ACTEMRA

PRODUCT(s) AFFECTED

- ACTEMRA INJ 162/0.9
- ACTEMRA INJ 200/10ML
- ACTEMRA INJ 400/20ML
- ACTEMRA INJ 80MG/4ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of Polyarticular juvenile idiopathic arthritis, Rheumatoid arthritis, OR systemic juvenile idiopathic arthritis AND trial and failure or contraindication or intolerance to both Humira and Enbrel

AGE RESTRICTION

2 years of age and older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ADAPALENE

PRODUCT(s) AFFECTED

- ADAPALENE CRE 0.1%
- ADAPALENE GEL 0.1%
- ADAPALENE GEL PMP 0.3%
- EPIDUO FORTE GEL 0.3-2.5%
- EPIDUO GEL 0.1-2.5%

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of acne.

AGE RESTRICTION

PA applies to members 26 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ADCIRCA

PRODUCT(s) AFFECTED
ADCIRCA TAB 20MG

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Receiving nitrate therapy (includes intermittent use)

REQUIRED MEDICAL INFORMATION
Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has tried and had an insufficient response to at least one other PAH agent (e.g., sildenafil) therapy.

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Initial - 6 months. Renewal - 12 months

OTHER CRITERIA
None

ADDERALL XR

PRODUCT(s) AFFECTED

- AMPHETAMINE CAP 10MG ER
  AMPHETAMINE CAP 15MG ER
  AMPHETAMINE CAP 20MG ER
  AMPHETAMINE CAP 25MG ER
  AMPHETAMINE CAP 30MG ER
  AMPHETAMINE CAP 5MG ER

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

One of the following: a) diagnosis of attention deficit hyperactivity disorder (ADHD), OR b) diagnosis of attention deficit disorder (ADD)

AGE RESTRICTION

PA applies to members 19 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ADEMPAS

PRODUCT(s) AFFECTED

- ADEMPAS TAB 0.5MG
  ADEMPAS TAB 1MG
  ADEMPAS TAB 2MG
  ADEMPAS TAB 1.5MG
  ADEMPAS TAB 2.5MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Pregnancy, coadministration with nitrates or nitric oxide donors (eg, amyl nitrite), phosphodiesterase (PDE) inhibitors, or nonspecific PDE inhibitors (eg, dipyridamole or theophylline)

REQUIRED MEDICAL INFORMATION

Diagnosis of persistent/recurrent chronic thromboembolic pulmonary HTN (WHO group 4) after surgical treatment or inoperable chronic thromboembolic pulmonary hypertension or PAH (WHO group 1)

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

6 months - initial. 12 months - renewal

OTHER CRITERIA

None

AFINITOR

PRODUCT(s) AFFECTED

- AFINITOR DIS TAB 2MG
  AFINITOR DIS TAB 3MG
  AFINITOR DIS TAB 5MG
  AFINITOR TAB 10MG
  AFINITOR TAB 2.5MG
  AFINITOR TAB 5MG
  AFINITOR TAB 7.5MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with Sutent or Nexavar OR Diagnosis of pancreatic neuroendocrine tumors (pNET) that are unresectable, locally advanced or metastatic OR Diagnosis of renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery OR Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin OR Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection OR progressive, well-differentiated, non-functional, neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin with unresectable, locally advanced or metastatic disease.

AGE RESTRICTION

18 years of age or older for RCC, pNET, and renal angiomyolipoma with TSC. 1 year of age or older for SEGA

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ALDURAZYME

PRODUCT(s) AFFECTED

- ALDURAZYME INJ 2.9MG/5ML

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of Hurler or Hurler-Scheie form of Mucopolysaccharidosis I (MPS I) or Diagnosis of Scheie form of MPS I with moderate to severe symptoms.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ALPHA-1-PROTEINASE INH

PRODUCT(s) AFFECTED

- ARALAST NP INJ 1000MG
  PROLASTIN-C INJ 1000MG
  GLASSIA INJ
  ZEMAIRA INJ 1000MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Not covered for patients with IgA deficiency

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

Pulmonologist

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ALECENSA

PRODUCT(s) AFFECTED

- ALECENSA CAP 150MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of metastatic anaplastic lymphoma kinase positive non-small cell lung cancer. Documentation of intolerance or disease progression following therapy with crizotinib

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

1 year

OTHER CRITERIA

None

AMPYRA

PRODUCT(s) AFFECTED

- AMPYRA TAB 10MG

COVERED USES

All-FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Contraindicated in patients with a history of seizures or seizure disorder, renal failure or renal impairment of CrCl of 50ml/min or less

REQUIRED MEDICAL INFORMATION

Diagnosis of MS, SrCr level with and estimated creatnine clearance greater than 50ml/min, baseline timed 25 foot walk

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial approval: 3 months Extended appr: 12 months

OTHER CRITERIA

Patient must be able to ambulate at least 25 feet

APOKYN

PRODUCT(s) AFFECTED

- APOKYN INJ 10MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of Parkinson's disease

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ARANESP

PRODUCT(s) AFFECTED

- ARANESP INJ 100MCG/0.5ML
- ARANESP INJ 100MCG/1ML
- ARANESP INJ 10MCG
- ARANESP INJ 150MCG
- ARANESP INJ 200MCG PFS
- ARANESP INJ 200MCG SOL
- ARANESP INJ 25MCG/0.42ML
- ARANESP INJ 25MCG/1ML
- ARANESP INJ 300MCG/0.6ML
- ARANESP INJ 300MCG/1ML
- ARANESP INJ 40MCG/0.4ML
- ARANESP INJ 40MCG/1ML
- ARANESP INJ 500MCG
- ARANESP INJ 60MCG/0.3ML
- ARANESP INJ 60MCG/1ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. One of the following: Patient is on dialysis, OR all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial): Other causes of anemia have been ruled out. Anemia by lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request. Cancer is a non-myeloid malignancy. Patient is concurrently on chemo, or will receive concomitant chemo for a minimum of 2 months, or anemia is caused by cancer chemo. Will not be approved if patient is not receiving cancer chemotherapy. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of MDS. Serum erythropoietin level is 500 mU/mL or less, or dx of transfusion-dependent MDS. CKD (init, reauth), Chemo (init), MDS (init): Verify iron evaluation for adequate iron stores.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

CKD (Init): 6 mo. CKD (reauth): 12 mo. Chemo (init, reauth): 3 mo. MDS: (init) 3 mo, (reauth) 12 mo.

OTHER CRITERIA

Subject to ESRD review. CKD (Reauth): Dx of CKD. Most recent or average (avg) Hct over 3 mo is 33% or less OR most recent or avg Hgb over 3 months is 11 g/dL or less. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Chemo (Reauth): Anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Patient is concurrently on chemo, or will receive concomitant chemo for a minimum of 2 months, or anemia is caused by cancer chemo. Will not be approved if patient is not receiving cancer chemotherapy. MDS (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Off-label uses (except MDS): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%.

ARCALYST

PRODUCT(s) AFFECTED

- ARCALYST INJ 220MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of cryopyrin-associated period syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS).

AGE RESTRICTION

12 years of age or older

PRESCRIBER RESTRICTION

Prescribed by or in consultation with or recommendation of, an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve doses based on FDA labeling

AUBAGIO

PRODUCT(s) AFFECTED

- AUBAGIO TAB 14MG
- AUBAGIO TAB 7MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D. First clinical episode with MRI features consistent with multiple sclerosis.

EXCLUSION CRITERIA

Severe hepatic impairment. Current treatment with leflunomide. Patients who are pregnant or women of childbearing potential not using reliable contraception.

REQUIRED MEDICAL INFORMATION

Diagnosis of relapsing forms of multiple sclerosis (e.g., relapsing-remitting MS or progressive-relapsing MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis AND Patient has tried and had an insufficient response to at least one other formulary MS disease modifying therapy (e.g., Avonex, Betaseron, Copaxone, Gilenya, Tecfidera or Tysabri)

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease)

BELEODAQ

PRODUCT(s) AFFECTED

- BELEODAQ INJ 500MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

BERINERT

PRODUCT(s) AFFECTED

- BERINERT INJ 500UNIT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Treatment of hereditary angioedema (HAE) attacks: Diagnosis of HAE. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks (eg, Firazyr, Kalbitor, or Ruconest).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

HAE: Prescribed by an immunologist, allergist, or rheumatologist

COVERAGE DURATION

12 months

OTHER CRITERIA

None

BOSULIF

PRODUCT(s) AFFECTED

- BOSULIF TAB 100MG
- BOSULIF TAB 500MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Signed statement of diagnosis from the physician, hepatic panel and CBC, trial and failure ofofimiatinib or dasatinib and documentation of a 90 day response

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

BOTOX

PRODUCT(s) AFFECTED

- BOTOX INJ 100UNIT
- BOTOX INJ 200UNIT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Neuromuscular Disorders (init): Strabismus, blepharospasm associated with dystonia (eg, benign essential blepharospasm), treatment of upper or lower limb spasticity, VII cranial nerve disorders (hemifacial spasms), and cervical dystonia Hyperhidrosis (HH): (Init) Dx of primary axillary HH. Score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS) or skin maceration with secondary infection. Failure, contraindication, or intolerance (F/C/I) to topical prescription strength drying agents [eg, Drysol, Hypercare, Xerac AC (aluminum chloride hexahydrate)]. Migraine :(Init) Dx of chronic migraines (greater than or equal to 15 migraine headache days per month with headache lasting 4 hours a day or longer). F/C/I to prophylactic therapy with at least two of the following agents, each given for a trial of at least two months: antidepressants [ie, Effexor (venlafaxine)], antiepileptics [ie, Depakote/Depakote ER (divalproex sodium), Topamax (topiramate)], beta-blockers [eg, atenolol, Inderal (propranolol), nadolol, timolol, Toprol XL (metoprolol)] Achalasia:(Init) High risk of complication from or failure to pneumatic dilation or myotomy, or prior dilation caused esophageal perforation, or patient has an epiphrenic diverticulum or hiatal hernia. Anal Fissure (AF)(Init): Dx of chronic AF. At least 2 months of both nocturnal pain and bleeding or post-defecation pain. Chronic Back Pain (CBP):(Init) Dx of low back pain lasting greater than or equal to six months. Urinary incont (UI):(init) Neurogenic detrusor overactivity associated with a neurologic condition (eg, spinal cord injury [SCI], multiple sclerosis) or detrusor sphincter dyssynergia with SCI. Overactive bladder (OAB): (init) Dx of OAB. One of the following symptoms: urge urinary incontinence, urgency, frequency.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Migraine (Initial): Prescribed by a neurologist or pain specialist. CBP (Initial): Prescribed by a neurologist, neurosurgeon, orthopedist, or pain specialist. UI, OAB (initial): Prescribed by a neurologist, neurosurgeon, or urologist.

COVERAGE DURATION

Achalasia: 6moCBP:1 tx(series of injxs)UI:3mo(1 dose,200units)Other:3mo

OTHER CRITERIA

UI, OAB, CBP, Neuromuscular Disorders:(Reauth) Confirmed improvement in symptoms with initial Botox treatment. At least 3 months have or will have elapsed since the last treatment with Botox HH:(Reauth) At least a 2-point improvement in HDSS. Migraine:(Reauth) Reduction in headache frequency or intensity. Submission of chart notes documenting decreased utilization of pain medications (eg, narcotic analgesics, NSAIDs) or triptans, or a reduction in the number of ER visits. Achalasia:(Reauth) Documentation of improvement or reduction in symptoms of achalasia (ie, dysphagia, regurgitation, chest pain). At least 6 months have or will have elapsed since last series of injections AF: (Reauth) Incomplete healing of fissure or recurrence of fissure. Improved symptoms with prior treatment with Botox.

CAPRELSA

PRODUCT(s) AFFECTED

- CAPRELSA TAB 100MG
- CAPRELSA TAB 300MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Congenital long QT syndrome

REQUIRED MEDICAL INFORMATION

Diagnosis of symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

CAYSTON

PRODUCT(s) AFFECTED

- CAYSTON INH 75MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of cystic fibrosis AND patient has evidence of P. aeruginosa in the lungs

AGE RESTRICTION

7 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations)

CERDELGA

PRODUCT(s) AFFECTED

- CERDELGA CAP 84MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Gaucher disease (Initial): Diagnosis of Gaucher disease type 1. Patient is an extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) of cytochrome P450 enzyme (CYP) 2D6 as detected by an FDA-cleared test.

AGE RESTRICTION

Gaucher disease (initial): 18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Gaucher disease (initial, reauth): 12 months

OTHER CRITERIA

Gaucher disease (Reauth): Patient’s condition has not progressed, as defined by ALL of the following: A) Hemoglobin level decreased greater than 1.5 g/dL from baseline, AND B) Platelet count decreased greater than 25% from baseline, AND C) Spleen volume increased greater than 25% from baseline, AND D) Liver volume increased greater than 20% from baseline.

CEREZYME

PRODUCT(s) AFFECTED

- CEREZYME INJ 400UNIT

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis for use. Gaucher disease: Long-term enzyme replacement therapy for patients with a confirmed diagnosis of Type 1 Gaucher disease that results in one or more of the following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly, splenomegaly.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

CHOLBAM

PRODUCT(s) AFFECTED

- CHOLBAM CAP 250MG
- CHOLBAM CAP 50MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Bile acid synthesis disorders due to single enzyme defects (BAS) (initial): diagnosis of a bile acid synthesis disorder due to a single enzyme defect. Peroxisomal disorders (PD) (initial): All of the following: 1) diagnosis of peroxisomal disorder, 2) patient exhibits at least one of the following: a) liver disease (eg, jaundice, elevated serum transaminases), OR b) steatorrhea, OR c) complications from decreased fat-soluble vitamin absorption (eg, poor growth), AND 3) Cholbam will be used as an adjunctive treatment.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

All uses (initial): Prescribed by a hepatologist, medical geneticist, pediatric gastroenterologist, OR other specialist that treats inborn errors of metabolism.

COVERAGE DURATION

All uses (initial, reauth): 12 months

OTHER CRITERIA

All uses (reauth): documentation of positive clinical response to Cholbam therapy

CHORIONIC GONADOTROPIN

PRODUCT(s) AFFECTED

- CHOR GONADOT INJ 10000UNT
- NOVAREL INJ 10000UNT
- PREGNYL INJ 10000UNT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Prepubertal Cryptorchidism: Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction. Male Hypogonadotropic Hypogonadism (MHH) (initial): Diagnosis of male hypogonadism secondary to pituitary deficiency, and low testosterone (below normal reference value provided by the physician's laboratory) and one of the following: a) low LH (below normal reference value provided by the physician's laboratory) or b) low FSH (below normal reference value provided by the physician's laboratory).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Prepubertal Cryptorchidism: 6 wks. MHH (initial, reauth): 12 months.

OTHER CRITERIA

Excluded if used to promote fertility. MHH (Reauth): Documentation of positive clinical response to therapy.

CIALIS

PRODUCT(s) AFFECTED

- CIALIS TAB 2.5MG
- CIALIS TAB 5MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Concurrent use of nitrates.

REQUIRED MEDICAL INFORMATION

Diagnosis of benign prostatic hyperplasia (BPH). Patient has experienced intolerance to or treatment failure with an alpha-blocker (e.g., doxazosin, prazosin, tamsulosin) or a 5-alpha reductase inhibitor (e.g., dutasteride, finasteride).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

CIMZIA

PRODUCT(s) AFFECTED

- CIMZIA KIT
- CIMZIA PREFL KIT 200MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Rheumatoid Arthritis (RA, initial): Diagnosis (dx) of moderately to severely active RA. Crohn's Disease (CD, initial): Dx of moderately to severely active CD. History (Hx) of failure, contraindication, or intolerance (F/C/I) to one of the following conventional therapies: 6-mercaptopurine (Purinethol), Azathioprine (Imuran), Corticosteroid (eg, prednisone, methylprednisolone), Methotrexate (Rheumatrex, Trexall). Hx of F/C/I to Humira OR for continuation of prior Cimzia therapy. Psoriatic Arthritis (PsA, initial): Dx of active PsA. Ankylosing Spondylitis (AS, initial): Dx of active AS. RA, PsA, AS (initial): Hx of F/C/I to Enbrel and Humira OR for continuation of prior Cimzia therapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

CD (init): Prescribed by or in consultation with a gastroenterologist. RA, AS (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist.

COVERAGE DURATION

RA, PsA, AS (init,reauth): 12 mos. CD (init): 16 wks. (reath): 12 mos.

OTHER CRITERIA

Reauthorization (all indications): Documentation of positive clinical response to Cimzia therapy. All indications (initial and reauth): Patient is not receiving Cimzia in combination with either of the following: Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Simponi (golimumab), Orencia (abatacept)] or Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].For a diagnosis of PsA, Patient is not receiving Cimzia in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].

CINRYZE

PRODUCT(s) AFFECTED

- CINRYZE SOL 500 UNIT

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

History of life-threatening immediate hypersensitivity reactions, including anaphylaxis to the product.

REQUIRED MEDICAL INFORMATION

Diagnosis of hereditary angioedema AND Medication will be used for routine prophylaxis against angioedema.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed or overseen by a hematologist or immunologist

COVERAGE DURATION

12 months

OTHER CRITERIA

None

COMETRIQ

PRODUCT(s) AFFECTED

- COMETRIQ KIT 100MG
- COMETRIQ KIT 140MG
- COMETRIQ KIT 60MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Gastrointestinal perforation. Fistula. Severe hemorrhage.

REQUIRED MEDICAL INFORMATION

Diagnosis of progressive, metastatic medullary thyroid cancer

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

COSENTYX

PRODUCT(s) AFFECTED

- COSENTYX INJ 150MG/ML
- COSENTYX PEN INJ 150MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Failure, contraindication, or intolerance to Enbrel (etanercept) OR Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Cosentyx therapy. All indications (Initial, reauth): Patient is not receiving Cosentyx in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Cosentyx in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]. For a diagnosis of PsA or plaque psoriasis, Patient is not receiving Cosentyx in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS (Initial): Prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION

All indications (Initial, reauth): 12 months

OTHER CRITERIA

All indications (Reauth): Documentation of positive clinical response to Cosentyx therapy.

COTELLIC

PRODUCT(s) AFFECTED

- COTELLIC TAB 20MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of unresctable OR metastatic malignant melanoma with BRAF V600E OR V600K mutation. Documentation of combination therapy with vemurafenib

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

1 year

OTHER CRITERIA

None

CRINONE

PRODUCT(s) AFFECTED

- CRINONE GEL 4% VAG
- CRINONE GEL 8% VAG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

All indications: Excluded if for fertility uses.

REQUIRED MEDICAL INFORMATION

Secondary amenorrhea: Diagnosis of secondary amenorrhea (the absence of menses in women who have already started menstruation who are not pregnant, breastfeeding, or in menopause).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

DACOGEN

PRODUCT(s) AFFECTED

- DECITABINE INJ 50MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Myelodysplastic syndrome (MDS): Diagnosis of myelodysplastic syndrome.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with a hematologist/oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

DAKLINZA

PRODUCT(s) AFFECTED

- DAKLINZA TAB 30MG
- DAKLINZA TAB 60MG
- DAKLINZA TAB 90MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Criteria will be applied consistent with current AASLD/IDSA guideline. For genotype 1, ONE of the following: 1) Patient has a contraindication or intolerance to Harvoni and Zepatier OR 2) For continuation of prior Daklinza therapy. For genotype 3 patients with cirrhosis: patient is ineligible for treatment with peginterferon alfa confirmed by medical record documentation (eg, chart note, laboratory values) of ONE of the following: intolerance to interferon, autoimmune hepatitis or other autoimmune disorders, hypersensitivity to peginterferon or any of its components, major uncontrolled depressive illness, baseline neutrophil count below 1500/uL, baseline platelet count below 90,000/uL, baseline hemoglobin below 10 g/dL, history of preexisting cardiac disease, or decompensated hepatic disease. All: One of the following: 1) Patient has not failed a prior HCV NS5A-containing regimen (eg, Daklinza) OR 2) patient has failed prior therapy with an NS5A-containing regimen AND submission of medical records (eg, chart notes) documenting that the patient does not have NS5A inhibitor resistance-associated variants detected using commercially available assays. All: One of the following: 1) requested daily dosage is less than 90 mg OR 2) both of the following: requested daily dosage is equal to 90 mg and patient is concomitantly receiving a moderate CYP3A inducer (eg, bosentan, dexamethasone, efavirenz, etravirine, modafinil).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine

COVERAGE DURATION

12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline

OTHER CRITERIA

None

DARZALEX

PRODUCT(s) AFFECTED

- DARZALEX SOL 100MG/5ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of multiple myeloma, documented pretreatment with 3 prior therapies one of which must have included a proteasome inhibitor and an immunomodulatory agent OR the patient is double-refractory to proteasome inhibitor and immunomodulatory agent.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

1 year

OTHER CRITERIA

None

DEFERASIROX

PRODUCT(s) AFFECTED

- JADENU TAB 180MG
- JADENU TAB 360MG
- JADENU TAB 90MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Chronic Iron Overload Due to Blood Transfusions (Initial): Diagnosis of chronic iron overload due to blood transfusions (transfusional hemosiderosis). Patient has a baseline ferritin level more than 1,000 mcg/L. Patient has required the transfusion of at least 100 mL/kg packed red blood cells. Myelodysplastic Syndrome (MDS) (Initial): Diagnosis of MDS. Patient has Low or Intermediate-1 disease or is a potential transplant patient. Patient has received more than 20 red blood cell transfusions. Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT) (Initial): Diagnosis of chronic iron overload due to NTDT. Liver iron concentration (LIC) 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw) or higher. Serum ferritin level greater than 300 mcg/L.

AGE RESTRICTION

Iron Overload Due to Blood Transfusions (initial): 2 years of age or older. NTDT (initial): 10 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Iron Overload Due to Blood Transfusions, MDS (initial, reauth):12 mo. NTDT (initial, reauth): 6mo.

OTHER CRITERIA

Iron Overload Due to Blood Transfusions, MDS (Reauth): Patient experienced a reduction from baseline in serum ferritin level or LIC. NTDT (Reauth): Patient has LIC 3 mg Fe/g dw or higher. Patient experienced a reduction from baseline in serum ferritin level or LIC.

EGRIFTA

PRODUCT(s) AFFECTED

- EGRIFTA SOL 2MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

HIV-associated lipodystrophy (initial): All of the following: 1) diagnosis of HIV-associated lipodystrophy, 2) one of the following: a) waist-circumference of greater than or equal to 95 cm (37.4 inches) in men, OR b) waist-circumference of greater than or equal to 94 cm (37 inches) for women, 3) one of the following: a) Waist-to-hip ratio of greater than or equal to 0.94 for men, OR b) waist-to-hip ratio of greater than or equal to 0.88 for women, 4) body mass index (BMI) greater than 20 kg/m^2, AND 5) fasting blood glucose (FBG) levels less than or equal to 150 mg/dL (8.33 mmol/L), AND 6) patient has been on a stable regimen of antiretrovirals (eg, NRTIs, NNRTI, Protease Inhibitors, Integrase Inhibitors) for at least 8 weeks.

AGE RESTRICTION

(Initial): 18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

(initial, reauth): 6 months

OTHER CRITERIA

(reauth): documentation of clinical improvement (eg, improvement in visceral adipose tissue [VAT], decrease in waist circumference, belly appearance, etc) while on Egrifta therapy.

ELAPRASE

PRODUCT(s) AFFECTED

- ELAPRASE INJ 6MG/3ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of Hunter Syndrome (Mucopolysaccharidosis II (MPS II))

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ELIGARD

PRODUCT(s) AFFECTED

- ELIGARD INJ 22.5MG
- ELIGARD INJ 30MG
- ELIGARD INJ 45MG
- ELIGARD INJ 7.5MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. History of failure, contraindication, or intolerance to Lupron Depot (7.5 mg, 22.5 mg, 30 mg, and 45 mg).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

EMPLICITI

PRODUCT(s) AFFECTED

- EMPLICITI INJ 300MG
- EMPLICITI INJ 400MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of multiple myeloma, documentation of combination therapy with lenalidomide and dexamethasone. Prescriber must document prior treatment with 1 to 3 previous therapies.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

1 year

OTHER CRITERIA

None

ENBREL

PRODUCT(s) AFFECTED

- ENBREL INJ 25/0.5ML
- ENBREL INJ 25MG
- ENBREL INJ 50MG/ML
- ENBREL SRCLK INJ 50MG/ML

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Active serious infection (including tuberculosis)

REQUIRED MEDICAL INFORMATION

Diagnosis of one of the following : A) moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs B) moderate to severe polyarticular juvenile idiopathic arthritis and patient had an inadequate response, intolerance or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) C) psoriatic arthritis and patient had an inadequate response, intolerance, or contraindication to methotrexate D) ankylosing spondylitis and patient had an inadequate response, intolerance or contraindication to one or more NSAIDs E) moderate to severe chronic plaque psoriasis (affecting more than 5% of body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) and patient had an inadequate response, intolerance or contraindication to one or more oral systemic treatments (i.e. methotrexate, cyclosporine, acitretin, sulfasalazine).

AGE RESTRICTION

2 years of age or older for JIA. 18 years of age or older for all other indications

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial 3 months (plaque psoriasis), 12 months (others). Renewal 12 months.

OTHER CRITERIA

Patient has been tested for TB and latent TB has been ruled out or is being treated. For renewal, patient has stable disease or has improved while on therapy (e.g., for pJIA, reduction in disease flares, improvement in ACR scoring. For RA, improvement in tender/swollen joint count, improvement in ACR scoring. For PsA, improvement in number of swollen/tender joints, pain, stiffness. For AS, improvement in AS symptoms, such as stiffness and back pain).

ENTRESTO

PRODUCT(s) AFFECTED

- ENTRESTO TAB 24-26MG
- ENTRESTO TAB 49-51MG
- ENTRESTO TAB 97-103MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Initial, reauth: Excluded if patient has a history of angioedema associated with use of the following: Angiotensin converting enzyme (ACE) Inhibitor therapy, Angiotensin receptor blocker (ARB) therapy.

REQUIRED MEDICAL INFORMATION

Heart failure (HF) (initial): Diagnosis of heart failure (with or without hypertension). Ejection fraction is less than or equal to 40 percent. Heart failure is classified as NYHA Class II, III or IV. Patient is receiving concomitant therapy with one of the following beta-blockers at a maximally tolerated dose or has a contraindication or intolerance to beta-blocker therapy: bisoprolol, carvedilol or metoprolol succinate. Patient is not concomitantly on aliskiren therapy. Patient is not pregnant. Patient will discontinue use of any concomitant ACE Inhibitor or ARB. ACE inhibitors must be discontinued at least 36 hours prior to initiation of Entresto.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

HF (initial): Prescribed by or in consultation with a cardiologist

COVERAGE DURATION

HF (initial reath): 12 months

OTHER CRITERIA

HF (reauth): documentation of positive clinical response to therapy.

ERBITUX

PRODUCT(s) AFFECTED

- ERBITUX INJ 100MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Head and Neck Cancer: Diagnosis of locally or regionally advanced squamous cell head and neck cancer and used in combination with radiation therapy, or diagnosis of recurrent or metastatic squamous cell head and neck cancer and 1 of the following: failure of platinum-based chemotherapy, or used in combination with 1 of the following: cisplatin (Platinol AQ), carboplatin (Paraplatin), cisplatin (Platinol AQ) plus 5-FU (Adrucil), or carboplatin (Paraplatin) plus 5-FU (Adrucil). Colorectal Cancer: Diagnosis of metastatic carcinoma of the colon or rectum. One of the following: Used in combination with either FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or FOLFIRI (fluorouracil, leucovorin, and irinotecan), OR failure or intolerance to irinotecan-based chemotherapy, oxaliplatin-based chemotherapy, or intensive therapy (eg, FOLFOX or FOLFIRI), OR used as monotherapy in patients not appropriate for intensive therapy. Tumor expresses wild-type KRAS gene and wild type NRAS gene. Non-Small Cell Lung Cancer (NSCLC): Diagnosis of recurrent or metastatic NSCLC stage IIIB or IV. One of the following: Used in combination with vinorelbine (Navelbine) and cisplatin (Platinol AQ), OR used as a single-agent for continuation maintenance therapy and Erbitux was given first-line with chemotherapy. ECOG performance status 0-2. Epidermal growth factor receptor (EGFR) expression by immunohistochemistry.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist

COVERAGE DURATION

12 months.

OTHER CRITERIA

Subject to Part B vs. Part D review. Approve for continuation of prior therapy.

ERIVEDGE

PRODUCT(s) AFFECTED

- ERIVEDGE CAP 150MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of metastatic basal cell carcinoma OR Diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ESBRIET

PRODUCT(s) AFFECTED

- ESBRIET CAP 267MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Appropriate diagnosis (idopathic pulmonary fibrosis [IPF]) and monitoring (hepatiac function/LFTs)

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescriber must be a pulmonologist

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ESRD THERAPY

PRODUCT(s) AFFECTED

- PROCRIT INJ 10000/ML
  PROCRIT INJ 20000/ML
  PROCRIT INJ 4000/ML
  PROCRIT INJ 2000/ML
  PROCRIT INJ 3000/ML
  PROCRIT INJ 40000/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Hemogloblin less than 10 g/dl for patients receiving Cancer Chemotherapy and Hemoglobin less than 12 and Hematacrit less than 33 for other approved FDA indications in addition to supporting statement of diagnosis from physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

3 months

OTHER CRITERIA

None

EXJADE

PRODUCT(s) AFFECTED

- EXJADE TAB 125MG
- EXJADE TAB 250MG
- EXJADE TAB 500MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Medical documentation of FDA approved diagnosis, serum ferritin levels and serum creatinine.

AGE RESTRICTION

Covered for those 2 years of age and older with chronic iron overload due to blood transfusions

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

3 months

OTHER CRITERIA

None

FABRAZYME

PRODUCT(s) AFFECTED

- FABRAZYME INJ 35MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis for use. Fabry disease: For use in patients with Fabry disease. Agalsidase beta reduces globotriaosylceramide (GL-3) deposition in capillary endothelium of the kidney and certain other cell types.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

FARYDAK

PRODUCT(s) AFFECTED

- FARYDAK CAP 10MG
- FARYDAK CAP 15MG
- FARYDAK CAP 20MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

FENTANYL ORAL

PRODUCT(s) AFFECTED

- ABSTRAL SUB 100MCG
  ABSTRAL SUB 200MCG
  ABSTRAL SUB 300MCG
  ABSTRAL SUB 400MCG
  ABSTRAL SUB 600MCG
  ABSTRAL SUB 800MCG
  FENTANYL OT LOZ 1200MCG
  FENTANYL OT LOZ 1600MCG
  FENTANYL OT LOZ 200MCG
  FENTANYL OT LOZ 400MCG
  FENTANYL OT LOZ 600MCG
  FENTANYL OT LOZ 800MCG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Management of acute or post-operative pain, including headache/migraine, dental pain, or use in the emergency room. Opioid non-tolerant patients.

REQUIRED MEDICAL INFORMATION

Patient meets the following: A) Diagnosis of cancer and use is for breakthrough cancer pain, B) Must have tried and failed at least two of the following alts: HYDROMORPHONE, OXYMORPHONE, APAP/CODEINE, OXYCODODONE/APAP, OXYCODONE, HYDROCODONE/APAPC), C) other formulary short-acting strong narcotic analgesic alternatives (other than fentanyl) have been ineffective, not tolerated, or contraindicated, D) prescriber is registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy Access program

AGE RESTRICTION

16 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

FERRIPROX

PRODUCT(s) AFFECTED

- FERRIPROX SOL 100MG/ML
- FERRIPROX TAB 500MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of transfusional iron overload due to thalassemia syndromes AND patient has failed prior chelation therapy with Desferal or Exjade (failure is defined as a serum ferritin level greater than 2,500 mcg/L) or patient has a contraindication or intolerance to Desferal or Exjade AND Patient has an absolute neutrophil count greater than 1.5 x 109/L.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

For renewal, patient has experienced at least a 20% reduction in serum ferritin levels and has an absolute neutrophil count greater than 0.5 x 109/L

FIRAZYR

PRODUCT(s) AFFECTED

- FIRAZYR INJ 30MG/3ML

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of hereditary angioedema AND medication will be used for the treatment of acute attacks.

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

prescribed or overseen by a hematologist or immunologist

COVERAGE DURATION

12 months

OTHER CRITERIA

None

FIRMAGON

PRODUCT(s) AFFECTED

- FIRMAGON INJ 120MG
- FIRMAGON INJ 80MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of advanced or metastatic prostate cancer.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

FOLOTYN

PRODUCT(s) AFFECTED

- FOLOTYN INJ 40MG/2ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Peripheral T-cell lymphoma: Diagnosis of relapsed or refractory PTCL

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

FORTEO

PRODUCT(s) AFFECTED

- FORTEO SOL 600/2.4

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Documentation of past therapies and outcomes (failure defined as loss of BMD OR has fragility fracture(s) after a treatment with a first-line pharmacologic treatment Â¿bisphosphonate, Evista, or calcitonin). Diagnosis for use. Fracture history. Documentation of high risk for fracture for postmenopausal women, high risk defined with the presence of two of the following: low BMD scores (T-score less than or equal to -2.5 at the spine or hip or both), age greater than 70, or positive family history for osteoporosis in a 1st degree relative.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

2 years

OTHER CRITERIA

For postmenopausal women with osteoporosis at high risk for fracture and men with primary or hypogonadal osteoporosis, require documentation of trial and failure on at least one first-line therapy (alendronate, Evista, Atelvia, or Prolia) or documentation of intolerance to at least two first-line therapies. For patients with glucocorticoid induced osteoporosis, require documentation of trial and failure to either alendronate or Atelvia or documented intolerance to both alendronate and Atelvia

GAMASTAN S/D

PRODUCT(s) AFFECTED

- GAMASTAN S/D INJ

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Contraindications to immune globulin therapy (i.e., IgA deficiency with antibodies to IgA and a history of hypersensitivity or product specific contraindication).

REQUIRED MEDICAL INFORMATION

Immune globulin is being used intramuscularly. The immune globulin will be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis. Patient requires immunization for hepatitis A, measles, rubella, or varicella.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

3 months (Approve one dose only)

OTHER CRITERIA

Subject to Part B vs D review.

GATTEX

PRODUCT(s) AFFECTED

- GATTEX KIT 5MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary, pancreatic), colorectal cancer, or small bowel cancer

REQUIRED MEDICAL INFORMATION

Diagnosis of short bowel syndrome AND patient is receiving specialized nutritional support (i.e. parenteral nutrition)

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

For renewal, patient has a reduced need for parenteral support (20% reduction) after at least 6 months of therapy.

GILOTRIF

PRODUCT(s) AFFECTED

- GILOTRIF TAB 20MG
- GILOTRIF TAB 30MG
- GILOTRIF TAB 40MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician in patients with EGFR exon 19 deletions or exon 21 (L858R) substitution as detected by an medically accepted test OR metastatic squamous NSCLC progressing after platinum-based chemotherapy

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

GLEEVEC

PRODUCT(s) AFFECTED

- IMATINIB MES TAB 100MG
- IMATINIB MES TAB 400MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of one of the following in an adult: A) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B) Ph+ acute lymphoblastic leukemia (ALL), C) Gastrointestinal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy, D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, E) hypereosinophilic syndrome or chronic eosinophilic leukemia, F) myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, G) aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutation or with c-KIT mutational status unknown. Diagnosis of one of the following in a pediatric patient: A) Ph+ CML that is newly diagnosed in the chronic phase B) newly diagnosed Ph+ ALL

AGE RESTRICTION

18 years of age or younger - newly diagnosed CML in the chronic phase or newly diagnosed Ph+ ALL. 18 years of age or older for other indications.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

GRANIX

PRODUCT(s) AFFECTED

- GRANIX INJ 300/0.5
- GRANIX INJ 480/0.8

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Primary prophylaxis of chemotherapy-induced febrile neutropenia (CFN): One of the following: 1) patient is receiving chemotherapy regimens associated with a greater than 20% incidence of FN, OR 2) both of the following: a) patient receiving chemotherapy regimen associated with 10-20% incidence of FN, AND b) one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia. Secondary prophylaxis of FN: Both of the following: 1) patients receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm^3), AND 2) patients with a history of FN during a previous course of chemotherapy. All indications: History of failure or intolerance to Zarxio (filgrastim-sndz).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

All uses: Prescribed by or in consultation with a hematologist/oncologist or infectious disease specialist

COVERAGE DURATION

CFN, secondary prophylaxis of FN: 3mo or duration of tx

OTHER CRITERIA

None

GROWTH HORMONE

PRODUCT(s) AFFECTED

- GENOTROPIN INJ 0.2MG
  GENOTROPIN INJ 0.4MG
  GENOTROPIN INJ 0.6MG
  GENOTROPIN INJ 0.8MG
  GENOTROPIN INJ 1.2MG
  GENOTROPIN INJ 1.4MG
  GENOTROPIN INJ 1.6MG
  GENOTROPIN INJ 1.8MG
  GENOTROPIN INJ 12MG
  GENOTROPIN INJ 1MG
  GENOTROPIN INJ 2MG
  GENOTROPIN INJ 5MG
  NORDITROPIN INJ 10/1.5ML
  NORDITROPIN INJ 15/1.5ML
  NORDITROPIN INJ 30/3ML
  NORDITROPIN INJ 5/1.5ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

H.P. ACTHAR GEL

PRODUCT(s) AFFECTED

- H.P. ACTHAR INJ 80UNIT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Infantile Spasm (West Syndrome): Diagnosis of infantile spasms (West Syndrome). Multiple Sclerosis (MS): Acute exacerbations of MS. Rheumatic disorders: As adjunctive therapy for short-term administration in: psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), ankylosing spondylitis. Collagen diseases: During an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematous, systemic dermatomyositis (polymyositis). Dermatologic diseases: Severe erythema multiforme, Stevens-Johnson syndrome. Allergic states: Serum sickness. Ophthalmic diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa, such as: keratitis, iritis and iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation. Respiratory diseases: Symptomatic sarcoidosis. Edematous state: To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus. All indications except for infantile spasms: History of failure, contraindication, or intolerance to treatment with two corticosteroids.

AGE RESTRICTION

Infantile spasms: less than 2 years old

PRESCRIBER RESTRICTION

Infantile Spasm, MS: neurologist. Rheumatic disorder, collagen disease: rheumatologist. Dermatologic: dermatologist. Allergic state: allergist, immunologist. Ophthalmic disease: optometrist, ophthalmologist. Respiratory diseases: pulmonologist. Edematous state: nephrologist, rheumatologist.

COVERAGE DURATION

Infantile Spasms: 4 weeks. MS: 3 weeks. All other FDA-approved uses: 3 months.

OTHER CRITERIA

None

HALAVEN

PRODUCT(s) AFFECTED

- HALAVEN INJ 1MG/2ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Breast Cancer: Diagnosis of recurrent or metastatic breast cancer. Previous treatment with both of the following: one anthracycline [eg, doxorubicin, Ellence (epirubicin)] and one taxane [eg, paclitaxel, Taxotere (docetaxel)]. Liposarcoma: Diagnosis of unresectable or metastatic liposarcoma. Previous treatment with one anthracycline-containing regimen.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

All Uses: prescribed by or in consultation with an oncologist.

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

HEPATITIS C

PRODUCT(s) AFFECTED

- HARVONI TAB 90-400MG
- SOVALDI TAB 400MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Must submit documentation of chronic hepatitis C genotype (confirmed by HCV RNA level within the last 6 months). Must submit laboratory results within 6 weeks of initiating therapy including: 1) CBC w Platelets, 2) AST/ALT, 3)Total Bilirubin, 4)Serum Albumin, 5)PT/INR, 6)Serum Creatinine, and 7)GFR. FOR GENOTYPE 1: Must include subtype, trial/failure, contraindication to, or intolerance to Harvoni prior to approval of Sovaldi . FOR GENOTYPES 2 and 3: Approvable for Combination of Sovaldi and Ribavirin. FOR GENOTYPE 4: Approvable for combination of sovaldi + PEG + Ribavirin or Harvoni. FOR GENOTYPES 5 and 6: trial/failure, contraindication to, or intolerance to Harvoni prior to approval of Sovaldi + PEG + Ribavirin.

AGE RESTRICTION

Patient must be age 18 or over.

PRESCRIBER RESTRICTION

Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist

COVERAGE DURATION

Duration of approval per AASLD Guidelines

OTHER CRITERIA

None

HERCEPTIN

PRODUCT(s) AFFECTED

- HERCEPTIN INJ 440MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of one of the following: A) HER2 overexpressing breast cancer AND patient is node positive OR node negative and either ER/PR negative or ER/PR positive with one high risk feature (i.e. pathological tumor size greater than 2 cm, Grade 2-3, or age less than 35 years) AND medication is for adjuvant treatment as part of a regimen consisting of: doxorubicin, cyclophosphamide, and either paclitaxel or docetaxel OR with docetaxel and carboplatin OR as a single agent following multi-modality anthracycline-based therapy, B) HER2-overexpressing metastatic breast cancer AND medication will be used in combination with paclitaxel for first-line treatment OR as a single agent in a patient who received one or more chemotherapy regimens for metastatic disease OR in combination with Perjeta (pertuzumab) in a patient who has not received prior anti-HER2 therapy (e.g., trastuzumab) or chemotherapy for metastatic disease OR in combination with Tykerb (lapatinib) as second-line treatment of HER2+ recurrent or metastatic disease, C) HER2 overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma AND patient has not received prior treatment for metastatic disease AND medicaton will be used in combination with cisplatin and capecitabine or 5-fluorouracil

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Subject to B vs D. Prescriber has assessed the patient's cardiac function/left ventricular ejection fraction prior to initiation of therapy. Female patients of child-bearing potential have been advised of the risk of fetal harm and the need for contraception.

HETLIOZ

PRODUCT(s) AFFECTED

- HETLIOZ CAP 20MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of Non-24-hour-sleep-wake disorder (Non-24) AND patient has documented blindness

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

6 months (initial), 12 months (renewal)

OTHER CRITERIA

For renewal, patient experienced an objective improvement (e.g., improvement in timing of nighttime sleep, improvement in duration of nighttime sleep, or reduction in daytime sleep).

HRM

PRODUCT(s) AFFECTED

- NATPARA INJ 100MCG
  NATPARA INJ 50MCG
  NATPARA INJ 25MCG
  NATPARA INJ 75MCG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Verify the medication is being used for an FDA-approved diagnosis

AGE RESTRICTION

Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

HRM - ANALGESICS

PRODUCT(s) AFFECTED

- ASCOMP/COD CAP 30MG
- BUT/APAP/CAF CAP 50-300-40MG
- BUT/APAP/CAF CAP COD 50-300-40-30MG
- BUT/APAP/CAF CAP COD 50-325-40-30MG
- INDOMETHACIN CAP 25MG
- INDOMETHACIN CAP 50MG
- INDOMETHACIN CAP 75MG ER
- KETOROLAC INJ 15MG/ML
- KETOROLAC INJ 30MG/ML
- KETOROLAC INJ 60MG/2ML
- KETOROLAC TAB 10MG
- PENTAZ/NALOX TAB 50-0.5MG
- TENCON TAB 50-325MG
- VANATOL LQ SOL
- ZEBUTAL CAP

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is 1) being prescribed for an FDA-approved indication AND 2) If formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) (ALTERNATIVES for the following diagnoses include A) ACUTE PAIN/INFLAMMATION: acetaminophen/codeine, tramadol, tramadol/APAP, morphine sulfate, hydrocodone/APAP, oxycodone, oxycodone/APAP, etodolac, diflunisal, fenoprofen, ibuprofen, ketoprofen, meclofenamate, nabumetone, piroxicam, sulindac, tolmetin, meloxicam, naproxen. B) OSTEOARTHRITIS: etodolac, diflunisal, fenoprofen, ibuprofen, ketoprofen, meclofenamate, nabumetone, piroxicam, sulindac, tolmetin, meloxicam, naproxen. C) GOUT: etodolac, ketoprofen, meloxicam, piroxicam, sulindac. D) HEADACHE: ibuprofen, naproxen) AND 3) the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND 5) anticipated treatment course/duration

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Not covered under Part D benefit if a hospice program drug benegits is available for the drug in question

HRM - ANTI-ARRHYTHMICS

PRODUCT(s) AFFECTED

- DIGITEK TAB 0.25MG
  DIGOXIN INJ 0.25MG/ML
  DIGOXIN SOL 50MCG/ML
  DIGOXIN TAB 0.25MG
  DISOPYRAMIDE CAP 100MG
  DISOPYRAMIDE CAP 150MG
  LANOXIN TAB 0.1875MG
  LANOXIN TAB 0.25MG
  NORPACE CAP 100MG CR
  NORPACE CAP 150MG CR

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives (DIGOXIN: Digoxin 0.125mg dose, propranolol or sotalol for atrial fibrilation, DISOPYRAMIDE: dofetilide, amiodarone, propafenone, mexiletine, multaq) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication, AND Monitoring plan for adverse side effects, AND anticipated treatment course/duration.

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

HRM - ANTIDEPRESSANTS

PRODUCT(s) AFFECTED

- AMITRIPTYLIN TAB 100MG
  AMITRIPTYLIN TAB 10MG
  AMITRIPTYLIN TAB 150MG
  AMITRIPTYLIN TAB 25MG
  AMITRIPTYLIN TAB 50MG
  AMITRIPTYLIN TAB 75MG
  CDP/AMITRIP TAB 10-25MG
  CDP/AMITRIP TAB 5-12.5MG
  CLOMIPRAMINE CAP 25MG
  CLOMIPRAMINE CAP 50MG
  CLOMIPRAMINE CAP 75MG
  DOXEPIN HCL CAP 100MG
  DOXEPIN HCL CAP 10MG
  DOXEPIN HCL CAP 150MG
  DOXEPIN HCL CAP 25MG
  DOXEPIN HCL CAP 50MG
  DOXEPIN HCL CAP 75MG
  DOXEPIN HCL CON 10MG/ML
  IMIPRAM HCL TAB 10MG
  IMIPRAM HCL TAB 25MG
  IMIPRAM HCL TAB 50MG
  IMIPRAM PAM CAP 100MG
  IMIPRAM PAM CAP 125MG
  IMIPRAM PAM CAP 150MG
  IMIPRAM PAM CAP 75MG
  PERPHEN/AMIT TAB 2-10MG
  PERPHEN/AMIT TAB 2-25MG
  PERPHEN/AMIT TAB 4-10MG
  PERPHEN/AMIT TAB 4-25MG
  PERPHEN/AMIT TAB 4-50MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND prescriber attestation that benefit outweighs risk of drugs found to be high risk medications for beneficiaries age 65 and older.

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

HRM - ANTIEMETIC DRUGS

PRODUCT(s) AFFECTED

- HYDROXYZ HCL TAB 10MG
- HYDROXYZ HCL TAB 25MG
- HYDROXYZ HCL TAB 50MG
- PHENADOZ SUP 12.5MG
- PHENERGAN SUP 12.5MG
- PHENERGAN SUP 25MG
- PHENERGAN SUP 50MG
- PROMETHAZINE INJ 25MG/ML
- PROMETHAZINE INJ 50MG/ML
- PROMETHAZINE SOL 6.25/5ML
- PROMETHAZINE SUP 12.5MG
- PROMETHAZINE SUP 25MG
- PROMETHAZINE SUP 50MG
- PROMETHAZINE TAB 12.5MG
- PROMETHAZINE TAB 25MG
- PROMETHAZINE TAB 50MG
- PROMETHEGAN SUP 25MG
- PROMETHEGAN SUP 50MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives (Nausea and Vomiting: granisetron, ondansetron or Allergic Reactions: desloratadine,) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND anticipated treatment course/duration.

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Must try and fail, have contraindication or intolerance to at least 2 non-HRM alternatives: Nausea/Vomiting: granisetron, ondansetron_Allergic Reactions: cetirizine solution, desloratadine, levocetirizine. Part D coverage is not allowed if a hospice program drug benefit is available for the drug in question.

HRM - ANTIHISTAMINES

PRODUCT(s) AFFECTED

- HYDROXYZ HCL INJ 25MG/ML
- HYDROXYZ HCL INJ 50MG/ML
- PROMETH/PE SYP 6.25-5/5

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION

PA applies to patients 65 years or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

HRM - ANTIHYPERTENSIVE AGENTS

PRODUCT(s) AFFECTED

- METHYLD/HCTZ TAB 250/15
- METHYLD/HCTZ TAB 250/25
- METHYLDOPA TAB 250MG
- METHYLDOPA TAB 500MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives (Low dose thiazide or a second generation calcium channel blocker OR ACE inhibitor, ARB, beta-blocker or combination product based on specific chronic conditions) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor side effects, AND anticipated treatment course/duration

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Low dose thiazide or a second generation calcium channel blocker OR ACE inhibitor, ARB, beta-blocker or combination product based on specific chronic conditions

HRM - ANTIPARKINSON AGENTS

PRODUCT(s) AFFECTED

- BENZTROPINE TAB 0.5MG
- BENZTROPINE TAB 1MG
- BENZTROPINE TAB 2MG
- TRIHEXYPHEN ELX 0.4MG/ML
- TRIHEXYPHEN TAB 2MG
- TRIHEXYPHEN TAB 5MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND prescriber attestation that benefit outweighs risk of drugs found to be high risk medications for beneficiaries age 65 and older

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

HRM - ANTIPSYCHOTICS

PRODUCT(s) AFFECTED

- THIORIDAZINE TAB 100MG
- THIORIDAZINE TAB 10MG
- THIORIDAZINE TAB 25MG
- THIORIDAZINE TAB 50MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives (haloperidol, quetiapine, risperidone, aripiprazole, asenapine, iloperidone, lurasidone, olanzapine, paliperidone, ziprasidone) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND anticipated treatment course/duration

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Applies to New Starts only. Must try/fail, have contraindication or intolerance to at least 2 of the following: haloperidol, quetiapine, risperidone, aripiprazole, asenapine, iloperidone, lurasidone, olanzapine, paliperidone, ziprasidone

HRM - BARBITURATES

PRODUCT(s) AFFECTED

- BUT/APAP/CAF CAP 50-325-40MG
- BUT/APAP/CAF TAB
- BUT/ASA/CAF/ CAP COD 30MG
- BUT/ASA/CAFF CAP
- BUTAL/APAP TAB 50-325MG
- PHENOBARB SOL 20MG/5ML
- PHENOBARB TAB 100MG
- PHENOBARB TAB 15MG
- PHENOBARB TAB 16.2MG
- PHENOBARB TAB 30MG
- PHENOBARB TAB 32.4MG
- PHENOBARB TAB 60MG
- PHENOBARB TAB 64.8MG
- PHENOBARB TAB 97.2MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND prescriber attestation that benefit outweighs risk of drugs found to be high risk medications for beneficiaries age 65 and older

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

HRM - CARDIOVASCULAR, CALCIUM CHANNEL BLOCKER(S)

PRODUCT(s) AFFECTED

- NIFEDIPINE CAP 10MG
- NIFEDIPINE CAP 20MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION

PA applies to patients 65 years or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Requires trial of at least one Non-HRM alternative: extended-release nifedipine, nicardipine, amlodipine

HRM - DEMENTIA AGENTS

PRODUCT(s) AFFECTED

- ERGOLOID MES TAB 1MG ORAL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION

PA applies to patients 65 years or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Requires trial of at least one Non-HRM alternative: donepezil, galantamine, rivastigmine, memantine

HRM - GASTROINTESTINAL(S)

PRODUCT(s) AFFECTED

- TRIMETHOBENZ CAP 300MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION

PA applies to patients 65 years or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

HRM - ONCOLOGY

PRODUCT(s) AFFECTED

- MEGESTROL AC SUS 40MG/ML
  MEGESTROL AC TAB 40MG
  MEGESTROL AC TAB 20MG
  MEGESTROL SUS 625MG/5M

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives for diagnosis of cachexia secondary to chronic illness (dronabinol, oxandrolone) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attestts to tthe medical necessity for using this high risk medication and the intent to monitor for side effects, AND anticipated treatment course/duration. For treatment of cancer related diagnosis or endometrial hyperplasia, or endometriosis, requests will be automatically approved.

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Applies to New Starts only

HRM - ORAL AND TRANSDERMAL ESTROGENS AND PROGESTINS

PRODUCT(s) AFFECTED

- CLIMARA PRO DIS WEEKLY
- COMBIPATCH DIS .05/.14
- COMBIPATCH DIS .05/.25
- ESTRA/NORETH TAB 0.5-0.1
- ESTRA/NORETH TAB 1-0.5MG
- ESTRADIOL DIS 0.025MG/BI-WEEKLY
- ESTRADIOL DIS 0.025MG/WEEKLY
- ESTRADIOL DIS 0.0375MG/BI-WEEKLY
- ESTRADIOL DIS 0.0375MG/WEEKLY
- ESTRADIOL DIS 0.05MG/BI-WEEKLY
- ESTRADIOL DIS 0.05MG/WEEKLY
- ESTRADIOL DIS 0.06MG
- ESTRADIOL DIS 0.075MG/BI-WEEKLY
- ESTRADIOL DIS 0.075MG/WEEKLY
- ESTRADIOL DIS 0.1MG/BI-WEEKLY
- ESTRADIOL DIS 0.1MG/WEEKLY
- ESTRADIOL TAB 0.5MG
- ESTRADIOL TAB 1MG
- ESTRADIOL TAB 2MG
- ESTROPIPATE TAB 0.75MG
- ESTROPIPATE TAB 1.5MG
- ESTROPIPATE TAB 3MG
- FYAVOLV TAB 0.5-2.5
- FYAVOLV TAB 1-5
- JINTELI TAB 1MG-5MCG
- LOPREEZA TAB 0.5-0.1
- LOPREEZA TAB 1-0.5MG
- MENEST TAB 0.3MG
- MENEST TAB 0.625MG
- MENEST TAB 1.25MG
- MENEST TAB 2.5MG
- MIMVEY LO TAB 0.5-0.1
- MIMVEY TAB 1-0.5MG
- NORETH/ETHIN TAB 0.5-2.5
- PREMARIN TAB 0.3MG
- PREMARIN TAB 0.45MG
- PREMARIN TAB 0.625MG
- PREMARIN TAB 0.9MG
- PREMARIN TAB 1.25MG
- PREMPHASE TAB
- PREMPRO TAB .625-2.5
- PREMPRO TAB 0.3-1.5
- PREMPRO TAB 0.45-1.5
- PREMPRO TAB 0.625-5

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND anticipated treatment course/duration. Non-HRM Alternatives: IF BEING USED TO TREAT Bone Density issues must try 2 of the safer alternatives: alendronate, risedronate, ibandronate, raloxifene OR (zoledronic acid for bed-bound patients or for post-hip fracture). IF BEING USED TO TREAT Post-menopausal symptoms must try 2 of the safer alternatives: citalopram, fluoxetine, sertraline, venlafaxine, Pristiq, Estrace Vaginal Cream. IF BEING USED TO TREAT Vaginal Symptoms must try vaginal Estrace cream

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Bone Density: alendronate, risedronate, ibandronate, raloxifene (zoledronic acid for bed-bound patients or for post-hip fracture). Vaginal Symptoms: vaginal estrogen cream

HRM - PLATELET INHIBITORS

PRODUCT(s) AFFECTED

- DIPYRIDAMOLE TAB 25MG
- DIPYRIDAMOLE TAB 50MG
- DIPYRIDAMOLE TAB 75MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION

PA applies to patients 65 years or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Requires trial of at least one Non-HRM alternative: clopidogrel, Aggrenox

HRM - SEDATIVE HYPNOTIC AGENTS

PRODUCT(s) AFFECTED

- ESZOPICLONE TAB 1MG
  ESZOPICLONE TAB 2MG
  ESZOPICLONE TAB 3MG
  ZALEPLON CAP 10MG
  ZALEPLON CAP 5MG
  ZOLPIDEM ER TAB 12.5MG
  ZOLPIDEM ER TAB 6.25MG
  ZOLPIDEM TAB 10MG
  ZOLPIDEM TAB 5MG
  ZOLPIDEM TAR SUB 1.75MG
  ZOLPIDEM TAR SUB 3.5MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives , Silenor(less than or equal to 6mg/d)) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication, AND Monitoring plan for adverse side effects, AND anticipated treatment course/duration.

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Non-HRM alternatives, must inadequate response, intolerable side effect, or contraindication to both: Rozerem (8 mg/d), Silenor (less than or equal to 6mg/d)

HRM - SKELETAL MUSCLE RELAXANTS

PRODUCT(s) AFFECTED

- CARISOPR/ASA TAB 200-325
  CARISOPRODOL TAB 350MG
  CHLORZOXAZON TAB 500MG
  CYCLOBENZAPR TAB 10MG
  CYCLOBENZAPR TAB 5MG
  CYCLOBENZAPR TAB 7.5MG
  METHOCARBAM TAB 500MG
  METHOCARBAM TAB 750MG
  ORPHENADRINE TAB 100MG ER

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND the prescribing physician attests that the benefit outweighs risk of therapy and intent to monitor for side effects, AND anticipated treatment course/duration.

AGE RESTRICTION

Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

HRM - SULFONYLUREAS

PRODUCT(s) AFFECTED

- GLYB/METFORM TAB 1.25-250
  GLYB/METFORM TAB 2.5-500
  GLYB/METFORM TAB 5-500MG
  GLYBURID MCR TAB 1.5MG
  GLYBURID MCR TAB 3MG
  GLYBURID MCR TAB 6MG
  GLYBURIDE TAB 1.25MG
  GLYBURIDE TAB 2.5MG
  GLYBURIDE TAB 5MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION

PA applies to patients 65 years or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Requires trial of at least one Non-HRM alternative: glimepiride, glipizide

HUMIRA

PRODUCT(s) AFFECTED

- HUMIRA INJ 10MG/0.2
  HUMIRA KIT 20MG/0.4
  HUMIRA KIT 40MG/0.8
  HUMIRA PEDIA INJ CROHNS 3 CT
  HUMIRA PEDIA INJ CROHNS 6 CT
  HUMIRA PEN INJ 40MG/0.8
  HUMIRA PEN INJ CROHNS

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Active serious infection (including tuberculosis)

REQUIRED MEDICAL INFORMATION

Diagnosis of one of the following: A) moderate to severe rheumatoid arthritis and inadequate response, intolerance, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) (e.g., hydroxychloroquine [HCQ], sulfasalazine, methotrexate [MTX], leflunomide, azathioprine, cyclosporine) B) moderate to severe polyarticular juvenile idiopathic arthritis, juvenile idiopathic arthritis with an inadequate response, intolerance or contraindication to one or more non-biologic DMARDs (e.g., HCQ, sulfasalazine, MTX, leflunomide, azathioprine, cyclosporine) C) psoriatic arthritis and inadequate response, intolerance, or contraindication to MTX D) ankylosing spondylitis and inadequate response, intolerance or contraindication to one or more NSAIDs E) moderate to severe chronic plaque psoriasis (affecting more than 5% of body surface area or crucial body areas such as the hands, feet, face, or genitals) and inadequate response, intolerance or contraindication to one or more oral systemic treatments (e.g., MTX, cyclosporine, acitretin, sulfasalazine) F) moderate to severe Crohn's disease and inadequate response, intolerance, or contraindication to two or more of the following: corticosteroids (e.g., prednisone, methylprednisolone) or non-biologic DMARDs (e.g., azathioprine, MTX, mercaptopurine) G) moderate to severe ulcerative colitis and inadequate response, intolerance or contraindication to two or more of the following: corticosteroids (e.g., prednisone, methylprednisolone), 5-ASA (i.e. mesalamine, sulfasalazine, balsalazide, olsalazine) or non-biologic DMARDs (azathioprine, MTX, mercaptopurine). H) Moderate to severe hidradenitis suppurativa I) Non-infectious intermediate, posterior and panuveitis in adult patients with an inadequate response, intolerance, or contraindication to ONE of the following; systemic or ophthalmic corticosteroids (e.g., prednisone, methylprednisolone)

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial - 16 weeks (CD), 12 weeks (UC), 12 months (others). Renewal - 12 months.

OTHER CRITERIA

Patient has been tested for TB and latent TB has been ruled out or is being treated as per guidelines. For renewal, patient has stable disease or has improved while on therapy (For pJIA, reduction in disease flares, and improvement in ACR scoring. For RA, improvement in tender/swollen joint count, improvement in ACR scoring. For PsA, improvement in number of swollen/tender joints, pain, stiffness. For AS, improvement in AS symptoms, such as stiffness and back pain. For CD, symptomatic remission. For UC, clinical remission, reduction in steroid use.)

HYDROXYPROGESTERONE CAPROATE

PRODUCT(s) AFFECTED

- HYDROXY CAPR INJ 1.25/5ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Breast, cervical, hepatocellular, uterine, or vaginal cancers, hepatic or thromboembolic disease, jaundice, or vaginal bleeding

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from physician

AGE RESTRICTION

16 years of age and older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Up to 21 weeks

OTHER CRITERIA

None

IBRANCE

PRODUCT(s) AFFECTED

- IBRANCE CAP 100MG
- IBRANCE CAP 125MG
- IBRANCE CAP 75MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Appropriate diagnosis 1) used in combination with letrozole for the treatment of postmenopausal women with estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced breast cancer OR 2)treatment of HR-positive, HER2-negative advanced or metastatic breast cancer in combination with fulvestrant in women with disease progression following endocrine therapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ICLUSIG

PRODUCT(s) AFFECTED

- ICLUSIG TAB 15MG
- ICLUSIG TAB 45MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of chronic myelogenous leukemia (CML) and patient has tried and failed, resistance, relapse or contraindication to at least two FDA-approved tyrosine kinase inhibitors OR T315l mutation-positive CML as a single agent without resistance to tyrosine kinase inhibitors OR Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia and the patient has tried and failed, resistance, relapse or contraindication to at least two FDA-approved tyrosine kinase inhibitors.

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

IMBRUVICA

PRODUCT(s) AFFECTED

- IMBRUVICA CAP 140MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

INCRELEX

PRODUCT(s) AFFECTED

- INCRELEX INJ 40MG/4ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Increlex is contraindicated in patients with allergies to mecasermin or any component of the Increlex formulation, for growth promotion in patients with closed epiphyses, for IV administration, in patients with active or suspected neoplasia. Increlex should be discontinued if neoplasia develops while on therapy.

REQUIRED MEDICAL INFORMATION

Increlex (mecasermin [rDNA origin] injection) is indicated for the long-term treatment of growth failure in children with severe primary IGF-1 deficiency (Primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. Child has one of the following conditions: Severe primary IGF-1 deficiency, OR Growth hormone gene deletion with developed neutralizing antibodies to growth hormone, OR Genetic mutation of GH receptor (i.e. Laron Syndrome), AND Child has severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex, AND Child with IGF-1 level greater than or equal to 3 standard deviations below normal based on lab reference range for age and sex, AND Child with normal or elevated growth hormone (GH) levels based on at least one growth hormone stimulation test, AND Evidence of open epiphyses

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Pediatric or Endocrinologist

COVERAGE DURATION

6 months

OTHER CRITERIA

None

INLYTA

PRODUCT(s) AFFECTED

- INLYTA TAB 1MG
- INLYTA TAB 5MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of advanced renal cell carcinoma AND patient failed one or more systemic therapies for renal cell carcinoma (e.g., sunitinib-, bevacizumab-, temsirolimus-, or cytokine-containing regimens)

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

INTRON-A

PRODUCT(s) AFFECTED

- INTRON A INJ 10MU
  INTRON-A INJ 18MU POW
  INTRON A INJ 50MU
  INTRON-A INJ 18MU SOL

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Uncontrolled depression. Solid organ transplant other than liver. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon and ribavirin.

REQUIRED MEDICAL INFORMATION

Diagnosis of hairy cell leukemia OR Diagnosis of Condylomata acuminata OR Diagnosis of AIDS-related Kaposi's sarcoma OR Clinically aggressive follicular lymphoma and the medication will be used concurrently with anthracycline-containing chemotherapy or is not a candidate for anthracycline-containing chemotherapy OR Malignant melanoma and the request for coverage is within 56 days of surgery and the patient is at high risk of disease recurrence OR Diagnosis of chronic hepatitis B with compensated liver disease and patient has evidence of hepatitis B viral replication and patient has been serum hepatitis B surface antigen-positive for at least 6 months OR Diagnosis of chronic hepatitis C with compensated liver disease and is receiving combination therapy with ribavirin, unless ribavirin is contraindicated, and the medication will not be used as part of triple therapy with a protease inhibitor and patient has a clinical reason for not using peginterferon

AGE RESTRICTION

1 year of age or older for HBV. 3 years of age or older for HCV. 18 years of age or older for other indications.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Condylomata: 3 mos. HBV e antigen pos: 16 wks, e antigen neg: 48 wks. KS: 16 wks. Others: 12 mos

OTHER CRITERIA

None

IRESSA

PRODUCT(s) AFFECTED

- IRESSA TAB 250MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of metastatic, non-small cell lung cancer, EGFR-positive OR treatment of epidermal growth factor receptor mutation-positive non-small cell lung cancer

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

1 year

OTHER CRITERIA

None

ISTODAX

PRODUCT(s) AFFECTED

- ISTODAX INJ 10MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Diagnosis of cutaneous T-cell lymphoma AND prior use of one systemic therapy such one of the following, a retinoid (ex. Bexarotene (Targretin), all-trans retinoic acid (Vesanoid), acitretin (Soriatane).

ITRACONAZOLE

PRODUCT(s) AFFECTED

- ITRACONAZOLE CAP 100MG
- SPORANOX SOL 10MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of onychomycosis requires a positive laboratory test such as (potassium hydroxide-KOH preparation, fungal culture, or nail biopsy) to confirm the diagnosis.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

6 months

OTHER CRITERIA

None

JAKAFI

PRODUCT(s) AFFECTED

- JAKAFI TAB 10MG
- JAKAFI TAB 15MG
- JAKAFI TAB 20MG
- JAKAFI TAB 25MG
- JAKAFI TAB 5MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of myelofibrosis (primary, post-poycythemia vera or post-essential thrombocythemia) AND patient has two or more of the following: age older than 65 years, white blood cell count greater than 25 x 109/L, hemoglobin less than 10 g/dL, peripheral blasts more than 1%, constitutional symptoms (e.g., night sweats, fevers, unintentional weight loss, debilitating fatigue)

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

6 months

OTHER CRITERIA

None

JEVTANA

PRODUCT(s) AFFECTED

- JEVTANA INJ 60/1.5ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Prostate Cancer: Diagnosis of castration-resistant metastatic prostate cancer AND patient has been previously treated with a docetaxel-containing regimen AND patient is receiving concurrent prednisone

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

JUXTAPID

PRODUCT(s) AFFECTED

- JUXTAPID CAP 10MG
  JUXTAPID CAP 20MG
  JUXTAPID CAP 30MG
  JUXTAPID CAP 40MG
  JUXTAPID CAP 5MG
  JUXTAPID CAP 60MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of homozygous familial hypercholesterolemia. Reauthorization: demonstration of a positive clinical response to Juxtapid therapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

KADCYLA

PRODUCT(s) AFFECTED

- KADCYLA INJ 100MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Patient has a diagnosis of HER2-positive metastatic breast cancer and the member has been previously treated with trastuzumab and a taxane

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Prescriber has assessed the patient's hepatic function and left ventricular ejection fraction prior to initiation of therapy. Female patients of child-bearing potential had pregnancy status verified prior to the initiation of Kadcyla and have been advised of the risk of fetal harm and the need for contraception.

KALYDECO

PRODUCT(s) AFFECTED

- KALYDECO PAK 50MG
- KALYDECO PAK 75MG
- KALYDECO TAB 150MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Cystic Fibrosis (Initial): Diagnosis of CF and one of the following CFTR gene mutations: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, or R117H (Reauthorization): Documentation of one of the following while on Kalydeco therapy: Improved lung function or stable lung function.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

KANUMA

PRODUCT(s) AFFECTED

- KANUMA INJ 20/10ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Lysosomal acid lipase deficiency: Diagnosis of lysosomal acid lipase deficiency (LAL-D). Diagnosis was confirmed by an enzymatic blood (e.g., dried blood spot test) or genetic test.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with a specialist experienced in the treatment of inborn errors of metabolism, gastroenterologist, or lipidologist

COVERAGE DURATION

12 months

OTHER CRITERIA

None

KEVEYIS

PRODUCT(s) AFFECTED

- KEVEYIS TAB 50MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

All Uses (Initial and Reauth): Hepatic insufficiency (e.g., Child-Pugh class A). Severe pulmonary disease [e.g., severe chronic obstructive pulmonary disease]. Concomitant use with high dose aspirin (i.e., greater than 100 mg per day).

REQUIRED MEDICAL INFORMATION

Periodic paralysis (Initial): Diagnosis of one of the following: Primary hyperkalemic periodic paralysis, Primary hypokalemic periodic paralysis, or Paramyotonia Congenita with periodic paralysis

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

All uses (Initial): Prescribed by or in consultation with a neurologist

COVERAGE DURATION

All uses (Initial): 3 months. (Reauth): 12 months

OTHER CRITERIA

All uses (Reauth): Documentation of positive clinical response to Keveyis therapy.

KEYTRUDA

PRODUCT(s) AFFECTED

- KEYTRUDA INJ 100MG/4M
- KEYTRUDA SOL 50MG

COVERED USES

All medically accepted indications not otherwise excluded from PART D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors express PD-L1 OR recurrent or metastatic head and neck squamous cell carcinoma (HNSCC) with disease progression on or after platinum-containing chemotherapy OR unresectable or metastatic melanoma

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

KINERET

PRODUCT(s) AFFECTED

- KINERET INJ

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Kineret therapy. Neonatal-Onset Multisystem Inflammatory Disease (NOMID) (initial): Diagnosis of NOMID AND dx of NOMID has been confirmed by one of the following: NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation OR evidence of active inflammation including both of the following: clinical symptoms (eg, rash, fever, arthralgia) and elevated acute phase reactants (eg, ESR, CRP). All Uses (initial, reauth): Patient is not receiving Kineret in combination with a biologic disease modifying antirheumatic drug (DMARD) [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Kineret in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

RA (initial): Prescribed by or in consultation with a rheumatologist. NOMID (initial): Prescribed by or in consultation with allergist/immunologist or rheumatologist or pediatrician.

COVERAGE DURATION

All Uses (initial, reauth): 12 months

OTHER CRITERIA

All Uses (Reauth): Documentation of positive clinical response to Kineret therapy.

KORLYM

PRODUCT(s) AFFECTED

- KORLYM TAB 300MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Not covered for pregnant women. Contraindicated in patients taking simvastatin, lovastatin, and CYP3A substrates with narrow therapeutic ranges, such as cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus, and patients who require concomitant treatment with systemic corticosteroids for serious medical conditions or illnesses. Women with a history of unexplained vaginal bleeding. Women with endometrial hyperplasia with atypia or endometrial carcinoma.

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

KUVAN

PRODUCT(s) AFFECTED

- KUVAN POW 100MG
  KUVAN POW 500MG
  KUVAN TAB 100MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Based on data regarding the relationship between Phe level and brain function, the National Institutes of Health (NIH) consensus panel recommends that Phe levels be maintained between:2-6 mg/dL (120-360 micromol/L) if less than 12 years of age, 2-10 mg/dL (120-600 micromol/L) if greater than 12 and less than 18 years of age, and 2-15 mg/dL (120-900 micromol/L) if greater than 18 years of age Initial extension will ONLY be granted for members who meet ALL of the following criteria: Documented response to therapy as defined by greater than or equal to 30% reduction in baseline Phe level, AND Documented compliance with Kuvan, AND Still under the appropriate care and re-evaluations of a specialist knowledgeable in the management of PKU Extended Approval: 6 month intervals, based on documentation of ALL of the following: Maintenance of greater than or equal to 30% reduction in baseline Phe level, AND Documented compliance with Kuvan, AND Still under the appropriate care and re-evaluations of a specialist knowledgeable in the management of PKU.

AGE RESTRICTION

1 month of age or older

PRESCRIBER RESTRICTION

Specialist knowledgeable in the management of PKU

COVERAGE DURATION

Initial Approval: 2 months. Extended Approval: 6 month intervals

OTHER CRITERIA

None

KYNAMRO

PRODUCT(s) AFFECTED

- KYNAMRO INJ 200MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of Homozygous familial hypercholesterolemia. (Reauthorization): a) patient initiated on Kynamro therapy within the past 6 months AND b) documentation of provider acknowledgement that the patients LDL-C level reduction achieved is sufficiently robust by Week 28 to warrant the potential risk of liver toxicity. OR a) patient has been maintained on Kynamro therapy for longer than 6 months AND b) documentation of positive clinical response to Kynamro therapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial: 6 months trial. Reauthorization: 12 months if demonstrated benefit

OTHER CRITERIA

None

LENVIMA

PRODUCT(s) AFFECTED

- LENVIMA CAP 10 MG
  LENVIMA CAP 14 MG
  LENVIMA CAP 18 MG
  LENVIMA CAP 20 MG
  LENVIMA CAP 24 MG
  LENVIMA CAP 8 MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer OR advanced renal cell carcinoma following one prior anti-angiogenic therapy in combination with everolimus

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

LETAIRIS

PRODUCT(s) AFFECTED

- LETAIRIS TAB 10MG
- LETAIRIS TAB 5MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)AND pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with two forms of reliable contraception in female patients of reproductive potential.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial - 6 months. Renewal - 12 months

OTHER CRITERIA

None

LEUKINE

PRODUCT(s) AFFECTED

- LEUKINE INJ 250MCG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of one of the following: A) Patient has undergone allogeneic or autologous bone marrow transplant (BMT) and engraftment is delayed or failed and Patient does not have excessive leukemic myeloid blasts in bone marrow/peripheral blood (more than 10%) OR B) Patient is undergoing autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis OR C) Medication will be used for myeloid reconstitution after an autologous or allogeneic BMT OR D) Patient has acute myeloid leukemia and administration will be after completion of induction chemotherapy

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

LIDOCAINE PATCH

PRODUCT(s) AFFECTED

- LIDOCAINE PATCH 5%

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

For the FDA-labeled indication of post-herpetic neuralgia, no additional criteria are required to be met. For diabetic neuropathy: the patient must have previous use and inadequate response or intolerance to Cymbalta or Lyrica.

LONSURF

PRODUCT(s) AFFECTED

- LONSURF TAB 15-6.14
- LONSURF TAB 20-8.19

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of metastatic colorectal cancer, previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based regimens, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

1 year

OTHER CRITERIA

For initial treatment: Absolute neutrophil count 1,500/mm(3) or greater or febrile neutropenia resolved, platelet count 75,000/mm(3) or greater, and grade 3 or 4 nonhematological reactions resolved to grade 0 or 1

LUMIZYME

PRODUCT(s) AFFECTED

- LUMIZYME INJ 50MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of late (non-infantile) onset Pompe disease (GAA) deficiency

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

LUPANETA PACK

PRODUCT(s) AFFECTED

- LUPANETA KIT 11.25-5 LUPANETA KIT 3.75-5

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Endometriosis (initial): Diagnosis of endometriosis. One of the following: Patient has had surgical ablation to prevent recurrence, or history of failure, contraindication, or intolerance to one NSAID or one oral contraceptive. History of failure, contraindication, or intolerance to Lupron Depot (7.5 mg, 22.5 mg, 30 mg, and 45 mg).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Endomet (init, reauth): 6 months

OTHER CRITERIA

Endometriosis (reauthorization): Patient is experiencing recurrence of symptoms after an initial course of therapy.

LUPRON

PRODUCT(s) AFFECTED

- LEUPROLIDE INJ 1MG/0.2
  LUPR DEP-PED INJ 11.25MG
  LUPR DEP-PED INJ 15MG
  LUPR DEP-PED INJ 30MG
  LUPRON DEPOT INJ 11.25MG
  LUPRON DEPOT INJ 22.5MG
  LUPRON DEPOT INJ 3.75MG
  LUPRON DEPOT INJ 45MG
  LUPRON DEPOT INJ 7.5MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Pregnancy in patients with child-bearing potential. Breastfeeding. Undiagnosed abnormal vaginal bleeding.

REQUIRED MEDICAL INFORMATION

Diagnosis of one of the following: A) advanced or metastatic prostate cancer (7.5 mg 1-month, 22.5 mg 3-month, 30 mg 4-month, & 45 mg 6-month depots only), B) Endometriosis (3.75 mg 1-month & 11.25 mg 3-month depots only) and for initial, patient has had an inadequate pain control response or patient has an intolerance or contraindication to one of the following: Danazol OR Combination [estrogen/progesterone] Oral Contraceptives OR Progestins and for retreatment course, Patient is experiencing recurrence of symptoms after an initial course of therapy with leuprolide acetate and Norethindrone acetate 5 mg daily will be co-administered, or C) Anemia due to uterine Leiomyomata (Fibroids) (3.75 mg 1-month &11.25 mg 3-month depots only) and Patient is preoperative

AGE RESTRICTION

Uterine fibroids, ednometriosisand prostate cancer - 18 years of age or older, CPP- age 2-11 female OR 2-12 male

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Endometriosis- 6 months, Uterine fibroids -3 months, Prostate cancer, Precocious Puberty -12 months

OTHER CRITERIA

For endometriosis and uterine fibroids, patient will be using nonhormonal contraception during and for 12 weeks after therapy.

LYNPARZA

PRODUCT(s) AFFECTED

- LYNPARZA CAP 50MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Appropriate diagnosis and testing for BRCA mutation (deleterious or suspected deleterious germline BRCA mutated (as detected by an FDA approved test) advanced ovarian cancer that has been treated with 3 or more prior lines of chemotherapy)

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

MAKENA

PRODUCT(s) AFFECTED

- MAKENA INJ 250MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Preterm birth prophylaxis: Patient had a previous singleton (single offspring) spontaneous preterm birth. Patient is having a singleton pregnancy. Therapy will be started between 16 weeks, 0 days and 20 weeks, 6 days of gestation. Therapy will be continued until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Preterm birth prophylaxis: Prescribed by a specialist in obstetrics and gynecology

COVERAGE DURATION

Preterm birth prophylaxis: 21 weeks

OTHER CRITERIA

None

MEKINIST

PRODUCT(s) AFFECTED

- MEKINIST TAB 0.5MG
- MEKINIST TAB 2MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

A documented BRAF V600E or V600K mutations as detected by an FDA-approved test

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Mekinist is not indicated for the treatment of patients who have received prior BRAF-inhibitor therapy (i.e. Zelboraf, Tafinlar).

METHYLIN CHEW

PRODUCT(s) AFFECTED

- METHLPHENIDA CHW 2.5MG
- METHYLPHENID CHW 10MG
- METHYLPHENID CHW 5MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

One of the following: a) diagnosis of attention deficit hyperactivity disorder (ADHD), OR b) diagnosis of attention decficit disorder (ADD), OR c) diagnosis of narcolepsy as confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)

AGE RESTRICTION

PA applies to members 19 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

METHYLPHENIDATE ER

PRODUCT(s) AFFECTED

- METHYLPHENID CAP 10MG
  METHYLPHENID CAP 20MG ER
  METHYLPHENID CAP 30MG
  METHYLPHENID CAP 40MG ER
  METHYLPHENID CAP 50MG
  METHYLPHENID CAP 60MG
  METHYLPHENID TAB 18MG ER
  METHYLPHENID TAB 27MG ER
  METHYLPHENID TAB 36MG ER
  METHYLPHENID TAB 54MG ER
  RITALIN LA CAP 10MG
  RITALIN LA CAP 60MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

One of the following: a) diagnosis of attention deficit hyperactivity disorder (ADHD), OR b) diagnosis of attention decficit disorder (ADD)

AGE RESTRICTION

PA applies to members 19 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

METHYLTESTOSTERONE

PRODUCT(s) AFFECTED

- METHITEST TAB 10MG
- METHYLTESTOS CAP 10MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Hypogonadism (HG) (Initial): Diagnosis (dx) of HG in a male patient. 1) Two pre-treatment serum total testosterone (T) levels less than reference range for the lab OR 2) Both of the following: Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome). Delayed puberty (DP): Dx of DP in males. Breast cancer (BC): Dx for the palliative treatment of inoperable BC in women.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

HG(init): New to T tx:6 mo. New to plan and cont T tx:12 mo, (reauth): 12 mo. BC: 12 mo. DP: 6 mo.

OTHER CRITERIA

HG (Reauth): 1) Total serum T level within or below the normal limits of the reporting lab, or 2) Total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Calculated free or bioavailable T level within or below the normal limits of the reporting lab, or calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.

MIRVASO

PRODUCT(s) AFFECTED

- MIRVASO GEL 0.33%

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Rosacea (init): Diagnosis of rosacea. Patient has moderate to severe persistent (nontransient) facial erythema.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Rosacea (init, reauth): 12 months

OTHER CRITERIA

Rosacea (reauth) Documentation of positive clinical response to Mirvaso therapy.

MOZOBIL

PRODUCT(s) AFFECTED

- MOZOBIL INJ

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Patient is to undergo autologous stem cell transplantation for the treatment of non-Hodgkin's lymphoma or multiple myeloma AND Patient will concomitantly receive a daily dose of a granulocyte colony-stimulating factor (G-CSF) for 4 days prior to the first evening dose of Mozobil and on each day prior to apheresis while using Mozobil.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

4 days

OTHER CRITERIA

None

MYALEPT

PRODUCT(s) AFFECTED

- MYALEPT INJ 11.3MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Lipodystrophy (initial): Diagnosis of congenital or acquired generalized lipodystrophy AND Patient is refractory to current standards of care for lipid and diabetic management AND One or more of the following metabolic abnormalities are present: A) Insulin resistance (defined as requiring more than 200 units per day), B) Hypertriglyceridemia, or C) Diabetes

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Initial: Prescribed by or in consultation with an endocrinologist

COVERAGE DURATION

Initial and reauth: 12 months

OTHER CRITERIA

Lipodystrophy (reauth): Patient has experienced an objective response to therapy, such as A) Sustained reduction in hemoglobin A1c (HbA1c) level from baseline OR B) Sustained reduction in triglyceride (TG) levels from baseline

NAGLAZYME

PRODUCT(s) AFFECTED

- NAGLAZYME INJ 1MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis for use: The intravenous administration of Naglazyme is indicated for patients with Maroteaux-Lamy syndrome (Mucopolysaccharidosis IV)

AGE RESTRICTION

3 months of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial approval: 6 months Extended approval: Annual review will be based on response to therapy

OTHER CRITERIA

If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

NEULASTA

PRODUCT(s) AFFECTED

- NEULASTA INJ 6MG/0.6M

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Primary prophylaxis of chemotherapy-induced febrile neutropenia (CFN): One of the following: 1) patient is receiving chemotherapy regimens associated with a greater than 20% incidence of FN, OR 2) both of the following: a) patient receiving chemotherapy regimen associated with 10-20% incidence of FN, AND b) one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia. Secondary prophylaxis of FN: Both of the following: 1) patients receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm^3), AND 2) patients with a history of FN during a previous course of chemotherapy. Neutropenia associated with dose-dense chemotherapy (NDDC): One of the following: 1) patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, OR 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown. Treatment of FN (off-label): Both of the following: 1) patients receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm^3), AND 2) patients with FN at high risk for infection-associated complications. Acute radiation syndrome (ARS): Patient was acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

All uses (initial): Prescribed by a hematologist/oncologist

COVERAGE DURATION

FN (treatment), ARS: 1 mo. CFN, NDDC, FN (prophylaxis): 3 mo or duration of tx.

OTHER CRITERIA

None

NEUPOGEN

PRODUCT(s) AFFECTED

- NEUPOGEN INJ 300/0.5
  NEUPOGEN INJ 480/0.8
  NEUPOGEN INJ 300MCG
  NEUPOGEN INJ 480MCG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of one of the following: A) congenital, cyclic, or idiopathic neutropenia, B) severe febrile neutropenia (FN) with the following: Has not received prophylactic pegfilgrastim and Used as adjunct to appropriate antibiotics in high-risk patients and any one of the following: 65 years or older, Uncontrolled primary disease, Pneumonia, Hypotension and multiorgan dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalization when developed fever, Prior FN, Severe (ANC less than 100/mcL) or anticipated prolonged (more than 10 days) neutropenia, C) Autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis, D) Undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT, E) Acute myeloid leukemia and will be given after completion of induction or consolidation chemotherapy, F) Acute lymphoblastic leukemia and will be given after completion of the first few days of chemotherapy of the initial induction or first post-remission course, G) Myelodysplastic syndrome with severe neutropenia and recurrent infection, H) Receiving radiation therapy, not on chemotherapy, and expected to have prolonged delays in treatment due to neutropenia, I) Neutropenia associated with HIV infection and antiretroviral therapy, J) Aplastic anemia, K)Primary prophylaxis of FN in one of the following patients: 20% or higher risk of FN based on chemotherapy regimen OR Less than 20% risk of FN based on chemotherapy regimen with one of the following: 65 years or older, Poor performance status, Poor nutritional status, Previous FN, Extensive prior treatment including large radiation ports, Cytopenias due to bone marrow involvement by tumor, Administration of combined chemoradiotherapy, Presence of open wounds or active infections, Other serious comorbidities (including renal or liver dysfunction) or Receiving dose-dense chemotherapy regimen in breast or small cell lung cancer or non-HodgkinÂ¿s lymphoma.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

NEXAVAR

PRODUCT(s) AFFECTED

- NEXAVAR TAB 200MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Diagnosis of advanced renal cell carcinoma AND prior therapy with Sutent (sunitinib) or Votrient (Pazopanib) OR For the treatment of patients with locally recurrent or metastatic, progressive, differentiated thyroid carcinoma that is refractory to radioactive iodine treatment OR For the treatment of patients with unresectable hepatocellular carcinoma

NINLARO

PRODUCT(s) AFFECTED

- NINLARO CAP 2.3MG
- NINLARO CAP 3MG
- NINLARO CAP 4MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of multiple myeloma, documentation of combination therapy with lenalidomide and dexamethasone. History of 1 prior therapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

1 year

OTHER CRITERIA

None

NON-PREFERRED TIRF

PRODUCT(s) AFFECTED

- FENTORA TAB 100MCG
  FENTORA TAB 200MCG
  FENTORA TAB 400MCG
  FENTORA TAB 600MCG
  FENTORA TAB 800MCG
  LAZANDA SPR 100MCG
  LAZANDA SPR 300MCG
  LAZANDA SPR 400MCG
  SUBSYS SPR 100MCG
  SUBSYS SPR 200MCG
  SUBSYS SPR 400MCG
  SUBSYS SPR 600MCG
  SUBSYS SPR 800MCG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

For the management of breakthrough cancer pain. Patient is currently taking a long-acting opioid around the clock for cancer pain. Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids: Morphine sulfate at doses of greater than or equal to 60 mg/day, Fentanyl transdermal patch at doses greater than or equal to 25 µg/hr, Oxycodone at a dose of greater than or equal to 30 mg/day, Oral hydromorphone at a dose of greater than or equal to 8 mg/day, Oral oxymorphone at a dose of greater than or equal to 25 mg/day, or an alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day). History of failure or intolerance to generic fentanyl lozenge AND Abstral sublingual tablets.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with one of the following: Pain specialist, Oncologist, Hematologist, Hospice care specialist, or Palliative care specialist.

COVERAGE DURATION

12 months

OTHER CRITERIA

None

NORTHERA

PRODUCT(s) AFFECTED

- NORTHERA CAP 100MG
- NORTHERA CAP 200MG
- NORTHERA CAP 300MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Request will be approved for the following indication(s): orthostatic dizziness, light-headedness, or the feeling that you are about to black out in adults with neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure (i.e., Parkinson disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

NUPLAZID

PRODUCT(s) AFFECTED

- NUPLAZID TAB 17MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of Parkinson disease psychosis including hallucinations and/or delusions

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

NUVIGIL

PRODUCT(s) AFFECTED

- ARMODAFINIL TAB 150MG
- ARMODAFINIL TAB 200MG
- ARMODAFINIL TAB 250MG
- ARMODAFINIL TAB 50MG
- NUVIGIL TAB 50MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of one of the following: A) excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) and documentation of residual excessive sleepiness B) excessive sleepiness associated with narcolepsy confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder by either a primary complaint of excessive sleepiness or insomnia which is temporally associated with a work period (usually night work) that occurs during the habitual sleep phase or polysomnography and the MSLT demonstrate loss of a normal sleep-wake pattern.

AGE RESTRICTION

17 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

OSA/hypopnea syndrome - 6 months (initial), 12 months (renewal). Other diagnoses - 12 months.

xgeva

OTHER CRITERIA

None

OCTREOTIDE

PRODUCT(s) AFFECTED

- OCTREOTIDE INJ 1000MCG
- OCTREOTIDE INJ 100MCG
- OCTREOTIDE INJ 200MCG
- OCTREOTIDE INJ 500MCG
- OCTREOTIDE INJ 50MCG/ML
- SANDOSTATIN KIT LAR 10MG
- SANDOSTATIN KIT LAR 20MG
- SANDOSTATIN KIT LAR 30MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ODOMZO

PRODUCT(s) AFFECTED

- ODOMZO CAP 200MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of locally advanced basal cell carcinoma of the skin and specific documentation of negative pregnancy status

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

1 year

OTHER CRITERIA

None

OLYSIO

PRODUCT(s) AFFECTED

- OLYSIO CAP 150MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Both of the following: A) Criteria will be applied consistent with current AASLD/IDSA guideline AND B) Patient is without decompensated liver disease (defined as Child-Pugh Class B or C). All genotype 1 (except Sovaldi plus Olysio therapy) and 4: history of intolerance or contraindication to Harvoni and Zepatier therapy OR patient is currently on Olysio therapy. All Sovaldi plus Olysio therapy: one of the following: a) history of failure, intolerance or contraindication to Harvoni and Zepatier therapy OR b) both of the following: 1. history of failure to Harvoni OR Zepatier AND 2. The patient has NS5A inhibitor resistant-associated variants detected using commercially available assays, OR c) patient is currently on Olysio therapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine

COVERAGE DURATION

12 to 24 wks. Criteria will be applied consistent with current AASLD/IDSA guideline

OTHER CRITERIA

None

ONMEL

PRODUCT(s) AFFECTED

- ONMEL TAB 200MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

All of the following: 1) Diagnosis of onychomycosis of the toenail as confirmed by one of the following: a) positive potassium hydroxide (KOH) preparation, OR b) culture, OR c) histology, AND 2) patient's condition is causing debility or a disruption in their activities of daily living, AND 3) patient has had a trial and inadequate response, intolerance or hypersensitivity to oral terbinafine.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

3 months

OTHER CRITERIA

None

OPDIVO

PRODUCT(s) AFFECTED

- OPDIVO INJ 40MG/4ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of unresectable or metastatic melanoma and disease progression following ipilimumab [Yervoy]) and testing for BRAF V600 mutation OR Diagnosis of metastatic squamous non-small cell lung cancer (NSCLC) with progression on or after platinum-based chemotherapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

OPIOID ANTAGONIST

PRODUCT(s) AFFECTED

- BUPRENORPHIN SUB 2MG
- BUPRENORPHIN SUB 8MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

OPSUMIT

PRODUCT(s) AFFECTED

- OPSUMIT TAB 10MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Pregnancy.

REQUIRED MEDICAL INFORMATION

Diagnosis of pulmonary arterial hypertension WHO group I AND diagnosis was confirmed by right heart catheterization AND female patients are enrolled in the OPSUMIT REMS program

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

6 months - initial. 12 months - renewal

OTHER CRITERIA

For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.)

ORENCIA IV

PRODUCT(s) AFFECTED

- ORENCIA INJ 250MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Juvenile Idiopathic Arthritis (JIA) (Initial): Diagnosis of moderately to severely active polyarticular JIA. All indications (Initial, reauth): One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Orencia IV therapy. Patient is not receiving Orencia in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Orencia in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

RA, JIA (Initial): Prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION

All indications (Initial, reauth): 12 months

OTHER CRITERIA

All indications (Reauth): Documentation of positive clinical response to Orencia therapy.

ORENCIA SC

PRODUCT(s) AFFECTED

- ORENCIA INJ 125MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Orencia SC therapy, OR prior maintenance therapy of at least 4 weeks with Orencia IV. Patient is not receiving Orencia in combination with a biologic disease modifying antirheumatic drug (DMARD) [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Orencia in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

RA (Initial): Prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION

RA (Initial, reauth): 12 months

OTHER CRITERIA

RA (Reauth): Documentation of positive clinical response to Orencia therapy. Patient is not receiving Orencia in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Orencia in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

ORENITRAM

PRODUCT(s) AFFECTED

- ORENITRAM TAB 0.125MG
- ORENITRAM TAB 0.25MG
- ORENITRAM TAB 1MG
- ORENITRAM TAB 2.5MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.

COVERAGE DURATION

PAH: Initial: 6 months. Reauth: 12 months.

OTHER CRITERIA

PAH (Reauth): Documentation of positive clinical response to therapy.

ORKAMBI

PRODUCT(s) AFFECTED

- ORKAMBI TAB 200-125

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Initial Therapy: Must have 1. Diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test AND 2. If less than 18 years of age, baseline ophthalmological exam completed. Continuation of therapy: Documentation patient is tolerating and responding to medication (i.e. improved FEV1, weight gain, decreased exacerbations, etc.)

AGE RESTRICTION

Must be greater than or equal to 12 years of age

PRESCRIBER RESTRICTION

Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation

COVERAGE DURATION

1 year

OTHER CRITERIA

None

OTEZLA

PRODUCT(s) AFFECTED

- OTEZLA TAB 10/20/30

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Psoriatic arthritis (PsA, initial): Diagnosis of active PsA. Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. PsA, plaque psoriasis (initial): History of failure, contraindiation, or intolerance to both Humira and Enbrel, OR for continuation of prior Otezla therapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION

Initial, Reauth: 12 months

OTHER CRITERIA

Reauthorization (all indications): Documentation of positive clinical response to Otezla therapy. All indications (initial, reauth): Patient is not receiving Otezla in combination with either of the following: a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Simponi (golimumab), Orencia (abatacept)] OR a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]

OXANDRIN

PRODUCT(s) AFFECTED

- OXANDROLONE TAB 10MG
- OXANDROLONE TAB 2.5MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Breast or prostate cancer in men. Breast cancer in women with hypercalcemia. Pregnancy. Nephrosis or nephrotic phase of nephritis. Hypercalcemia.

REQUIRED MEDICAL INFORMATION

Patient is receiving treatment as an adjunct therapy to promote weight gain and has one of the following: Extensive surgery, Chronic infections, Severe trauma, Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons and Patient has had an inadequate response, intolerance, or contraindication to nutritional supplements and a nutritional consult was performed OR Oxandrin (oxandrolone) will be used to counterbalance protein catabolism associated with chronic corticosteroid administration OR Patient has bone pain associated with osteoporosis.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Osteoporosis bone pain: 1 month. Other diagnoses: 3 months

OTHER CRITERIA

For renewal, patient has experienced an objective improvement (i.e. weight gain, increase in lean body mass, or reduction in muscle pain/weakness)

PART B VS PART D

PRODUCT(s) AFFECTED

- ABELCET INJ 5MG/ML
  ACETYLCYST SOL 10%
  ACETYLCYST SOL 20%
  ACYCLOVIR NA INJ 50MG/ML
  ADRUCIL INJ 2.5G/50ML
  ALBUTEROL NEB 0.083%
  ALBUTEROL NEB 0.5%
  ALBUTEROL NEB 0.63MG/3ML
  ALBUTEROL NEB 1.25MG/3ML
  AMBISOME INJ 50MG
  AMINOSYN 7% INJ /LYTE
  AMINOSYN II INJ 10%
  AMINOSYN II INJ 7%
  AMINOSYN II INJ 8.5/LYTE
  AMINOSYN INJ 8.5/LYTE
  AMINOSYN-HBC INJ 7%
  AMINOSYN-PF INJ 10%
  AMINOSYN-PF INJ 7%
  AMINOSYN-RF INJ 5.2%
  AMPHOTERICIN INJ 50MG
  ANZEMET TAB 100MG
  ANZEMET TAB 50MG
  ASTAGRAF XL CAP 0.5MG
  ASTAGRAF XL CAP 1MG
  ASTAGRAF XL CAP 5MG
  ATGAM INJ 250MG
  AVASTIN INJ
  AVASTIN INJ 400/16ML
  AZASAN TAB 100MG
  AZASAN TAB 75 MG
  AZATHIOPRINE INJ 100MG
  AZATHIOPRINE TAB 50MG
  BENLYSTA INJ 120MG
  BETHKIS NEB 300/4ML
  BIVIGAM INJ 10%
  BLEOMYCIN INJ 30UNIT
  BROVANA NEB 15MCG
  BUDESONIDE SUS 0.25MG/2ML
  BUDESONIDE SUS 0.5MG/2ML
  BUDESONIDE SUS 1MG/2ML
  BUPRENORPHIN INJ 0.3MG/ML CARPUJECT
  BUTORPHANOL INJ 1MG/ML
  BUTORPHANOL INJ 2MG/ML
  CARIMUNE NF INJ 3GM
  CELLCEPT IV INJ 500MG
  CLADRIBINE INJ 1MG/ML
  CLINIMIX E INJ 2.75/D10
  CLINIMIX E INJ 2.75/D5W
  CLINIMIX E INJ 4.25/D10
  CLINIMIX E INJ 4.25/D25
  CLINIMIX E INJ 4.25/D5W
  CLINIMIX E INJ 5%/D15W
  CLINIMIX E INJ 5%/D20W
  CLINIMIX E INJ 5%/D25W
  CLINIMIX INJ 2.75/D5W
  CLINIMIX INJ 4.25/D10
  CLINIMIX INJ 4.25/D20
  CLINIMIX INJ 4.25/D25
  CLINIMIX INJ 4.25/D5W
  CLINIMIX INJ 5%/D15W
  CLINIMIX INJ 5%/D20W
  CLINIMIX INJ 5%/D25W
  CROMOLYN SOD NEB 20MG/2ML
  CYCLOPHOSPH CAP 25MG
  CYCLOPHOSPH CAP 50MG
  CYCLOSPORINE CAP 100MG
  CYCLOSPORINE CAP 100MG MOD
  CYCLOSPORINE CAP 25MG
  CYCLOSPORINE CAP 25MG MOD
  CYCLOSPORINE CAP 50MG MOD
  CYCLOSPORINE INJ 50MG/ML
  CYCLOSPORINE SOL MODIFIED
  CYTARABINE INJ 100MG/ML
  CYTARABINE INJ 20MG/ML
  DOXORUBICIN INJ 2MG/ML LIPOPH SOL
  DOXORUBICIN INJ 2MG/ML SOL
  DRONABINOL CAP 10MG
  DRONABINOL CAP 2.5MG
  DRONABINOL CAP 5MG
  EMEND CAP 125MG
  EMEND CAP 40MG
  EMEND CAP 80MG

EMEND PAK 80 & 125
ENGERIX-B INJ 10/0.5ML
ENGERIX-B INJ 20MCG/ML
ENGERIX-B PFSINJ 10/0.5ML
ENVARSUS XR TAB 0.75MG
ENVARSUS XR TAB 1MG
ENVARSUS XR TAB 4MG
FLEBOGAMMA INJ DIF 10%
FLUOROURACIL INJ 5GM/100M
FREAMINE HBC INJ 6.9%
GABLOFEN INJ 10000/20
GABLOFEN INJ 40000/20
GABLOFEN INJ 50MCG/ML
GAMMAGARD INJ 2.5GM/25
GAMMAKED INJ 20GM/200
GAMMAPLEX INJ 20GM
GAMUNEX-C INJ 40/400ML
GANCICLOVIR INJ 500MG
GENGRAF CAP 100MG
GENGRAF CAP 25MG
GENGRAF SOL 100MG/ML
GRANISETRON TAB 1MG
HEPATAMINE SOL 8%
HYPERRAB S/D INJ 150/ML 10ML VIAL
HYPERRAB S/D INJ 150/ML 2ML VIAL
INTRALIPID INJ 20%
IPRATROPIUM SOL 0.02%INH
IPRATROPIUM/ALBUTEROL SOL NEB
IRINOTECAN INJ 100/5ML
LEVALBUTEROL NEB 0.31MG
LEVALBUTEROL NEB 0.63MG
LEVALBUTEROL NEB 1.25MG
LIORESAL INT INJ 0.05MG/1
LIORESAL INT INJ 10MG/20
LIORESAL INT INJ 10MG/5ML
MYCOPHENOLAT CAP 250MG
MYCOPHENOLAT SUS 200MG/ML
MYCOPHENOLAT TAB 500MG
MYCOPHENOLIC TAB 180MG DR
MYCOPHENOLIC TAB 360MG DR
NEBUPENT INH 300MG
NEPHRAMINE INJ 5.4%
NULOJIX INJ 250MG
NUTRILIPID EMU 20%
OCTAGAM INJ 1GM
OCTAGAM INJ 2GM/20ML
ONDANSETRON SOL 4MG/5ML
ONDANSETRON TAB 24MG
ONDANSETRON TAB 4MG
ONDANSETRON TAB 4MG ODT
ONDANSETRON TAB 8MG
ONDANSETRON TAB 8MG ODT
OXALIPLATIN INJ 100MG
PERFOROMIST NEB 20MCG
PLENAMINE INJ 15%
PREMASOL SOL 10%
PREMASOL SOL 6%
PRIVIGEN INJ 40GRAMS
PROCALAMINE INJ 3%
PROGRAF INJ 5MG/ML
PROSOL INJ 20%
RAPAMUNE SOL 1MG/ML
RECOMBIVA HB INJ 10MCG/ML PFS
RECOMBIVA HB INJ 10MCG/ML SOL
RECOMBIVA HB INJ 5MCG/0.5
RECOMBIVA-HB INJ 40MCG/ML
REMODULIN INJ 10MG/ML
REMODULIN INJ 1MG/ML
REMODULIN INJ 2.5MG/ML
REMODULIN INJ 5MG/ML
RHEUMATREX TAB 2.5MG 4X2
RHEUMATREX TAB 2.5MG 4X3
RHEUMATREX TAB 2.5MG 4X4
RHEUMATREX TAB 2.5MG 4X5
RHEUMATREX TAB 2.5MG 4X6
SANDIMMUNE SOL 100MG/ML
SIMULECT INJ 20MG
SIROLIMUS TAB 0.5MG
SIROLIMUS TAB 1MG
SIROLIMUS TAB 2MG
TACROLIMUS CAP 0.5MG
TACROLIMUS CAP 1MG
TACROLIMUS CAP 5MG
TECENTRIQ INJ 1200/20
THYMOGLOBULN INJ 25MG
TOBRAMYCIN NEB 300/5ML
TRAVASOL INJ 10%
TROPHAMINE INJ 10%
VECTIBIX INJ 100MG
VINBLASTINE INJ 10MG

VINCASAR PFS INJ 1MG/ML VINCRISTINE INJ 1MG/ML
ZORTRESS TAB 0.25MG

COVERED USES

This medication requires review for determination of coverage under Medicare Part B or Medicare Part D.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION

AGE RESTRICTION

PRESCRIBER RESTRICTION

COVERAGE DURATION

OTHER CRITERIA

PCSK9 INHIBITOR

PRODUCT(s) AFFECTED

- PRALUENT PFS INJ 150MG/ML
  PRALUENT PFS INJ 75MG/ML
  PRALUENT SOLN PEN-INJ 150MG/ML
  PRALUENT SOLN PEN-INJ 75MG/ML
  REPATHA INJ 140MG/ML
  REPATHA SURE INJ 140MG/ML

COVERED USES

All medically accepted indications not otherwise excluded form Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

MUST MEET CRITERIA #1, #2 OR #3. 1. Diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by genotyping OR Simon Broome criteria: Total cholesterol greater than 290mg/dL or LDL cholesterol greater than 190mg/dL, PLUS ONE OF THE FOLLOWING: Tendon xanthomas in patient, or 1st degree relative (parent, sibling, child), or 2nd degree relative (grandparent, uncle, aunt) OR DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation 2. Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genotyping OR diagnosis based on the following: a. History of untreated LDL-C greater than 500 mg/dL AND xanthoma before 10 years of age OR b. Documention of HeFH in both parents 3. Diagnosis of clinical atherosclerotic cardiovascular disease (CVD) as defined as one of the following: a. acute coronary syndrome, b. history of myocardial infarction, c. stable/unstable angina, d. coronary or other arterial revascularization, e. stroke, f. transient ischemic stroke (TIA), g. peripheral arterial disease presumed to be atherosclerotic region. AND MEETS CRITERIA #4, #5, AND #6 4. Provide baseline and current LDL-C 5. LDL-C greater than or equal to 100 mg/dL 6. Used in combination with maximally tolerated high-intensity statin OR MEETS CRITERIA #7 AND #8. 7. Statin intolerant 8. LDL-C greater than or equal to 100 mg/dL CONTINUING THERAPY:Will continue to be used in combination with maximally tolerated statin (unless statin intolerant)

AGE RESTRICTION

Repatha: 13 years of age or older for diagnosis HoFM, Diagnosis CVD or HeFH : 18 years of age or older

PRESCRIBER RESTRICTION

Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist

COVERAGE DURATION

Initial - 8 weeks. Renewal - 12 months.

OTHER CRITERIA

None

PEGASYS

PRODUCT(s) AFFECTED

- PEGASYS INJ
  PEGASYS INJ 180MCG/M
  PEGASYS INJ PROCLICK 135MCG/0.5ML
  PEGASYS INJ PROCLICK 180MCG/0.5ML

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Uncontrolled depression. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon.

REQUIRED MEDICAL INFORMATION

Diagnosis of hepatitis C with compensated liver disease and patient will be receiving one of the following: A) Combination therapy with sofosbuvir for initial treatment of genotype 3, 4, 5 or 6 OR B) Combination therapy with sofosbuvir for retreatment of genotype 2, 3, 4, 5 or 6. OR Diagnosis of hepatitis B.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

hepatologist, gastroenterologist, or infectious disease specialist

COVERAGE DURATION

HBV: 12 mos. HCV: based on current AASLD guidelines.

OTHER CRITERIA

For renewal of HCV, approval is based on the requirements outlined in the FDA-approved labeling, including viral load, presence of cirrhosis, and response to prior therapy.

PEGINTRON

PRODUCT(s) AFFECTED

- PEG-INTRON KIT 120 RP
  PEG-INTRON KIT 150 RP
  PEG-INTRON KIT 50MCG RP
  PEG-INTRON KIT 80MCG RP
  PEGINTRON KIT 120MCG
  PEGINTRON KIT 150MCG
  PEGINTRON KIT 50MCG
  PEGINTRON KIT 80MCG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Uncontrolled depression. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon and ribavirin.

REQUIRED MEDICAL INFORMATION

Diagnosis of hepatitis C for initial therapy with Sovaldi in patients with genotype 3, 4, 5, or 6 OR retreatment of genotypes 2,3,4,5, or 6.

AGE RESTRICTION

HCV: 18 years of age or older if used as triple therapy, otherwise 3 years of age or older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial - 16 weeks. Renewal - duration based on FDA approved labeling

OTHER CRITERIA

For renewal, approval is based on the requirements outlined in the FDA-approved labeling, including viral load, presence of cirrhosis, and response to prior therapy.

PERJETA

PRODUCT(s) AFFECTED

- PERJETA INJ 420/14ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Metastatic breast cancer: Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive metastatic breast cancer. One of the following: a) patient has not received prior anti-HER2 therapy or chemotherapy for metastatic disease AND used in combination with Herceptin (trastuzumab) and a taxane (eg, docetaxel, paclitaxel), OR b) patient was previously treated with chemotherapy and Herceptin (trastuzumab) without Perjeta AND used in combination with Herceptin (trastuzumab). Non-metastatic breast cancer: One of the following diagnoses: HER2-positive early stage breast cancer, HER2-positive locally advanced breast cancer, or HER2-positive inflammatory breast cancer. Used in combination with both Herceptin (trastuzumab) and a taxane (eg, docetaxel, paclitaxel).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

All Uses: Prescribed by or in consultation with an oncologist.

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

POMALYST

PRODUCT(s) AFFECTED

- POMALYST CAP 1MG
- POMALYST CAP 2MG
- POMALYST CAP 3MG
- POMALYST CAP 4MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Documentation of ALL of the following: 1. Disease has progressed within 60 days of completion of the last therapy 2. If female of reproductive potential ALL of the below: Two negative pregnancy tests obtained prior to initiating therapy with Pomalyst, monthly negative pregnancy tests during therapy 3. Patient has been counseled about the use of reliable contraception before, during, and 1 month after initiation of therapy with Pomalyst 4. Patient assessment to determine if prophylactic aspirin or antithrombic treatment (warfarin, clopidogrel) will need to be taken to reduce the risk of VTE (embolism, stroke) 5. Registered and certified to be compliant with Pomalyst REMS (Risk Evalutation and Mitigation Strategy) program

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist or hematologist

COVERAGE DURATION

12 months

OTHER CRITERIA

A documented diagnosis of multiple myeloma and received at least two prior therapies including lenalidomide (Revlimid) and bortezomib (Velcade)

PROCYSBI

PRODUCT(s) AFFECTED

- PROCYSBI CAP 25MG
- PROCYSBI CAP 75MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Nephropathic cystinosis: Diagnosis of nephropathic cystinosis, confirmed by elevated leukocyte cystine levels (LCL) or genetic analysis of the CTNS gene AND History of failure or intolerance to therapy with Cystagon (immediate-release cysteamine bitartrate)

AGE RESTRICTION

2 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

PROMACTA

PRODUCT(s) AFFECTED

- PROMACTA TAB 12.5MG
- PROMACTA TAB 25MG
- PROMACTA TAB 50MG
- PROMACTA TAB 75MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Documented diagnosis of chronic, relapsed or refractory idiopathic thrombocytopenic purpura OR Chronic hepatitis C infection associated thrombocytopenia OR severe aplastic anemia who have had an insufficient response to immunosuppressive therapy.

AGE RESTRICTION

1 year of age and older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Requests for coverage for thrombocytopenia in chronic hepatitis C patients will be approved if the platelet count is less than 50 billion cells/L. Promacta should be withheld when platelet counts exceed 400,000/mcL or if there is no response within 4 weeks of treatment at the maximum dose (75mg/day). Not covered in the presence of clinical symptoms of liver injury or evidence of hepatic decompensation.

PROVIGIL

PRODUCT(s) AFFECTED

- MODAFINIL TAB 100MG
- MODAFINIL TAB 200MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Obstructive sleep apnea/hypopnea syndrome (OSAHS) (Initial): Diagnosis (dx) of OSAHS defined by one of the following: 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), and 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work sleelp disorder (SWSD) (Initial):Dx of SWSD confirmed by symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, or sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). No other medical condition or medication accounts for the symptoms. Narcolepsy (initial): Dx of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming that a sleep study is not feasible). MS Fatigue (initial): Dx of multiple sclerosis (MS). Patient is experiencing fatigue. Depression (initial): Treatment-resistant depression defined as diagnosis of major depressive disorder (MDD) or bipolar depression, AND history of failure, contraindication, or intolerance to at least two antidepressants from different classes (eg, SSRIs, SNRIs, bupropion). Used as adjunctive therapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

OSAHS/MS/dep(init), SWSD (init,reauth): 3 mo.OSAHS/dep(reauth): 12mo. MS (reauth): 6mo. Other: 12mo

OTHER CRITERIA

OSAHS (Reauth): Documentation of positive clinical response to prior therapy. SWSD (Reauth): Documentation of positive clinical response to prior therapy. Patient still requires treatment for SWSD. Narcolepsy (reauth): Documentation of positive clinical response to prior therapy. MS Fatigue (reauth): Patient is experiencing relief of fatigue with modafinil therapy. Idiopathic Hypersomnia (reauth): Documentation of positive clinical response to modafinil therapy. Depression (reauth): Documentation of positive clinical response to modafinil therapy. Used as adjunctive therapy.

PULMONARY FIBROSIS

PRODUCT(s) AFFECTED

- OFEV CAP 100MG
- OFEV CAP 150MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of idiopathic pulmonary fibrosis

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescriber must be a pulmonologist

COVERAGE DURATION

12 months

OTHER CRITERIA

None

PULMOZYME

PRODUCT(s) AFFECTED

- PULMOZYME SOL 1MG/ML

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of cystic fibrosis

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations). Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

QUININE SULFATE

PRODUCT(s) AFFECTED

- QUININE SULF CAP 324MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Prolongation of QT interval. Glucose-6-phosphate dehydrogenase deficiency. Myasthenia gravis. Known hypersensitivity to mefloquine or quinidine. Optic neuritis.

REQUIRED MEDICAL INFORMATION

Patient has a diagnosis of one of the following: A) uncomplicated Plasmodium falciparum malaria B) uncomplicated Plasmodium vivax malaria C) babesiosis

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

One month

OTHER CRITERIA

None

RAVICITI

PRODUCT(s) AFFECTED

- RAVICTI LIQ 1.1GM/ML

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Acute hyperammonemia. N-acetylglutamate synthase (NAGS) deficiency

REQUIRED MEDICAL INFORMATION

Diagnosis of urea cycle disorder involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamoylase (OTC), or argininosuccinic acid synthetase (AAS) confirmed via enzymatic, biochemical, or genetic testing AND patient has tried and had an inadequate response, is intolerant, or has a contraindication to Buphenyl

AGE RESTRICTION

2 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

REGRANEX

PRODUCT(s) AFFECTED

- REGRANEX GEL 0.01%

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diabetic Neuropathic Ulcers: Diabetic patient with ulcer wound. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Diabetic Neuropathic Ulcers: Maximum 5 months.

OTHER CRITERIA

None

RELISTOR

PRODUCT(s) AFFECTED

- RELISTOR INJ 12/0.6ML
  RELISTOR INJ 8/0.4ML
  RELISTOR PFS INJ 12/0.6ML

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Known or suspected mechanical gastrointestinal obstruction. On renewal, patient does not have severe or persistent diarrhea.

REQUIRED MEDICAL INFORMATION

Methylnaltrexone is approved for opioid-induced constipation in adult patients with chronic non-cancer pain and for opioid-induced constipation in adult patients with advanced illness who are receiving palliative care, when response to laxative therapy has not been sufficient.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

4 months

OTHER CRITERIA

For renewal, the patient has responded to therapy (i.e. increase in bowel movements)

REVATIO

PRODUCT(s) AFFECTED

- REVATIO SUS 10MG/ML
- SILDENAFIL INJ
- SILDENAFIL TAB 20MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

REVLIMID

PRODUCT(s) AFFECTED

- REVLIMID CAP 10MG
  REVLIMID CAP 2.5MG
  REVLIMID CAP 25MG
  REVLIMID CAP 15MG
  REVLIMID CAP 20MG
  REVLIMID CAP 5MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Documentation of diagnosis

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

RITUXAN

PRODUCT(s) AFFECTED

- RITUXAN INJ 500MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Diagnosis of rheumatoid arthritis AND in combination with methotrexate AND an inadequate response to one or more TNF antagonist therapies, such as infliximab, adalimumab, or etanercept

RUCONEST

PRODUCT(s) AFFECTED

- RUCONEST INJ 2100UNIT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Treatment of hereditary angioedema (HAE) attacks: Diagnosis of HAE. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks (eg, Berinert, Firazyr, or Kalbitor).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

HAE: Prescribed by an immunologist, allergist, or rheumatologist

COVERAGE DURATION

12 months

OTHER CRITERIA

None

SABRIL

PRODUCT(s) AFFECTED

- SABRIL POW 500MG
- SABRIL TAB 500MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of one of the following: A) infantile spasms B) complex partial seizures and patient had an inadequate response to at least one generic first-line agents (carbamazepine, lamotrigine, levetiracetam, oxcarbazepine, valproic acid, divalproex sodium) and at least one adjunctive agent (carbamazepine, clobazam, gabapentin, lamotrigine, levitiracetam, oxcarbazepine, valproic acid, divalproex sodium, topiramate) AND patient and prescriber are enrolled in the SHARE restricted distribution program.

AGE RESTRICTION

Seizures - 10 years of age or older. Infantile spasms - at least one month to 2 years of age

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

SEROSTIM

PRODUCT(s) AFFECTED

- SEROSTIM INJ 4MG
SEROSTIM INJ 5MG
SEROSTIM INJ 6MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

HIV wasting (Initial): Diagnosis of HIV-associated wasting syndrome or cachexia, and one of the following: unintentional weight loss greater than 10% over the last 12 months, or unintentional weight loss greater than 7.5% over the last 6 months, or loss of 5% body cell mass (BCM) within 6 months, or body mass index (BMI) less than 20 kg/m2, or patient is male and has BCM less than 35% of total body weight (TBW) and BMI less than 27 kg/m2, or patient is female and has BCM less than 23% of TBW and BMI less than 27 kg/m2. Nutritional evaluation since onset of wasting first occurred. Anti-retroviral tx has been optimized to decrease the viral load. Patient has not had weight loss as a result of other underlying treatable conditions (eg, depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes). Patient has tried and had an inadequate response or intolerance to dronabinol or megestrol acetate.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Initial, Reauth: Prescribed by or in consultation with an infectious disease specialist.

COVERAGE DURATION

Initial: 3 months, Reauth: 6 months

OTHER CRITERIA

HIV wasting (reauth): Evidence of positive response to therapy. One of the following targets or goals has not been achieved: weight, BCM, BMI. Patient is currently receiving treatment with antiretrovirals.

SIGNIFOR

PRODUCT(s) AFFECTED

- SIGNIFOR INJ 0.3MG/ML
- SIGNIFOR INJ 0.6MG/ML
- SIGNIFOR INJ 0.9MG/ML
- SIGNIFOR LAR INJ 20MG
- SIGNIFOR LAR INJ 40MG
- SIGNIFOR LAR INJ 60MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Cushing's disease (initial): Diagnosis of endogenous Cushing's disease (i.e, hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Either pituitary surgery has not been curative for the patient OR patient is not a candidate for pituitary surgery. (Reauthorization): Documentation of positive clinical response to Signifor therapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial: 6 months trial. Reauthorization: 12 months if demonstrated benefit

OTHER CRITERIA

None

SIMPONI

PRODUCT(s) AFFECTED

- SIMPONI AUTO-INJ 100MG/ML
  SIMPONI PFS INJ 100MG/ML
  SIMPONI AUTO-INJ 50/0.5ML
  SIMPONI PFS INJ 50/0.5ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall) OR failure, contraindication, or intolerance to methotrexate (Rheumatrex/Trexall). One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Patient is corticosteroid dependent (ie, an inability to successfully taper corticosteroids without a return of the symptoms of UC), OR history of failure, contraindication, or intolerance to one of the following: oral aminosalicylate, oral corticosteroid, azathioprine, 6-mercaptopurine. One of the following: Failure, contraindication, or intolerance to Humira (adalimumab), OR for continuation of prior Simponi therapy. All indications (Initial, reauth): Patient is not receiving Simponi in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)]. Patient is not receiving Simponi in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]. For a diagnosis of PsA, Patient is not receiving Simponi in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

RA, AS (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. UC (Initial): Prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION

UC (Initial): 12 weeks. UC (Reauth): 12 months. RA, AS, PsA (Initial, reauth): 12 months

OTHER CRITERIA

All indications (Reauth): Documentation of positive clinical response to Simponi therapy.

SIMPONI ARIA

PRODUCT(s) AFFECTED

- SIMPONI ARIA SOL 50MG/4ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall), OR failure, contraindication, or intolerance to methotrexate (Rheumatrex/Trexall). One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi Aria therapy. Patient is not receiving Simponi Aria in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)]. Patient is not receiving Simponi Aria in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

RA (Initial): Prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION

RA (Initial, reauth): 12 months

OTHER CRITERIA

RA (Reauth): Documentation of positive clinical response to Simponi Aria therapy. Patient is not receiving Simponi Aria in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)]. Patient is not receiving Simponi Aria in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

SOMATULINE

PRODUCT(s) AFFECTED

- SOMATULINE INJ 60/0.2ML
- SOMATULINE INJ 90/0.3ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis for use: Acromegaly in patients who have had an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy is not an option OR Unresectable, well- or moderately-differentiated, locally advanced or metastatic carcinoid gastroenteropancreatic neuroendocrine tumor, OR treatment of hyperthyroidism secondary to thyrotropinoma

AGE RESTRICTION

Adults: 18 years and older.

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial approval: 3 months. Extended approval: 3 months with dose adjusted according to response

OTHER CRITERIA

If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

SOMAVERT

PRODUCT(s) AFFECTED

- SOMAVERT INJ 10MG
  SOMAVERT INJ 15MG
  SOMAVERT INJ 20MG
  SOMAVERT INJ 25MG
  SOMAVERT INJ 30MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

SPRYCEL

PRODUCT(s) AFFECTED

- SPRYCEL TAB 100MG
  SPRYCEL TAB 20MG
  SPRYCEL TAB 70MG
  SPRYCEL TAB 140MG
  SPRYCEL TAB 50MG
  SPRYCEL TAB 80MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Coverage is provided for the following indications. 1. For newly diagnosed adults with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase. 2. For adults with chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including imatinib. 3. For adults with Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) with resistance or intolerance to prior therapy.

STELARA

PRODUCT(s) AFFECTED

- STELARA INJ 45MG/0.5 STELARA INJ 90MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. Plaque psoriasis (Initial): One of the following: a) History of failure, contraindication, or intolerance (F/C/I) to Enbrel (etanercept) OR Humira (adalimumab) OR b) for continuation of prior Stelara therapy. PsA (Initial): One of the following: a) History of failure, contraindication, or intolerance (F/C/I) to Enbrel (etanercept) and Humira (adalimumab) OR b) for continuation of prior Stelara therapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.

COVERAGE DURATION

All uses (Initial, reauth): 12 months

OTHER CRITERIA

Reauthorization (all indications): Documentation of positive clinical response to Stelara therapy. All indications (initial, reauth): Patient is not receiving Stelara in combination with either of the following: Biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Otezla (apremilast)] or a Janus Kinase Inhibitor [eg, Xeljanz (tofacitinib)].Patient is not receiving Stelara in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].

STIVARGA

PRODUCT(s) AFFECTED

- STIVARGA TAB 40MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

A documented diagnosis of metastatic colorectal cancer AND documentation of prior therapy with ALL of the following per the indication: 1. (fluoropyrimidine-, oxaliplatin-, and irinotecan)-based chemotherapy 2. bevacizumab (Avastin) 3. panitumumab (Vectibix) OR cetuximab (Erbitux) (for KRAS mutation-negative patients only) OR a documented diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate (Gleevec) and sunitinib malate (Sutent)

STRENSIQ

PRODUCT(s) AFFECTED

- STRENSIQ INJ 40MG/ML
- STRENSIQ INJ 80/0.8ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Hypophosphatasia: Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia AND for patients requesting the 80 mg/0.8 mL vial only: Patient's weight is greater than or equal to 40 kg

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Hypophosphatasia: Prescribed by or in consultation with a specialist experienced in the treatment of inborn errors of metabolism or endocrinologist

COVERAGE DURATION

Hypophosphatasia: 12 months

OTHER CRITERIA

None

SUBOXONE

PRODUCT(s) AFFECTED

- BUPREN/NALOX SUB 2-0.5MG
  BUPREN/NALOX SUB 8-2MG
  SUBOXONE MIS 12-3MG
  SUBOXONE MIS 2-0.5MG
  SUBOXONE MIS 4-1MG
  SUBOXONE MIS 8-2MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Patient has a diagnosis of opioid dependence

AGE RESTRICTION

16 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial - 3 months. Renewal - 9 months

OTHER CRITERIA

None

SUTENT

PRODUCT(s) AFFECTED

- SUTENT CAP 12.5MG
- SUTENT CAP 25MG
- SUTENT CAP 37.5MG
- SUTENT CAP 50MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Gastrointestinal stromal tumor AND after disease progression on or intolerance to imatinib

SYLATRON

PRODUCT(s) AFFECTED

- SYLATRON KIT 200MCG
- SYLATRON KIT 300MCG
- SYLATRON KIT 600MCG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

SYLVANT

PRODUCT(s) AFFECTED

- SYLVANT SOL 100MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Multicentric Castleman's disease (MCD) (Initial): Diagnosis of MCD. Patient is human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

MCD (Initial): Prescribed by or in consultation with hematologist/oncologist or rheumatologist.

COVERAGE DURATION

MCD (initial, reauth): 6 months

OTHER CRITERIA

MCD (reauth): Documentation of positive clinical response to Sylvant therapy. Patient is HIV negative and HHV-8 negative.

SYMLIN

PRODUCT(s) AFFECTED

- SYMLINPEN 60 INJ 1000MCG SYMLNPEN 120 INJ 1000MCG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Gastroparesis.

REQUIRED MEDICAL INFORMATION

One of the following diagnoses: A) Type 1 diabetes OR B) Type 2 diabetes.

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

SYNAGIS

PRODUCT(s) AFFECTED

- SYNAGIS INJ 50MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Patient will use palivizumab for immunoprophylaxis of respiratory syncytial virus (RSV) during the peak months of infection in the patientÂ¿s geographic region AND Patient meets one of the following criteria: A) Infants born at 28 weeks, six days gestation or earlier and who are younger than 12 months of age at the start of the RSV season OR B) Infants born at 29 to 31 weeks, six days gestation and who are younger than six months of age at the start of the RSV season OR C) Infants born at 32 to 34 weeks, six days gestation and who are younger than three months of age at the start of RSV season with at least one of the following risk factors may be dosed until 90 days of age: Child care attendance or Sibling younger than five years of age living in the same household (who is not a multiple birth younger than one year of age) OR D) Infants and children younger than one year of age at the start of RSV season with either congenital abnormalities of the airway or neuromuscular disease that compromises handling of respiratory secretions OR E) Infants and children younger than two years of age with hemodynamically significant congenital heart disease and who have at least one of the following criteria: Receiving medication to control congestive heart failure, Has moderate to severe pulmonary hypertension, or Has cyanotic heart disease OR F) Infants and children younger than two years of age who have received medical therapy (oxygen, bronchodilator, diuretic, or corticosteroid therapy) for chronic lung disease within six months of the start of the RSV season

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve 5 doses based on patient body weight

SYNRIBO

PRODUCT(s) AFFECTED

- SYNRIBO INJ 3.5MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of chronic myelogenous leukemia AND patient has tried and failed or has a contraindication or intolerance to 2 tyrosine kinase inhibitors

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

TAFINLAR

PRODUCT(s) AFFECTED

- TAFINLAR CAP 50MG
- TAFINLAR CAP 75MG

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

A documented positive BRAF V600E or V600K mutation as detected by an FDA-approved test

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Tafinlar should not be used in patients with wild-type BRAF melanoma due to the potential risk of tumor promotion in these patients

TAGRISSO

PRODUCT(s) AFFECTED

- TAGRISSO TAB 40MG
- TAGRISSO TAB 80MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of metastatic, non-small cell lung cancer with confirmed presence of T790M EGFR tumor mutation by cobasÂ¿ EGFR Mutation Test v2

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

1 year

OTHER CRITERIA

None

TALTZ

PRODUCT(s) AFFECTED

- TALTZ AUTO INJ 80MG/ML TALTZ PREF INJ 80MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Failure, contraindication, or intolerance to either Enbrel (etanercept) or Humira (adalimumab), OR for continuation of prior Taltz therapy. Patient is not receiving Taltz in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Taltz in combination with a Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]. Patient is not receiving Taltz in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION

All indications (Initial, reauth): 12 months

OTHER CRITERIA

All indications (Reauth): Documentation of positive clinical response to Taltz therapy. Patient is not receiving Taltz in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Taltz in combination with a Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]. Patient is not receiving Taltz in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].

TARCEVA

PRODUCT(s) AFFECTED

- TARCEVA TAB 100MG
- TARCEVA TAB 150MG
- TARCEVA TAB 25MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

For the diagnosis of locally advanced, unresectable, or metastatic carcinoma of pancreas, Tarceva is used in combination with gemcitabine. For the diagnosis of locally advanced or metastatic non-small cell lung cancer, the patient has met one of the following: 1. The patient has failed one or more prior chemotherapy regimens, such as platinum based chemotherapy OR 2. The patient has an epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation which requires no prerequisite therapy.

TARGRETIN

PRODUCT(s) AFFECTED

- BEXAROTENE CAP 75MG
  TASIGNA CAP 150MG
  TARGRETIN GEL 1%
  TASIGNA CAP 200MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Definite diagnosis of cutaneous T-cell lymphoma (CTCL) AND refractory to any prior systemic therapy (such as methotrexate)

TAZORAC

PRODUCT(s) AFFECTED

- TAZORAC CRE 0.05%
  TAZORAC GEL 0.05%
  TAZORAC CRE 0.1%
  TAZORAC GEL 0.1%

COVERED USES

All FDA-approved indication not otherwise excluded from Part D.

EXCLUSION CRITERIA

Pregnancy.

REQUIRED MEDICAL INFORMATION

Diagnosis of acne vulgaris and patient has tried an adequate trial with at least one other topical acne product (e.g., benzoyl peroxide, salicylic acid, clindamycin, erythromycin, adapalene, azelaic acid, and/or tretinoin) OR Diagnosis of stable moderate to severe plaque psoriasis and 20% or less body surface area involvement and patient has a contraindication or tried adequate trial with at least one other topical psoriasis product (e.g., medium to high potency corticosteroid and/or vitamin D analogs) AND females of child-bearing potential are using adequate birth control measures during therapy.

AGE RESTRICTION

12 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

TECHNIVIE

PRODUCT(s) AFFECTED

- TECHNIVIE TAB

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

All of the following: A) Criteria will be applied consistent with current AASLD/IDSA guideline, AND B) Patient is not receiving Technivie in combination with another HCV direct acting antiviral agent [eg, Harvoni (ledipasvir-sofosbuvir), Sovaldi (sofosbuvir), Olysio (simeprevir)], AND C) ONE of the following: History of intolerance or contraindication to Harvoni and Zepatier therapy OR patient is currently on Technivie therapy.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine

COVERAGE DURATION

12 wks. Criteria will be applied consistent with current AASLD/IDSA guideline

OTHER CRITERIA

None

THALOMID

PRODUCT(s) AFFECTED

- THALOMID CAP 100MG
- THALOMID CAP 150MG
- THALOMID CAP 200MG
- THALOMID CAP 50MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist

COVERAGE DURATION

AS, ulcers-1 month. ENL, MM-End of year. WM, GVHD, primary brain tumor-6 months. Other uses-3 months

OTHER CRITERIA

None

TOPICAL RETINOID

PRODUCT(s) AFFECTED

- AVITA CRE 0.025%
  TRETINOIN CRE 0.025%
  TRETINOIN CRE 0.1%
  TRETINOIN GEL 0.025%
  TRETINOIN GEL 0.05%
  AVITA GEL 0.025%
  TRETINOIN CRE 0.05%
  TRETINOIN GEL 0.01%
  TRETINOIN GEL 0.04%
  TRETINOIN GEL 0.1%

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

One of the following: Acne: Diagnosis of acne. Actinic keratosis (off-label): Diagnosis of actinic keratosis. Alopecia areata (off-label): Diagnosis of alopecia areata. Hyperkeratosis (off-label): Diagnosis of hyperkeratosis. Keloid scar (off-label): Diagnosis of keloid scar. Systematized epidermal nevus (off-label): Diagnosis of systematized epidermal nevus.

AGE RESTRICTION

PA applies to members 26 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

TRELSTAR

PRODUCT(s) AFFECTED

- TRELSTAR MIX INJ 11.25MG
- TRELSTAR MIX INJ 22.5MG
- TRELSTAR MIX INJ 3.75MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of FDA approved indications not otherwise excluded from Part D AND palliative treatment of advanced prostate cancer, central precocious puberty, endometrial hyperplasia, endometriosis, fibrocystic disease of breast, uterine leiomyoma

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

TRETINOIN/CLINDAMYCIN

PRODUCT(s) AFFECTED

- VELTIN GEL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Acne: Diagnosis of acne.

AGE RESTRICTION

PA applies to members 26 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

TYKERB

PRODUCT(s) AFFECTED

- TYKERB TAB 250MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Coverage is provided in combination with capecitabine, for the treatment of patients with advanced or metastatic breast cancer whose tumors overexpress HER2 and who have received prior therapy including an anthracycline, a taxane, and trastuzumab OR in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.

TYSABRI

PRODUCT(s) AFFECTED

- TYSABRI INJ 300/15ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

MULTIPLE SCLEROSIS:12 MONTHS. CROHN'S DISEASE: 6 MONTHS. RENEWAL: CROHN'S: 12 MONTHS.

OTHER CRITERIA

MULTIPLE SCLEROSIS: TRIAL OF AN INTERFERON OR COPAXONE. CROHN'S DISEASE: TRIAL OF A TNF-ALPHA INHIBITOR. RENEWAL: CROHN'S: PATIENT IS NOT ON CONCOMITANT CORTICOSTEROID TREATMENT AFTER 6 MONTHS ON NATALIZUMAB, OR HAS NOT RECEIVED MORE THAN 3 MONTHS OF A CORTICOSTEROID WITHIN THE PAST 12 MONTHS.

TYVASO

PRODUCT(s) AFFECTED

- TYVASO SOL 0.6MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.

COVERAGE DURATION

PAH: Initial: 6 months. Reauth: 12 months.

OTHER CRITERIA

Subject to Part B vs D review. PAH (Reauth): Documentation of positive clinical response to therapy.

UPTRAVI

PRODUCT(s) AFFECTED

- UPTRAVI TAB 1000MCG
  UPTRAVI TAB 1200MCG
  UPTRAVI TAB 1400MCG
  UPTRAVI TAB 1600MCG
  UPTRAVI TAB 200/800
  UPTRAVI TAB 200MCG
  UPTRAVI TAB 400MCG
  UPTRAVI TAB 600MCG
  UPTRAVI TAB 800MCG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization AND Patient has tried and had an insufficient response to at least one other PAH agent (e.g., sildenafil) therapy.

AGE RESTRICTION

18 years of age and older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

VALCHLOR

PRODUCT(s) AFFECTED

- VALCHLOR GEL 0.016%

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of mycosis fungoides-type cutaneous T-cell lymphoma AND patient has early stage disease (defined as Stage 1A or 1B) AND patient has received prior skin-directed therapy (e.g., very high potency class I topical corticosteroids for at least 3 months (i.e. clobetasol, diflorasone, halobetasol, augmented betamethasone diproprionate), phototherapy, topical nitrogen mustard, or a topical retinoid (e.g., bexarotene)).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

VARIZIG

PRODUCT(s) AFFECTED

- VARIZIG INJ 125UNIT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Presence of contraindications to immune globulin therapy (i.e., IgA deficiency with antibodies to IgA and a history of hypersensitivity or product specific contraindication).

REQUIRED MEDICAL INFORMATION

Immune globulin is being used intramuscularly. The immune globulin is being used for passive immunization or post exposure-prophylaxis of varicella. Patient is considered a high risk individual (i.e., immune compromised, pregnant woman, newborn of mother with varicella, premature infant, and infant less than 1 year old).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

3 months (approve one dose only)

OTHER CRITERIA

None

VELCADE

PRODUCT(s) AFFECTED

- VELCADE INJ 3.5MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma and at least 1 prior therapy

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist or hematologist

COVERAGE DURATION

12 months

OTHER CRITERIA

All uses: for continuation of therapy

VENCLEXTA

PRODUCT(s) AFFECTED

- VENCLEXTA TAB 100MG
  VENCLEXTA TAB 10MG
  VENCLEXTA TAB 50MG
  VENCLEXTA TAB START PK

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Treatment of chronic lymphocytic leukemia (CLL) for patients with 17p deletion (as detected by an approved test) and have had at least 1 prior therapy

AGE RESTRICTION

18 years and older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

VENTAVIS

PRODUCT(s) AFFECTED

- VENTAVIS SOL 10MCG/ML
- VENTAVIS SOL 20MCG/ML

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Congestive heart failure due to severe left ventricular systolic dysfunction.

REQUIRED MEDICAL INFORMATION

Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH AND Patient has New York Heart Association (NYHA) Functional Class III or IV.

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial - 6 months. Renewal - 12 months

OTHER CRITERIA

Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

VIEKIRA

PRODUCT(s) AFFECTED

- VIEKIRA PAK TAB

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

All of the following: A) Criteria will be applied consistent with current AASLD/IDSA guideline AND B) ONE of the following: 1) Patient has a contraindication or intolerance to Harvoni and Zepatier OR 2) For continuation of prior Viekira therapy AND C) Patient is not receiving Viekira Pak in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir-sofosbuvir), Sovaldi (sofosbuvir), Olysio (simeprevir)], AND D) Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C), AND E) ONE of the following: 1) Patient has not experienced prior failure with an NS5A inhibitor or NS3/4A protease inhibitor-containing regimen OR 2) patient has failed prior therapy with an NS5A inhibitor or NS3/4A protease inhibitor AND submission of medical records documenting that the patient does not have NS3 protease inhibitor or NS5A inhibitor resistance-associated variants detected using commercially available assays.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine

COVERAGE DURATION

12 to 24 wks. Criteria will be applied consistent with current AASLD/IDSA guideline

OTHER CRITERIA

None

VIVITROL

PRODUCT(s) AFFECTED

- VIVITROL INJ 380MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Alcohol dependence (init): History of alcohol dependence and confirmed abstinence at treatment initiation.
Opioid dependence (init): History of opioid dependence and confirmed opioid detoxification at treatment initiation.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Alcohol dependence, opioid dependence (init, reauth): 24 weeks

OTHER CRITERIA

Alcohol dependence, opioid dependence (reauth): Confirmation of clinical benefit to the patient.

VOTRIENT

PRODUCT(s) AFFECTED

- VOTRIENT TAB 200MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

VPRIV

PRODUCT(s) AFFECTED

- VPRIV INJ 400UNIT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Gaucher disease: Diagnosis of type 1 Gaucher disease. Patient has evidence of symptomatic disease (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Gaucher disease: 12 months

OTHER CRITERIA

None

XALKORI

PRODUCT(s) AFFECTED

- XALKORI CAP 200MG
- XALKORI CAP 250MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

None

XELJANZ

PRODUCT(s) AFFECTED

- XELJANZ XR TAB 11MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-IV-TR 300.29 for specific phobia diagnostic criteria), OR for continuation of prior tofacitinib therapy. Patient is not receiving tofacitinib in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving tofacitinib in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

RA (Initial): Prescribed by or in consultation with a rheumatologist

COVERAGE DURATION

RA (initial, reauth): 12 months

OTHER CRITERIA

RA (Reauth): Documentation of positive clinical response to tofacitinib therapy. Patient is not receiving tofacitinib in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving tofacitinib in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine).

XENAZINE

PRODUCT(s) AFFECTED

- TETRABENAZIN TAB 12.5MG TETRABENAZIN TAB 25MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Actively suicidal. Untreated or inadequately treated depression. Impaired hepatic function. Concomitant use of monoamine oxidase inhibitors. Concomitant use of reserpine or within 20 days of discontinuing reserpine.

REQUIRED MEDICAL INFORMATION

Diagnosis of chorea associated with Huntington's disease AND any medication possibly contributing to the underlying symptoms of chorea has been discontinued (e.g., antipsychotics, metoclopramide, amphetamines, methylphenidate, dopamine agonists, etc.) unless cessation would be detrimental to the underlying condition AND patient has been genotypes to CYP2D6 to determine whether the patient is a poor, intermediate or extensive metabolizer.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

Dosing will be approved per the FDA labeling based on CYP2D6 testing. For renewal, patient had an objective response to therapy.

XEOMIN

PRODUCT(s) AFFECTED

- XEOMIN INJ 50 UNIT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Cervical Dystonia (CD) (init): Diagnosis of CD (also known as spasmodic torticollis). Blepharospasm (initial): Diagnosis of blepharospasm. History of previous use of Botox (onabotulinumtoxinA) for the treatment of blepharospasm. Upper limb spasticity (ULS) (init): Diagnosis of upper limb spasticity.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

All indications (init, reauth): 3 months (for 1 dose)

OTHER CRITERIA

All indications (reauth): Confirmed improvement in symptoms with initial Xeomin treatment. At least 3 months have elapsed since the last treatment with Xeomin

XGEVA

PRODUCT(s) AFFECTED

- XGEVA INJ

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

DIAGNOSIS OF MULTIPLE MYELOMA

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

XIFAXAN

PRODUCT(s) AFFECTED

- XIFAXAN TAB 200MG
- XIFAXAN TAB 550MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Travelers' diarrhea (TD) (200 mg strength only): Diagnosis of travelers' diarrhea, AND one of the following: a) History of failure, contraindication, or intolerance to one of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin) OR b) resistance to all of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin). Prophylaxis of hepatic encephalopathy (HE) recurrence (550mg strength only): Used for the prophylaxis of hepatic encephalopathy recurrence, AND failure, contraindication or intolerance to lactulose. Irritable bowel syndrome with diarrhea (IBS-D) (550mg strength only) (initial): Diagnosis of IBS-D, AND history of failure, contraindication or intolerance to an antidiarrheal agent [eg, loperamide].

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

TD: One time only. HE: 6 months. IBS-D (initial, reauth): 2 weeks.

OTHER CRITERIA

IBS-D (reauth): Patient experiences IBS-D symptom recurrence AND patient has not already received 3 treatment courses of Xifaxan for IBS-D in their lifetime.

XOLAIR

PRODUCT(s) AFFECTED

- XOLAIR SOL 150MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Documentation of the following: A)moderate to severe chronic idiopathic urticaria and has remained symptomatic despite at least 2 weeks of H1 antihistamine therapy OR intolerance or contraindication of H1 antihistamine therapy OR B)Mod-severe persistent asthma (NHLBI definition) meeting all the following criteria: Evidence of reversible disease (12% or greater improvement in FEV1 with at least a 200ml increase or 20% or greater improvement in PEF as a result of a short-acting bronchodilator challenge). Evidence of specific allergic sensitivity to a perennial aeroallergen (+ skin test or in vitro test). Failure of an adequate trial of standard therapy as defined by a trial of at least a 3 month course of high-dose inhaled corticosteroids and long-acting beta2-agonists OR maximally tolerated doses of standard therapy OR intolerance or contraindication to standard therapy. Extended approval for 6 mo's if demonstrated benefit, meeting at least 2 of the following criteria: PEF improvement (12% or greater from baseline (prior to start of Xolair)), OR FEV1 improvement (12% or greater from baseline (prior to start of Xolair)), OR reduction in symptoms (wheezing, sob, cough, chest tightness), OR reduction in systemic corticosteroids and rescue drug use, OR reduction of asthma-related hospitalizations and other medical contacts.

AGE RESTRICTION

6 years of age or older

PRESCRIBER RESTRICTION

Allergist, immunologist, pulmonologist or dermatologist

COVERAGE DURATION

Initial: 6 months trial. Extended approval: 6 months if demonstrated benefit

OTHER CRITERIA

If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

XTANDI

PRODUCT(s) AFFECTED

- XTANDI CAP 40MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of metastatic castration-resistant prostate cancer \AND the patient has tried and had an inadequate response, contraindication or intolerance to Zytiga.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

XYREM

PRODUCT(s) AFFECTED

- XYREM SOL 500MG/ML

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Concomitant treatment with sedative hypnotic agents. Succinic semialdehyde dehydrogenase deficiency.

REQUIRED MEDICAL INFORMATION

Diagnosis of narcolepsy with excessive daytime sleepiness, cataplexy or both and for patients with excessive daytime sleepiness, patient has had a previous trial with or has a contraindication, intolerance, or allergy to Provigil or Nuvigil.

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

For renewal, the patient had a positive response to the medication (increased sleep quality for patients with narcolepsy)

YERVOY

PRODUCT(s) AFFECTED

- YERVOY INJ 50MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ZALTRAP

PRODUCT(s) AFFECTED

- ZALTRAP INJ 100/4ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Colon and/or rectal cancer: Diagnosis of metastatic colon and/or rectal cancer. Ziv-aflibercept is being used in combination with 5-fluorouracil, leucovorin, and irinotecan (FOLFIRI) regimen. Patient has disease that is resistant to or has progressed following an oxaliplatin-containing regimen [e.g., 5-fluorouracil, leucovorin, and oxaliplatin (FOLFOX)].

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Subject to Part B vs. Part D review. Approve for continuation of prior therapy.

ZARXIO

PRODUCT(s) AFFECTED

- ZARXIO INJ 300/0.5
- ZARXIO INJ 480/0.8

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Bone marrow/stem cell transplant (BMSCT): One of the following: 1) patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT, OR 2) for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis, OR 3) for peripheral stem cell transplant (PSCT) patients who have received myeloablative chemotherapy. Acute myeloid leukemia (AML): patients with AML following induction or consolidation chemotherapy, AND age greater than or equal to 55 years. Primary prophylaxis of chemotherapy-induced febrile neutropenia (CFN): One of the following: 1) patient is receiving chemotherapy regimens associated with a greater than 20% incidence of FN, OR 2) both of the following: a) patient receiving chemotherapy regimen associated with 10-20% incidence of FN, AND b) one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia. Secondary prophylaxis of FN: Both of the following: 1) patients receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm^3), AND 2) patients with a history of FN during a previous course of chemotherapy. Neutropenia associated with dose-dense chemotherapy (NDDC): One of the following: 1) Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, OR 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown. Treatment of FN (off-label): Both of the following: 1) patients receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm^3), AND 2) patients with FN at high risk for infection-associated complications.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by hematologist/oncologist except HIVN: Prescribed by hematologist/oncologist or infectious disease specialist

COVERAGE DURATION

BMSCT, AML, CFN, secondary prophy of FN, NDDC:3mo or duration of tx. HIVN:6mo. Tx of FN, ARS:1 mo.

OTHER CRITERIA

HIV-related neutropenia (HIVN)(off-label): Patients infected with HIV, and ANC less than or equal to 1000 (cells/mm^3).

ZAVESCA

PRODUCT(s) AFFECTED

- ZAVESCA CAP 100MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Supporting statement of diagnosis from the physician

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ZELBORAF

PRODUCT(s) AFFECTED

- ZELBORAF TAB 240MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ZEPATIER

PRODUCT(s) AFFECTED

- ZEPATIER TAB 50-100MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

All of the following: A) Criteria will be applied consistent with current AASLD/IDSA guideline AND B) Patient is not receiving Zepatier in combination with another HCV direct acting antiviral agent, AND D) patient does not have moderate to severe hepatic impairment (eg, Child-Pugh Class B or C), AND E) For genotype 1a, patient has been tested for the presence of NS5A resistance-associated polymorphisms (ie, polymorphisms at amino acid positions 28, 30, 31, or 93).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine

COVERAGE DURATION

12 to 16 wks. Criteria will be applied consistent with current AASLD/IDSA guideline

OTHER CRITERIA

None

ZOLINZA

PRODUCT(s) AFFECTED

- ZOLINZA CAP 100MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

None

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ZORBTIVE

PRODUCT(s) AFFECTED

- ZORBTIVE INJ 8.8MG

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Short Bowel Syndrome (SBS): Diagnosis of SBS. Patient is currently receiving specialized nutritional support (eg, intravenous parenteral nutrition, fluid, and micronutrient supplements). Patient has not previously received 4 weeks of treatment with Zorbtive.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

Prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION

SBS: 4 weeks.

OTHER CRITERIA

None

ZORTRESS

PRODUCT(s) AFFECTED

- ZORTRESS TAB 0.5MG
- ZORTRESS TAB 0.75MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Medication is being used for: A) Prevention of kidney transplant organ rejection AND patient is at low-to-moderate immunologic risk AND member is prescribed concurrent therapy with reduced doses of cyclosporine and corticosteroids, or B) Prevention of liver transplant organ rejection AND 30 or more days have passed since the transplant procedure AND the member is prescribed concurrent therapy with reduced doses of tacrolimus and corticosteroids

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

Prescriber is experienced in immunosuppressive therapy and management of transplant patients.

COVERAGE DURATION

12 months

OTHER CRITERIA

Part B if transplant covered by Medicare. otherwise Part D

ZUBSOLV

PRODUCT(s) AFFECTED

- ZUBSOLV SUB 1.4-0.36
  ZUBSOLV SUB 2.9-0.71
  ZUBSOLV SUB 8.6-2.1
  ZUBSOLV SUB 11.4-2.9
  ZUBSOLV SUB 5.7-1.4

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Opioid Dependence (initial): Diagnosis of opioid dependence AND Prescriber is certified through SAMHSA (Substance Abuse and Mental Health Services Administration) and provides registration number AND Patient is not receiving any other opioids since starting therapy, as verified in prescription claims history AND History of failure with Suboxone

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

Initial: 3 months. Renewal: 9 months.

OTHER CRITERIA

None

ZYDELIG

PRODUCT(s) AFFECTED

- ZYDELIG TAB 100MG
- ZYDELIG TAB 150MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

The patient has one of the following diagnoses: A) chronic lymphocytic leukemia AND The medication will be used in combination with rituximab AND The patient has relapsed on at least one prior therapy (e.g., purine analogues [fludarabine, pentostatin, cladribine], alkylating agents [chlorambucil, cyclophosphamide], or monoclonal antibodies [rituximab]) AND the patient does not have any co-morbidities that prevents the use of cytotoxic chemotherapy (i.e. severe neutropenia or thrombocytopenia, creatinine clearance less than 60 mL/minute), B) follicular lymphoma AND the patient has relapsed on at least two prior systemic therapies (e.g., rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine]), or C) small lymphocytic lymphoma AND The patient has relapsed on at least two prior systemic therapies(e.g., rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine]).

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ZYKADIA

PRODUCT(s) AFFECTED

- ZYKADIA CAP 150MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of metastatic non-small cell lung cancer AND patient has anaplastic lymphoma kinase (ALK)-positive disease as detected by an FDA-approved or Clinical Laboratory Improvement Amendments (CLIA)-approved facility AND patient had an inadequate response, progressed on, or had an intolerance or contraindication to Xalkori

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None

ZYTIGA

PRODUCT(s) AFFECTED

- ZYTIGA TAB 250MG

COVERED USES

All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

None

REQUIRED MEDICAL INFORMATION

Diagnosis of metastatic prostate cancer AND Patient has castration-resistant disease (defined by tumor growth/disease progression, risk in PsA levels, new metastases) AND Zytiga will be used in combination with prednisone.

AGE RESTRICTION

None

PRESCRIBER RESTRICTION

None

COVERAGE DURATION

12 months

OTHER CRITERIA

None