.....	67
Allzital.....	101	chlorzoxazone oral tablet 500 mg.....	109
Alunbrig.....	33	Cimzia.....	42
Ampyra.....	51	Cimzia Powder for Reconst.....	42
Anadrol-50.....	166	Cinqair.....	186
Androderm.....	223	Cinryze.....	35
AndroGel transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %).....	223	CombiPatch.....	106
AndroGel transdermal gel in packet 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram).....	223	Cometriq.....	36
Ascomp with Codeine.....	101	Copaxone subcutaneous syringe.....	91
Aubagio.....	221	Cosentyx.....	200
Austedo oral tablet 12 mg, 6 mg, 9 mg.....	56	COSENTYX (150 MG/ML) 300 MG DOSE-2 PENS.....	200
Avastin.....	27	COSENTYX (150 MG/ML) 300 MG DOSE-2 SYRINGES.....	200
Avonex (with albumin).....	122	Cosentyx Pen.....	200
Avonex intramuscular pen injector kit.....	122	Cotellic.....	44
Avonex intramuscular syringe kit.....	122	cyclobenzaprine oral tablet 10 mg, 5 mg.....	109
Bavencio.....	21	Cyramza.....	184
Beleodaq.....	25	Daklinza.....	48
Bendeka.....	26	Daraprim.....	181
Benlysta intravenous.....	24	Darzalex.....	52
Benlysta subcutaneous.....	24	Digitek.....	105
benztropine oral.....	98	Digox.....	105
Besponsa.....	120	DIGOXIN 0.25 MG/ML SYRINGE....	105
Betaseron subcutaneous kit.....	123	digoxin injection solution.....	105
bexarotene.....	28	digoxin oral solution 50 mcg/mL.....	105
Blinicyto intravenous kit.....	29	digoxin oral tablet.....	105
Bosulif oral tablet 100 mg, 500 mg.....	31	dronabinol.....	39
buprenorphine HCl sublingual.....	164	Duavee.....	106
Butalbital Compound W/Codeine.....	101	Dupixent.....	62
butalbital-acetaminop-caf-cod.....	101	Emflaza oral suspension.....	54
butalbital-acetaminophen oral tablet 50-325 mg.....	101	Emflaza oral tablet 18 mg, 30 mg, 36 mg, 6 mg.....	54



Empliciti.....	69	Humira.....	6
Enbrel subcutaneous recon soln.....	79	Humira Pediatric Crohn's Start.....	6
Enbrel subcutaneous syringe.....	79	Humira Pen.....	6
Enbrel SureClick.....	79	Humira Pen Crohn's-UC-HS Start.....	6
Epclusa.....	206	Humira Pen Psoriasis-Uveitis.....	6
EPOGEN 10,000 UNITS/ML VIAL SDV, P/F, OUTER.....	75	hydroxyprogesterone caproate.....	110
Epogen injection solution 2,000 unit/mL, 20,000 unit/2 mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL.....	75	Ibrance.....	167
Erivedge.....	245	Iclusig oral tablet 15 mg, 45 mg.....	179
Esbriet oral capsule.....	177	Idhifa.....	71
Esbriet oral tablet 267 mg, 801 mg.....	177	Ilaris (PF).....	38
estradiol oral.....	106	imatinib oral tablet 100 mg, 400 mg.....	113
estradiol transdermal patch semiweekly.....	106	Imbruvica.....	111
estradiol transdermal patch weekly.....	106	Imfinzi.....	63
estradiol-norethindrone acet.....	106	imiquimod.....	114
estropipate.....	106	Imlygic injection suspension 10exp6 (1 million) PFU/mL, 10exp8 (100 million) PFU/mL.....	216
eszopiclone.....	108	Inflectra.....	118
Exondys 51.....	81	Ingrezza oral capsule 40 mg, 80 mg.....	241
Extavia subcutaneous kit.....	123	Inlyta oral tablet 1 mg, 5 mg.....	22
Farydak.....	169	Intron A injection.....	121
fentanyl citrate.....	87	Iprivask.....	55
Flector.....	58	Iressa.....	89
Forteo.....	222	Jakafi.....	195
GATTEX 5 MG 30-VIAL KIT.....	218	Juxtapid oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 5 mg, 60 mg.....	134
Gattex One-Vial.....	218	Kalydeco.....	125, 126
Gazyva.....	154	Kanuma.....	198
Genotropin.....	211	Keveyis.....	57
Genotropin MiniQuick.....	211	Kevzara.....	197
Gilenya.....	88	Keytruda.....	175
Gilotrif.....	8	Kineret.....	14
glatiramer.....	91	Kisqali.....	187
Glatopa.....	91	Kisqali Femara Co-Pack oral tablet 200 mg/day(200 mg x 1)-2.5 mg, 400 mg/day(200 mg x 2)-2.5 mg, 600 mg/day(200 mg x 3)-2.5 mg.....	187
glyburide.....	107	Korlym.....	142
glyburide micronized.....	107	Kynamro.....	143
glyburide-metformin.....	107	Kyprolis intravenous recon soln 30 mg, 60 mg.....	40
Gocovri oral capsule,extended release 24hr 137 mg, 68.5 mg.....	13	Lanoxin oral tablet 187.5 mcg, 62.5 mcg.....	105
guanfacine oral tablet.....	102	Lartruvo.....	157
Haegarda.....	35	Lazanda.....	86
Harvoni.....	129	Lemtrada.....	10
Herceptin.....	232		
Hetlioz.....	217		
Humatrope.....	208		

Lenvima.....	131	Orencia ClickJect.....	3
Letairis.....	72	Orenitram.....	233
lidocaine topical adhesive patch,medicated.....	132	Orkambi.....	137
lidocaine topical ointment.....	133	Otezla.....	15
Lonsurf oral tablet 15-6.14 mg, 20-8.19 mg.....	238	Otezla Starter.....	15
Lynparza oral capsule.....	156	Phenadoz.....	99
Lynparza oral tablet.....	156	Plegridy.....	122
Margesic.....	101	Pomalyst.....	178
Mavyret.....	92	Portrazza.....	147
Mekinist oral tablet 0.5 mg, 2 mg.....	231	Praluent Pen.....	11
Menest.....	106	Praluent Syringe.....	11
Metaxall.....	109	Premarin oral.....	106
metaxalone.....	109	Premphase.....	106
methocarbamol oral.....	109	Prempro.....	106
Mimvey.....	106	Procrit injection solution 10,000 unit/mL, 2,000 unit/mL, 20,000 unit/2 mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL, 40,000 unit/mL.....	75
Mimvey Lo.....	106	Promacta.....	70
Mircera.....	78	promethazine oral.....	99
Mylotarg.....	90	promethazine rectal.....	99
Natpara.....	170	Promethegan.....	99
Nerlynx.....	148	quinine sulfate.....	183
Nexavar.....	214	Radicava.....	64
Ninlaro.....	127	Ravicti.....	94
nitrofurantoin macrocrystal.....	100	Rebif (with albumin).....	122
nitrofurantoin monohyd/m-cryst.....	100	Rebif Rebidose.....	122
Norditropin FlexPro.....	211	Rebif Titration Pack.....	122
Northera.....	61	Relistor oral.....	140
Nucala.....	138	Relistor subcutaneous solution.....	139
Nuplazid.....	176	Relistor subcutaneous syringe.....	139
Nutropin AQ.....	212	Remicade.....	115
Nutropin AQ Nuspin.....	212	Remodulin.....	236
Ocaliva.....	153	Renflexis.....	117
Ocrevus.....	155	Repatha Pushtonex.....	83
Odomzo.....	213	Repatha SureClick.....	83
Ofev.....	150	Repatha Syringe.....	83
Olysio.....	203	Revlimid.....	130
Omnitrope.....	208	Rituxan.....	192
Oncaspar.....	19	Rituxan Hycela.....	193
Onfi oral suspension.....	43	Rubraca.....	194
Onfi oral tablet 10 mg, 20 mg.....	43	Rydapt.....	141
Opdivo.....	152	Saizen.....	208
Opsumit.....	72	Saizen click.easy.....	208
Orencia.....	3		
Orencia (with maltose).....	2		

Serostim subcutaneous recon soln 4 mg, 5 mg, 6 mg.....	209	testosterone transdermal gel in packet...	223
sildenafil (antihypertensive) intravenous	173	tetrabenazine.....	224
sildenafil (antihypertensive) oral.....	172	Thalomid.....	225
Siliq.....	34	thioridazine.....	104
Simponi.....	96	Tracleer.....	72
Simponi ARIA.....	95	Tremfya.....	97
Sirturo.....	23	tretinoin.....	229
Sovaldi.....	205	TRETINOIN GEL MICRO 0.04%	
Sprycel oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg.....	53	TUBE.....	229
Stelara intravenous.....	240	TRETINOIN GEL MICRO 0.1%	
Stelara subcutaneous syringe.....	239	TUBE.....	229
Stivarga.....	185	tretinoin microspheres topical gel with pump.....	229
Strensiq.....	16	trihexyphenidyl.....	98
Sutent.....	215	Tymlos.....	1
Sylatron.....	174	Tysabri.....	146
Sylvant.....	202	Tyvaso.....	235
SymlinPen 120.....	180	Unituxin.....	60
SymlinPen 60.....	180	Uptravi oral tablet 1,000 mcg, 1,200 mcg, 1,400 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg.....	201
Synagis.....	168	Uptravi oral tablets,dose pack.....	201
Synribo.....	158	Velcade.....	30
Tafinlar.....	47	Venclexta oral tablet 10 mg, 100 mg, 50 mg.....	244
Tagrisso.....	165	Venclexta Starting Pack.....	244
TALTZ 80 MG/ML AUTOINJECTOR P/F,L/F,SDV,OUTER.....	128	Verzenio.....	4
Taltz Autoinjector (3 Pack).....	128	Viekira Pak.....	162
Taltz Syringe.....	128	Viekira XR.....	162
Tarceva oral tablet 100 mg, 150 mg, 25 mg.....	74	Vimizim.....	68
Targretin oral.....	28	Vosevi.....	207
Targretin topical.....	28	Votrient.....	171
Tasigna.....	149	Xadago.....	196
Tecentriq.....	20	Xalkori.....	46
Tecfidera oral capsule,delayed release(DR/EC) 120 mg, 120 mg (14)- 240 mg (46), 240 mg.....	59	Xeljanz.....	228
Technivie.....	160	Xeljanz XR.....	228
Temodar intravenous.....	220	Xermelo.....	219
Tencon oral tablet 50-325 mg.....	101	Xifaxan oral tablet 200 mg.....	188
testosterone cypionate.....	223	Xifaxan oral tablet 550 mg.....	189
testosterone enanthate.....	223	Xolair.....	159
testosterone transdermal gel.....	223	Xtandi.....	73
testosterone transdermal gel in metered- dose pump 12.5 mg/ 1.25 gram (1 % ).....	223	Yervoy.....	124
		Yondelis.....	230
		zaleplon.....	108
		Zebutal oral capsule 50-325-40 mg.....	101

Zejula.....	151
Zelboraf.....	243
Zepatier.....	65
Zinbryta.....	50
zolpidem oral.....	108
Zomacton.....	208
Zorbtive.....	210
Zydelig.....	112
Zykadia.....	41
Zytiga.....	5