



## **PA Criteria**

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| <b>Prior Authorization Group</b>    | ACTEMRA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                   | ACTEMRA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>           | Active infection (including TB), Concurrent therapy with other biologic agent(s).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b> | Screening for latent tuberculosis is required. If results are positive, patient must have completed treatment or must currently be receiving treatment for latent tuberculosis. For those at risk for Hepatitis B (HBV) infection, HBV has been ruled out or treatment has been initiated. For RA, must have an inadequate response or intolerance/contraindication to Enbrel or Humira (step applies to new starts only). For sJIA, pediatric patients must have active systemic features (e.g., fever) AND inadequate response, contraindication or intolerance to corticosteroids. |

### **Age Restrictions**

### **Prescriber Restrictions**

### **Coverage Duration**

### **Other Criteria**

Plan Year

For renewals, patient must have responded to Actemra therapy (e.g., condition improved or stabilized).

### **Prior Authorization Group**

### **Drug Names**

### **Covered Uses**

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restrictions**

### **Prescriber Restrictions**

### **Coverage Duration**

### **Other Criteria**

ACTIMMUNE

ACTIMMUNE

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

Plan Year

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

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| <b>Prior Authorization Group</b>    | ADCIRCA                                                                                                   |
| <b>Drug Names</b>                   | ADCIRCA                                                                                                   |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                          |
| <b>Exclusion Criteria</b>           | Patient requires nitrate therapy on a regular or intermittent basis.                                      |
| <b>Required Medical Information</b> | NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. |
| <b>Age Restrictions</b>             |                                                                                                           |
| <b>Prescriber Restrictions</b>      |                                                                                                           |
| <b>Coverage Duration</b>            | Plan Year                                                                                                 |
| <b>Other Criteria</b>               |                                                                                                           |

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| <b>Prior Authorization Group</b>    | ALPHA1-PROTEINASE INHIBITOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                   | ARALAST NP, GLASSIA, PROLASTIN-C, ZEMAIRA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>           | Immunoglobulin A (IgA) deficiency with antibodies against IgA.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b> | Patient has a congenital deficiency of alpha1-proteinase inhibitor (alpha1-PI) with clinically evident emphysema. Patients initiating therapy for the first time must meet the following criteria: 1) Alpha1-PI concentration is less than 11 micromoles per liter. 2) The FEV1 level is between 35% and 65% predicted OR greater than 65% predicted. 3) If the FEV1 is greater than 65% predicted, then the patient has experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment. |
| <b>Age Restrictions</b>             | 18 years of age and older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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| <b>Prior Authorization Group</b>    | AMPYRA                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                   | AMPYRA                                                                                                                                                                                                                                                                                                                                                       |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>           | History of seizures. Creatinine clearance less than or equal to 50 mL/min.                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b> |                                                                                                                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>            | Initial: 2 months, renewal: plan year                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>               | Prior to initiating therapy, patient must demonstrate sustained walking impairment but with the ability to walk 25 feet (with or without assistance). For continuation of therapy, patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting Ampyra. Dose does not exceed 10mg twice daily. |

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| <b>Prior Authorization Group</b>    | ANABOLIC STEROIDS                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                   | OXANDROLONE                                                                                                                                                                                                                                                                   |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, HIV-wasting.                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>           | A. Known or suspected nephrosis (the nephrotic phase of nephritis). B. Known or suspected hypercalcemia. C. Known or suspected carcinoma of the breast in women with hypercalcemia. D. Known or suspected carcinoma of the prostate or breast in male patients. E. Pregnancy. |
| <b>Required Medical Information</b> | A. Patient will be monitored for peliosis hepatitis and liver cell tumors. B. If patient has unfavorable blood lipids, therapy will be adjusted.                                                                                                                              |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>            | 6 months                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                               |

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| <b>Prior Authorization Group</b>    | ANAGRELIDE                                                                             |
| <b>Drug Names</b>                   | ANAGRELIDE HYDROCHLORIDE                                                               |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                       |
| <b>Exclusion Criteria</b>           | Severe hepatic impairment.                                                             |
| <b>Required Medical Information</b> | Patient has a diagnosis of thrombocythemia secondary to a myeloproliferative disorder. |
| <b>Age Restrictions</b>             |                                                                                        |
| <b>Prescriber Restrictions</b>      | Oncologist or hematologist                                                             |
| <b>Coverage Duration</b>            | 6 months                                                                               |
| <b>Other Criteria</b>               |                                                                                        |

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|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>    | ARANESP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                   | ARANESP ALBUMIN FREE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, myelodysplastic syndromes (MDS).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>           | Uncontrolled hypertension. Patients receiving chemotherapy with curative intent. Cancer patients not receiving concomitant myelosuppressive chemotherapy. Patients with myeloid cancer.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b> | For all uses: 1) pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, 2) for reauthorizations (patient received erythropoietin in previous month), an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. Additional requirements for cancer: 1) for initial therapy, at least 2 more months of chemotherapy is expected, 2) for reauthorizations, a) current Hgb is less than 10 g/dL, OR b) Hgb is greater than or equal to 10 but less than 11 g/dL AND patient is symptomatic. Additional requirements for CKD: 1) for CKD not on dialysis reauthorization, a) current Hgb is less than or equal to 10 g/dL, OR b) Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose, 2) for CKD on dialysis reauthorization, a) current Hgb is less than or equal to 11 g/dL, OR b) Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) symptomatic anemia, 2) pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, 3) for reauthorizations, a) current Hgb is less than or equal to 11 g/dL, OR b) Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. For all uses except MDS: 1) documentation of adequate iron stores, OR 2) patient is receiving supplemental iron. Adequate iron stores: serum ferritin is at least 100 ng/mL or transferrin saturation is at least 20%. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>            | 12 weeks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>               | Patients will be monitored for thrombotic and cardiac events. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (eg, used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

**Prior Authorization Group** ARCALYST  
**Drug Names** ARCALYST  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** Active or chronic infection, concurrent therapy with other biologics.  
**Required Medical Information** Patient has a diagnosis of cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS).  
**Age Restrictions** 12 years of age and older  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria** For renewal, patient's condition must have improved or stabilized.

**Prior Authorization Group** AVONEX  
**Drug Names** AVONEX  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** Concurrent use of any of the following medications: interferon-beta therapy (Betaseron, Extavia, or Rebif), Copaxone or mitoxantrone.  
**Required Medical Information** Have a relapsing form of MS (eg. relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease).  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria**

**Prior Authorization Group**  
**Drug Names**

B VS. D

ABELCET, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMIFOSTINE, AMINOSYN, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 8.5%/ELECTROL, AMINOSYN M, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-PF 7%, AMPHOTERICIN B, ASTRAMORPH, AVASTIN, AZATHIOPRINE, AZATHIOPRINE SODIUM, BICNU, BLEOMYCIN SULFATE, BONIVA, BUDESONIDE, BUSULFEX, CALCITRIOL, CAMPATH, CARBOPLATIN, CELLCEPT, CISPLATIN, CLADRIBINE, CLINIMIX 2.75%/DEXTROSE 5, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 2, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 5%/DEXTROSE 25%, CLINIMIX E 2.75%/DEXTROSE, CLINIMIX E 4.25%/DEXTROSE, CLINIMIX E 5%/DEXTROSE 15, CLINIMIX E 5%/DEXTROSE 20, CLINIMIX E 5%/DEXTROSE 25, CLINISOL SF 15%, COSMEGEN, CROMOLYN SODIUM, CUBICIN, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE, CYTARABINE AQUEOUS, DACARBAZINE, DAUNORUBICIN HCL, DECAVAC, DEPO-PROVERA, DEXRAZOXANE, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXIL, DOXORUBICIN HCL, DRONABINOL, DURAMORPH, ELITEK, ELSPAR, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FLUDARABINE PHOSPHATE, FLUOROURACIL, FREAMINE III, FREAMINE III 3%, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HEPATASOL, HERCEPTIN, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, IBANDRONATE SODIUM, IDARUBICIN HCL, IFEX, IFOSFAMIDE, INTRALIPID, INTRON-A, INTRON-A W/DILUENT, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTODAX, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVOCARNITINE, LIDOCAINE/PRILOCAINE, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE SODIUM, MITOMYCIN, MITOXANTRONE HCL, MORPHINE SULFATE, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYFORTIC, NEBUPENT, NEORAL, NEPHRAMINE, NULOJIX, ONDANSETRON HCL, ONDANSETRON ODT, ONTAK, OXALIPLATIN, PACLITAXEL, PENTOSTATIN, PERFOROMIST, PREMASOL, PROCALAMINE, PROGRAF, PROLEUKIN, PROSOL, PULMICORT, PULMOZYME, RAPAMUNE, RECOMBIVAX HB, REMODULIN, SANDIMMUNE, TACROLIMUS, TAXOTERE, TETANUS TOXOID ADSORBED, TETANUS/DIPHTHERIA TOXOID, TOBI, TOPOSAR, TOPOTECAN HCL, TPN ELECTROLYTES, TRAVASOL, TREANDA, TRISENOX, TROPHAMINE, TWINRIX, VANCOMYCIN HCL, VELCADE, VIDAZA, VINBLASTINE SULFATE, VINCASAR PFS, VINCRISTINE SULFATE, VINOURELBINE TARTRATE, ZEMPLAR, ZOMETA, ZORTRESS

**Covered Uses**

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

**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration**  
**Other Criteria**

NA

**Prior Authorization Group**  
**Drug Names**  
**Covered Uses**  
**Exclusion Criteria**  
**Required Medical Information**

BENZODIAZEPINES  
CLORAZEPATE DIPOTASSIUM, DIAZEPAM, DIAZEPAM INTENSOL  
All FDA-approved indications not otherwise excluded from Part D.

A. If for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the patient has experienced an inadequate treatment response to lorazepam AND B. If the patient is 65 years of age or older, the benefit of therapy with the prescribed medication outweighs the potential risk.

**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration**

Alcohol Withdrwl-1mo, Anxiety-3mo, Muscle Spasms-reflex 6mo,motor neuron disorder-Seizures-Plan Year

**Other Criteria**

**Prior Authorization Group**  
**Drug Names**  
**Covered Uses**  
**Exclusion Criteria**

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

Concurrent use of any of the following medications: interferon-beta therapy (Avonex, Betaseron, Extavia, or Rebif), Copaxone or mitoxantrone.

**Required Medical Information**

Have a relapsing form of MS (eg. relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease).

**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration**  
**Other Criteria**

Plan Year

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|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>    | BOSULIF                                                                                                                                                                                                               |
| <b>Drug Names</b>                   | BOSULIF                                                                                                                                                                                                               |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                      |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                       |
| <b>Required Medical Information</b> | Patient must have a diagnosis of CML confirmed by detection of the Philadelphia chromosome and/or BCR-ABL gene AND experienced resistance or intolerance to prior therapy including imatinib, nilotinib or dasatinib. |
| <b>Age Restrictions</b>             | 18 years of age or older                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                             |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                       |

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| <b>Prior Authorization Group</b>    | BUPRENORPHINE                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                   | BUPRENORPHINE HCL, SUBOXONE                                                                                                                                                                                                                                                                                                       |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b> | A. If the patient has been receiving Suboxone or Subutex (buprenorphine) there is documentation that the patient is not receiving other opioids and B. the patient will be monitored periodically (e.g., random urine drug screen, assessment of patient's progress (e.g., relapse, progress/accomplishment of treatment goals)). |
| <b>Age Restrictions</b>             | 16 years of age or older.                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>      | A. Prescribers must be certified through CSAT (The Center for Substance Abuse Treatment) of SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Suboxone and Subutex (buprenorphine)                                                                                                                  |
| <b>Coverage Duration</b>            | Buprenorphine - one month (Plan Year if pregnant). Buprenorphine-naloxone - Plan Year.                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>               | A. Buprenorphine and buprenorphine-naloxone should be part of an overall treatment program                                                                                                                                                                                                                                        |



**Prior Authorization Group** BYETTA  
**Drug Names** BYETTA  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** History of pancreatitis.  
**Required Medical Information** A. The patient is diagnosed as having type-2 diabetes with an HbA1c level greater than 7. B. The patient has a creatinine clearance of greater than 30mL/minute or normal kidney function. C. The patient demonstrated an inadequate treatment response, intolerance or contraindication to metformin or a sulfonylurea or a TZD. D. If the patient has received previous Byetta therapy for at least 3 months, the patient demonstrated an expected reduction in HbA1c since starting Byetta therapy.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

**Prior Authorization Group** CAPRELSA  
**Drug Names** CAPRELSA  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** Long QT syndrome.  
**Required Medical Information** Symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria** Hypocalcemia, hypokalemia, or hypomagnesemia must be corrected prior to Caprelsa administration. ECG should be obtained to monitor the QT at baseline, then 2 to 4 weeks after starting treatment or dose reduction/interruption, then 8 to 12 weeks after starting treatment or dose reduction/interruption, then every 3 months thereafter. ECG must be monitored more frequently if patient is receiving any drugs known to prolong the QT interval (e.g., anti-arrhythmic drugs, chloroquine, clarithromycin, dolasetron, granisetron, haloperidol, methadone, moxifloxacin, pimozide.)

**Prior Authorization Group** CAYSTON  
**Drug Names** CAYSTON  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information** Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing. Confirmation of Pseudomonas aeruginosa in cultures of the airways. For continuation of therapy, patient's lung function has not worsened while on Cayston (defined as a decreased in pulmonary function tests by more than 10%) OR there is a clinical reason to continue therapy (e.g., symptomatic improvement, decrease in the number of pulmonary infections and/or exacerbations).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

**Prior Authorization Group** CELEBREX  
**Drug Names** CELEBREX  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** Patient is being treated for post-operative pain following CABG surgery.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** 1 mo-acute pain, 6 mo-JRA, PlanYr-dysmenorrhea, OA, inflammatory arthritis.

**Other Criteria**

**Prior Authorization Group** CHANTIX  
**Drug Names** CHANTIX, CHANTIX STARTING MONTH PA  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

**Required Medical Information** A. Patient will be observed for neuropsychiatric symptoms (e.g., changes in behavior, hostility, agitation, depressed mood, and suicide related events, including ideation, behavior, and attempted suicide) while taking Chantix. B. If the patient is currently taking Chantix, the patient's treatment, including the use of Chantix, has resulted in smoking cessation.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** 12 weeks initial, 12 weeks additional upon renewal

**Other Criteria** If patient is currently taking branded Zyban, branded Zyban will be discontinued while patient is taking Chantix.

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| <b>Prior Authorization Group</b>    | COMETRIQ                                                                                  |
| <b>Drug Names</b>                   | COMETRIQ                                                                                  |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                          |
| <b>Exclusion Criteria</b>           | Severe hemorrhage                                                                         |
| <b>Required Medical Information</b> |                                                                                           |
| <b>Age Restrictions</b>             |                                                                                           |
| <b>Prescriber Restrictions</b>      |                                                                                           |
| <b>Coverage Duration</b>            | Plan Year                                                                                 |
| <b>Other Criteria</b>               | Therapy will be discontinued if gastrointestinal perforation or fistula formation occurs. |

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| <b>Prior Authorization Group</b>    | COPAXONE                                                                                                                                                                        |
| <b>Drug Names</b>                   | COPAXONE                                                                                                                                                                        |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                |
| <b>Exclusion Criteria</b>           | Concurrent use of any of the following medications: interferon-beta therapy (Avonex, Betaseron, Extavia, or Rebif) or mitoxantrone.                                             |
| <b>Required Medical Information</b> | Have relapsing-remitting MS OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease). |
| <b>Age Restrictions</b>             |                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                 |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                       |
| <b>Other Criteria</b>               |                                                                                                                                                                                 |

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| <b>Prior Authorization Group</b>    | EMSAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                   | EMSAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>           | A. Pheochromocytoma, B. Concurrent use of the following medications: dextromethorphan or St. John's Wort.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b> | A. Clinical diagnosis of major depressive disorder AND B. Patient not responsive to at least two (2) of the following antidepressants with documented trials of clinically sufficient doses and duration of six weeks each or longer: selective serotonin reuptake inhibitors (SSRI), serotonin/norepinephrine reuptake inhibitors (SNRI), bupropion, mirtazapine, or tricyclic/tetracyclic antidepressants. OR C. Clinical diagnosis of major depressive disorder for those patients who are unable to take any oral preparations (including commercially available liquid antidepressants). D. For requests over 6 mg/24 hours, patient must agree to adhere to a tyramine restrictive diet. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>      | Psychiatrist or receiving input from a psychiatry practice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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| <b>Prior Authorization Group</b>    | ENBREL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                   | ENBREL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>           | Active infection (including TB). Combination therapy with other biologic agent(s).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b> | Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to Enbrel request. For positive latent TB, patient must have completed or receiving treatment for LTBI prior to initiating Enbrel. For those at risk for Hepatitis B (HBV) infection, HBV has been ruled out or treatment has been initiated. For rheumatoid arthritis (RA) patient must meet one of the following criteria: 1) Inadequate response to methotrexate (MTX) OR 2) Inadequate response to another nonbiologic DMARD such as leflunomide, hydroxychloroquine, sulfasalazine if contraindicated or intolerant to MTX OR 3) Intolerance or contraindication to at least 2 nonbiologic DMARDs OR 4) Enbrel will be used as first-line therapy with MTX for severely active RA. For juvenile idiopathic arthritis, patient does not have fever or elevated inflammatory markers AND must meet one of the following criteria: 1) Patient had an inadequate response to prior tumor necrosis factor (TNF) inhibitor OR 2) Inadequate response, contraindication, or intolerance to MTX. For ankylosing spondylitis, patient had an inadequate response, contraindication or intolerance to at least 2 NSAIDs. For plaque psoriasis, patient meets BOTH of the following: 1) Has at least 5% of BSA affected or has crucial body areas (e.g., feet, hands, face, neck and/or groin) affected AND 2) Inadequate response to either phototherapy or a conventional systemic therapy, unless contraindicated or intolerant to such therapies. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>               | For renewal, patient's condition must have improved or stabilized.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

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| <b>Prior Authorization Group</b>    | EPLERENONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                   | EPLERENONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b> | A. Diagnosis of hypertension or post-myocardial infarction with LVEF less than or equal to 40% and clinical evidence of CHF after an acute MI. AND B. A serum potassium level of 5.5 mEq/L or less. C. For diagnosis of post MI with LVEF less than or equal to 40% and clinical evidence of CHF after an acute MI, the patient must meet the following requirement: creatinine clearance greater than 30 mL/min. D. For the diagnosis of hypertension, the patient must meet the following requirements: the patient does not have type-2 diabetes with microalbuminuria AND the patient has a creatinine clearance greater than 50 mL/min. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

EPO

PROCRIT

All FDA-approved indications not otherwise excluded from Part D, myelodysplastic syndromes (MDS).

Uncontrolled hypertension. Patients receiving chemotherapy with curative intent. Cancer patients not receiving concomitant myelosuppressive chemotherapy. Patients with myeloid cancer. Use to facilitate preoperative autologous blood donation.

For all uses except surgery: 1) pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, 2) for reauthorizations (patient received erythropoietin in previous month), an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. Additional requirements for cancer: 1) for initial therapy, at least 2 more months of chemotherapy is expected, 2) for reauthorizations, a) current Hgb is less than 10 g/dL, OR b) Hgb is greater than or equal to 10 but less than 11 g/dL AND patient is symptomatic. Additional requirements for CKD: 1) for CKD not on dialysis reauthorization, a) current Hgb is less than or equal to 10 g/dL, OR b) Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose, 2) for CKD on dialysis reauthorization, a) current Hgb is less than or equal to 11 g/dL, OR b) Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) symptomatic anemia, 2) pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, 3) for reauthorizations, a) current Hgb is less than or equal to 11 g/dL, OR b) Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for HIV: 1) concomitant use of zidovudine at a maximum dose of 4200 mg/week, 2) for reauthorizations, a) current Hgb is less than or equal to 11 g/dL, OR b) Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. For all uses except MDS: 1) documentation of adequate iron stores, OR 2) patient is receiving supplemental iron. Adequate iron stores: serum ferritin is at least 100 ng/mL or transferrin saturation is at least 20%. For surgery: 1) patient is at high risk for perioperative blood loss and scheduled for elective, noncardiac, nonvascular surgery, 2) pretreatment Hgb is greater than 10 but not more than 13 g/dL.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

12 weeks

Patients will be monitored for thrombotic and cardiac events. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (eg, used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).

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| <b>Prior Authorization Group</b>    | ERIVEDGE                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                   | ERIVEDGE                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b> | Patient meets the following criteria: 1) Metastatic BCC, OR 2) Locally advanced BCC that has recurred following surgery or the patient is not a candidate for radiation or surgery.                                                                                                                                                                                                                                                                       |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>               | For female patients of childbearing potential, verify pregnancy status prior to initiation of therapy and be instructed on the importance and proper use of appropriate contraceptive methods. Male patients are instructed on the importance and proper use of appropriate contraceptive methods. Prior authorization applies to new starts only. Refills will be approved unless use is not coverable under Part D per Medicare drug coverage policies. |



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| <b>Prior Authorization Group</b>    | EXJADE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                   | EXJADE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>           | CrCl less than 40 mL/min. Severe hepatic impairment. Platelet count less than 50,000/mcL. Patient with poor performance status and high-risk myelodysplastic syndrome (MDS) or advanced malignancies.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b> | For diagnosis of transfusion-dependent anemia with chronic iron overload due to blood transfusions (transfusional hemosiderosis): a) Pretreatment serum ferritin level within the last 60 days of at least 1000 mcg/L, b) Baseline and then monthly, or more frequently as indicated, monitoring of serum ferritin, serum creatinine/creatinine clearance, serum transaminases, bilirubin, and urinalysis (urine protein), c) On renewal, for patients with serum ferritin below 500 mcg/L, temporary interruption of Exjade therapy should be considered, d) For patients with persistent or severe increases in creatinine or liver function tests, the prescriber will consider dose modification or interruption of treatment. For iron overload in patients with NON-transfusion-dependent thalassemia: a) diagnosis of a NON-transfusion-dependent thalassemia syndrome and chronic iron overload, b) all liver iron concentrations (LIC) are measured by liver biopsy or by an FDA-cleared or approved method for identifying patients for treatment with deferasirox therapy, c) For initiation of Exjade: Pretreatment LIC of at least 5 mg per gram of dry weight AND pretreatment serum ferritin levels greater than 300 mcg/L on 2 consecutive measurements 1 month apart, d) For patients currently on Exjade therapy: Current LIC is greater than 3 mg per gram of dry weight OR Exjade will be withheld until the LIC reaches above 5 mg per gram of dry weight. |
| <b>Age Restrictions</b>             | Two years of age and older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>      | Hematologist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

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| <b>Prior Authorization Group</b>    | FENTANYL PATCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                   | FENTANYL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>           | A. Patients who are not opioid tolerant. (Patients are considered opioid tolerant if they have been taking at least 60 mg of oral morphine per day, 25 mcg of transdermal fentanyl/hr, 30 mg of oral oxycodone daily, 8 mg of oral hydromorphone daily, 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer.) B. Patients who do not require continuous opioid analgesia. C. Patients who are taking any CYP450 3A4 inhibitors who are not being carefully monitored. |
| <b>Required Medical Information</b> | Patient has been or will be assessed for clinical risks of opioid/substance abuse/or addiction by one of the following tools, or ANOTHER ASSESSMENT TOOL for opioid abuse: Screener and Opioid Assessment for Patients with Pain (SOAPP 1.0), Screener and Opioid Assessment for Patients with Pain, Revision (SOAPP-R), Opioid Risk Tool (ORT), Current Opioid Misuse Measure (COMM), The Diagnosis, Intractability, Risk, and Efficacy Score (DIRE).                                                         |
| <b>Age Restrictions</b>             | 2 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>            | 6 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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| <b>Prior Authorization Group</b>    | FORTEO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                   | FORTEO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>           | Paget's disease of bone, unexplained elevations of alkaline phosphatase, open epiphyses (ie, pediatric or young adult patient), prior radiation therapy involving the skeleton, history of a skeletal malignancy, bone metastases, pre-existing hypercalcemia, metabolic bone disease other than osteoporosis.                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b> | Patient meets one of the following criteria: prior fragility fracture OR inadequate response to a trial of bisphosphonate unless contraindicated or intolerant to bisphosphonate OR more than one risk factors for fracture (e.g., advanced age [postmenopausal women and men 50 years of age or older], parental history of hip fracture, low body mass index [less than 19kg/m <sup>2</sup> ], current smoker, chronic alcohol use [3 or more drinks per day], rheumatoid arthritis, chronic steroid use [at least 5 mg/day prednisone or equivalent for 3 months or longer], secondary causes of osteoporosis). |
| <b>Age Restrictions</b>             | Forteo should not be used in pediatric patients or young adults with open epiphyses                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>               | Therapy will be discontinued after a lifetime total of 24 months of treatment.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

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| <b>Prior Authorization Group</b>    | GILENYA                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                   | GILENYA                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>           | 1) Recent occurrence (within the last 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, class III or IV heart failure. 2) History or presence of Mobitz Type II 2nd or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. 3) Baseline QTc interval greater than or equal to 500ms. 4) Treatment with Class Ia or Class III anti-arrhythmic drugs. |
| <b>Required Medical Information</b> | Patient must have tried and failed an adequate trial with an interferon beta agent (Avonex, Betaseron, Extavia, Rebif) or Copaxone unless contraindicated or intolerant to such therapy.                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

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| <b>Prior Authorization Group</b>    | GLEEVEC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                   | GLEEVEC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, lymphoblastic lymphoma, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b> | For CML, ALL, and lymphoblastic lymphoma, patient must be positive for the Ph chromosome or BCR-ABL gene. For ALL or lymphoblastic lymphoma, patient meets one of the following: 1) newly diagnosed and Gleevec is used in combination with chemotherapy, or 2) disease is relapsed or refractory. For GIST, patient meets one of the following: 1) unresectable, recurrent, or metastatic GIST, 2) use of Gleevec for adjuvant therapy following resection, or 3) GIST is resectable and Gleevec will be used to improve surgical morbidity by reducing tumor size preoperatively.<br>Myelodysplastic/myeloproliferative disease is associated with PDGFR gene re-arrangements. Aggressive systemic mastocytosis is negative or unknown for D816V c-Kit mutation. For PVNS/TGCT, Gleevec will be used as a single agent. Patient has one of the following diagnoses: hypereosinophilic syndrome, chronic eosinophilic leukemia, desmoid tumor, dermatofibrosarcoma protuberans. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

GROWTH HORMONE

NORDITROPIN FLEXPRO, NORDITROPIN NORDIFLEX PEN, TEV-TROPIN

All FDA approved indications not otherwise excluded from Part D, including pediatric growth hormone deficiency (GHD), Turner syndrome (TS), Noonan syndrome (NS), chronic renal insufficiency (CRI), small for gestational age (SGA), Prader-Willi syndrome (PWS), idiopathic short stature (ISS), and short stature homeobox-containing gene deficiency (SHOXD), and adult GHD.

**Exclusion Criteria**

Active malignancy, active proliferative or severe non-proliferative diabetic retinopathy, acute critical illness, concurrent use with Increlex. Closed epiphyses for pediatric patients.

**Required Medical Information**

Pediatric GHD, TS, NS, CRI, SGA, PWS, ISS, SHOXD: evaluated for other causes of growth failure. Pediatric GHD, TS, CRI, PWS, SHOXD, NS: Younger than 2 yrs old, when applicable: pretreatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2 yrs old or older: pre-tx 1-yr ht velocity more than 2 SD below mean OR pre-tx ht more than 2 SD below mean plus 1-yr ht velocity more than 1 SD below mean. Pediatric GHD: delayed bone age AND failed 2 stim tests (peak below 10 ng/mL) prior to starting tx OR has a pituitary or CNS disorder plus a low pre-tx IGF-1/IGFBP3. Pediatric GHD in neonate: Randomly assessed pre-tx GH level below 20 ng/mL and other causes of hypoglycemia r/o and other treatments (txs) ineffective. TS: confirmed by karyotyping. CRI: not post-kidney transplant AND metabolic/endocrine/nutritional abnormalities treated or stabilized. SGA: did not manifest catch-up growth by age 2 AND birth wt below 2500g at gestational age (GA) of more than 37 wks OR birth wt or length below 3rd percentile for GA. PWS: r/o upper airway obstruction via appropriate test or exam AND GH will be d/c'd if severe respiratory impairment develops. SHOXD: confirmed by molecular or genetic testing. ISS: pediatric GHD r/o by appropriate stim test AND prior to starting GH tx, ht more than 2.25 SD below mean and adult ht prediction below 5 ft 3 in for boys and 4 ft 11 in for girls. Adult GHD: other causes of GHD-like symptoms assessed AND meets 1 of the following: 1) failed 2 stim tests (peak below 5 µg/L) prior to starting GH tx, 2) 3 or more pituitary hormone deficiencies or panhypopituitarism, 3) childhood-onset GHD with known mutations, embryopathic lesions, or irreversible structural lesions/damage, 4) low pre-tx IGF-1 and failed 1 stim test (peak below 5 µg/L) prior to starting GH tx.

**Age Restrictions**

TS and SGA: 2 years of age or older. NS and SHOX: 3 years of age or older.

**Prescriber Restrictions**

Endocrinologist, Pediatric Nephrologist

**Coverage Duration**

Plan Year

**Other Criteria**

Renewal for neonatal hypoglycemia: patient is euglycemic or tx will be adjusted to optimize efficacy. Renewal for pediatric GHD, TS, NS, CRI, SGA, PWS, ISS, SHOXD: patient is growing more than 2 cm/year. For renewal of PWS only: body composition has improved. Renewal for adult GHD: IGF-1 levels will be evaluated to confirm appropriateness of continued tx.

**Prior Authorization Group** HIGH RISK MEDICATION  
**Drug Names** DIPHENOXYLATE/ATROPINE, ESTRADIOL, GLYBURIDE, GLYBURIDE MICRONIZED, GLYBURIDE/METFORMIN HCL, TRANSDERM-SCOP  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information** Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria**

**Prior Authorization Group** HIGH RISK MEDICATION2  
**Drug Names** MENEST, THIORIDAZINE HCL  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information** Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria**

**Prior Authorization Group** HIZENTRA  
**Drug Names**  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** IgA deficiency with antibodies to IgA and a history of hypersensitivity, history of anaphylaxis or severe systemic reaction to the administration of human immune globulin or product components, and hyperprolinemia.  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria** If administered outside of a controlled healthcare setting, appropriate treatment (eg, anaphylaxis kit) will be made available for managing an acute hypersensitivity reaction to immune globulin. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

HUMIRA

HUMIRA, HUMIRA PEN-CROHNS DISEASE

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

Active infection (including TB), Combination therapy with other biologic agent(s).

Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to Humira request. For positive latent TB, patient must have completed or receiving treatment for LTBI prior to initiating Humira. For those at risk for Hepatitis B (HBV) infection, HBV has been ruled out or treatment has been initiated. For rheumatoid arthritis (RA) patient must meet one of the following criteria: 1) inadequate response to methotrexate (MTX) OR 2) inadequate response to another nonbiologic DMARD such as leflunomide, hydroxychloroquine, sulfasalazine if contraindicated or intolerant to MTX OR 3) intolerance or contraindication to at least 2 nonbiologic DMARDs OR 4) Humira will be used as first-line therapy with MTX for severely active RA. For juvenile idiopathic arthritis, patient does not have fever or elevated inflammatory markers AND must meet one of the following criteria: 1) patient had an inadequate response to prior tumor necrosis factor (TNF) inhibitor, OR 2) inadequate response, contraindication, or intolerance to MTX. For ankylosing spondylitis, patient had an inadequate response, contraindication, or intolerance to at least 2 NSAIDs. For Crohn's disease, patient must have an inadequate response to at least one conventional therapy (eg, corticosteroids, sulfasalazine, azathioprine, mesalamine) unless contraindicated or intolerant to such therapies. For plaque psoriasis, patient must have at least 5% of BSA affected or has crucial body areas (eg, feet, hands, face, neck and/or groin) affected AND an inadequate response to either phototherapy or a conventional systemic therapy, unless contraindicated or intolerant to such therapies. For moderately to severely active ulcerative colitis (new starts only): 1) inadequate response to immunosuppressant therapy (eg, corticosteroids, azathioprine, mercaptopurine) OR 2) intolerance or contraindication to immunosuppressant therapy AND 3) no previous trial of TNF inhibitor therapy.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Initial: 3 months for Crohn's disease, plan year for other indications. Renewal: plan year

For renewal, patient's condition must have improved or stabilized.

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| <b>Prior Authorization Group</b>    | ICLUSIG                                                                                                                                                                             |
| <b>Drug Names</b>                   | ICLUSIG                                                                                                                                                                             |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                    |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                     |
| <b>Required Medical Information</b> | 1) Diagnosis of CML or Ph+ ALL was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene AND 2) Patient experienced resistance or intolerance to prior TKI therapy. |
| <b>Age Restrictions</b>             | 18 years of age or older                                                                                                                                                            |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                     |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                           |
| <b>Other Criteria</b>               | Hepatic function will be monitored prior to starting and during treatment with Iclusig.                                                                                             |

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| <b>Prior Authorization Group</b>    | INCIVEK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                   | INCIVEK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>           | Failed previous therapy with a treatment regimen that includes a protease inhibitor (eg, Incivek, Victrelis). Concomitant administration with a drug that is highly dependent on CYP3A for clearance or a strong inducer of CYP3A (ie, alfuzosin, atorvastatin, cisapride, dihydroergotamine, ergonovine, ergotamine, methylergonovine, lovastatin, oral midazolam, pimozone, rifampin, simvastatin, St. John's wort, triazolam, Adcirca or Revatio when used for PAH). Concomitant use of any of the following ritonavir-boosted HIV protease inhibitors: lopinavir, darunavir, or fosamprenavir for new starts. |
| <b>Required Medical Information</b> | Diagnosis of chronic hepatitis C and meets the following criteria: 1) Detectable viral load prior to starting therapy for all patients, 2) HCV Genotype 1, 3) Must be given in combination with pegylated interferon (ie, Pegasys or PegIntron) and ribavirin, 4) Assess viral load at weeks 4, 12, and 24 of Incivek triple therapy, 5) Viral load less than or equal to 1,000 IU/mL at week 4 of treatment.                                                                                                                                                                                                     |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>            | Initial: 6 weeks. Continuation of therapy: Up to 12 weeks.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>               | Patients who are already taking Incivek and one of the following ritonavir-boosted HIV protease inhibitors: lopinavir, darunavir, or fosamprenavir will be monitored closely by the prescriber for HCV treatment response and for potential HCV and HIV virologic rebound.                                                                                                                                                                                                                                                                                                                                        |

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| <b>Prior Authorization Group</b>    | INCRELEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                   | INCRELEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>           | Epiphyseal closure, active malignancy, or concurrent use with GH therapy. Patient has secondary causes of IGF-1 deficiency (e.g., hypothyroidism, malignancy, chronic systemic disease, skeletal disorders, malnutrition, celiac disease).                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b> | Diagnosis of severe primary insulin-like growth factor-1 (IGF-1) deficiency (Primary IGFD) or with growth hormone (GH) gene deletion with neutralizing antibodies to GH. Prior to starting therapy, a height greater than or equal to 3 SD below the mean for chronological age and sex, and an IGF-1 level greater than or equal to 3 SD below the mean for chronological age and sex. One stimulation test showing patient has a normal or elevated GH level. For continuation of therapy, patient grew more than 2 cm/year. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>      | Endocrinologist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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| <b>Prior Authorization Group</b>    | INFERGEN                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                   | INFERGEN                                                                                                                                                                                                                                                                                                               |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>           | Decompensated liver disease, autoimmune hepatitis, uncontrolled major depression or severe mental illness.                                                                                                                                                                                                             |
| <b>Required Medical Information</b> | Diagnosis of chronic hepatitis C and meets the following criteria: 1) Detectable viral load prior to starting therapy, 2) Patient had a documented adverse reaction (ADR) or is at higher risk for an ADR to a pegylated interferon. If used as monotherapy, must have a contraindication or intolerance to ribavirin. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>            | Allow up to 48 weeks                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                        |



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| <b>Prior Authorization Group</b>    | INLYTA                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                   | INLYTA                                                                                                                                                                                                                                                                                                                      |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b> | Patient has a diagnosis of advanced renal cell carcinoma (RCC) that has progressed after at least 1 prior systemic therapy for RCC. Examples of prior systemic therapies for RCC include regimens containing bevacizumab, pazopanib, sorafenib, sunitinib, temsirolimus, and cytokines (interferon alpha or interleukin-2). |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                             |

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| <b>Prior Authorization Group</b>    | INVEGA SUSTENNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                   | INVEGA SUSTENNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>           | A. Diagnosis of dementia-related psychosis. B. Prior use of risperidone demonstrated a hypersensitivity reaction.                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b> | A. Diagnosis of acute and maintenance treatment of schizophrenia. AND B. The patient has a history of non-compliance and/or refuses to utilize oral medication. AND C. The patient has received at least ONE of the following: a. three test doses of oral Risperdal (risperidone) b. three test doses of oral Invega c. previous use of Invega Sustenna. D. If the patient is increasing the dose of Invega Sustenna, the patient must have a history of two prior injections of Invega Sustenna. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>      | Psychiatrist or receiving input from a psychiatry practice                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

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| <b>Prior Authorization Group</b>    | ITRACONAZOLE                                                                                                                                                                                                                   |
| <b>Drug Names</b>                   | ITRACONAZOLE                                                                                                                                                                                                                   |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                               |
| <b>Exclusion Criteria</b>           | A. For onychomycosis, ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF). B. If the patient is currently receiving any of the following medications: cisapride, dofetilide, pimozide, quinidine. |
| <b>Required Medical Information</b> | For onychomycosis, diagnosis has been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy).                                                                                         |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>            | 12 weeks                                                                                                                                                                                                                       |
| <b>Other Criteria</b>               | Criteria applies to capsule dosage form only.                                                                                                                                                                                  |

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| <b>Prior Authorization Group</b>    | IVIG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                   | CARIMUNE NANOFILTERED, FLEBOGAMMA, GAMMAGARD LIQUID, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, CLL, Kawasaki syndrome, and pure red cell aplasia (PRCA).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>           | IgA deficiency with antibodies to IgA and a history of hypersensitivity, history of anaphylaxis or severe systemic reaction to human immune globulin or product components.                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b> | Coverage is provided for: 1) ITP. 2) Confirmed diagnosis of CIDP. 3) CLL with a serum IgG less than 500 mg/dL or a history of recurrent bacterial infections. 4) Kawasaki syndrome in conjunction with high-dose aspirin. 5) PRCA secondary to parvovirus B19 infection. For all indications, patients with any of the following risk factors for acute renal failure must receive the minimum concentration available of IGIV and the minimum infusion rate practicable: pre-existing renal insufficiency, diabetes mellitus, age over 65 years, volume depletion, sepsis, paraproteinemia, or receiving concomitant nephrotoxic drugs. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>               | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

**Prior Authorization Group** JAKAFI  
**Drug Names** JAKAFI  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information** Have intermediate or high-risk myelofibrosis.  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria**

**Prior Authorization Group** LETAIRIS  
**Drug Names** LETAIRIS  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** Pregnancy.  
**Required Medical Information** NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy and will be excluded monthly during therapy, AND 2) Patient will use reliable contraception during treatment and for one month after stopping treatment.  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria**

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| <b>Prior Authorization Group</b>    | LEUKINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                   | LEUKINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), myelodysplastic syndromes (MDS), acute lymphocytic leukemia (ALL)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>           | Hypersensitivity to yeast-derived products. Use of Leukine within 24 hours preceding or following chemotherapy or radiotherapy. Use of Leukine for prophylaxis of FN. When Leukine is used for treatment of acute FN: patient received prophylactic Neulasta during the current chemotherapy cycle. When Leukine is used for acute myelogenous leukemia (AML): excessive leukemic myeloid blasts (greater than or equal to 10%) in the bone marrow or peripheral blood.                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b> | Complete blood counts with differential and platelet counts will be monitored at baseline and regularly throughout therapy. For treatment of acute FN: 1) patient has a non-myeloid cancer and is currently receiving treatment with myelosuppressive anti-cancer drugs, AND 2) meets one of the following: a) patient received prophylactic filgrastim or sargramostim during the current chemotherapy cycle, OR b) patient is at risk for infection-associated complications or poor clinical outcomes of FN. For AML and ALL: Leukine will be used following induction or consolidation chemotherapy. For MDS: patient has neutropenia and recurrent or resistant infections. Leukine is used for one of the following reasons: 1) mobilization of peripheral blood progenitor cells (PBPC), 2) use following PBPC transplant, or 3) use following bone marrow transplant. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>            | 6 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>    | LIDODERM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                   | LIDODERM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>           | Patient has a sensitivity to local anesthetics of the amide type.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b> | A. The diagnosis is post-herpetic neuralgia AND B. The skin where the patch is to be applied is intact. AND C. Patient demonstrated an inadequate treatment response to a one month trial of gabapentin OR Lyrica OR D. The patient has a contraindication or had a confirmed adverse event with gabapentin OR Lyrica.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

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| <b>Prior Authorization Group</b>    | LUMIZYME                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                   | LUMIZYME                                                                                                                                                                                                                                                                 |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b> | Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of GAA enzyme activity or by DNA testing that identifies mutations in the GAA gene. Patient has late-onset (non-infantile) Pompe disease with no evidence of cardiac hypertrophy. |
| <b>Age Restrictions</b>             | 8 years of age and older                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>               | Appropriate medical support is readily available when Lumizyme is administered in the event of anaphylaxis, severe allergic reaction, or acute cardiorespiratory failure.                                                                                                |

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|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>    | LUPRON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                   | LEUPROLIDE ACETATE, LUPRON DEPOT, LUPRON DEPOT-PED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D. Breast cancer (leuprolide acetate injection only). Ovarian cancer (Lupron Depot 3.75mg and 3 Month 11.25mg only).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>           | Use as neoadjuvant androgen deprivation therapy (ADT) for radical prostatectomy. Pregnancy for female patients except for children with CPP. Breastfeeding (Lupron Depot 3.75mg and 3 Month 11.25mg only). Undiagnosed abnormal vaginal bleeding (Lupron Depot 3.75mg and 3 Month 11.25mg only).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b> | For prostate cancer, must meet one of the following: 1) Locally advanced, recurrent or metastatic disease, 2) Use as neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with intermediate or high risk of recurrence, 3) Use as neoadjuvant therapy with brachytherapy to shrink the prostate to an acceptable size for brachytherapy. For breast cancer (leuprolide acetate injection only): 1) Premenopausal woman with hormone receptor positive disease AND 2) Use with adjuvant therapy OR in combination with endocrine therapy if disease is recurrent or metastatic. For endometriosis: must have at least a 3-month trial and failure of oral contraceptives OR progestins OR danazol. Allow only one time retreatment AND meet all of the following: 1) recurrence of symptoms 2) receive add-back therapy (eg, norethindrone) 3) bone mineral density within normal limits. For uterine leiomyomata, must have anemia (HCT less than or equal to 30% and/or Hgb less than or equal to 10g/dL) AND use Lupron with iron therapy. For ovarian cancer stromal tumor type: must have relapsed stage II-IV granulosa cell tumors. For epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: disease is stable, recurrent, or persistent with primary therapy AND use Lupron (3.75mg only) as a single agent. For CPP: onset of secondary sexual characteristics earlier than 8 years of age in female patients and 9 years of age in male patients. Clinical diagnosis confirmed prior to initiation of therapy with the following: 1) Pubertal response to GnRH stim test, AND 2) Bone age advanced one year beyond chronological age. Baseline evaluation should include: 1) Adrenal steroid level to exclude congenital adrenal hyperplasia, 2) Beta human chorionic gonadotropin level to rule out a chorionic gonadotropin secreting tumor, 3) Pelvic/adrenal/testicular ultrasound to rule out steroid secreting tumor, 4) CT of the head to rule out intracranial tumor. |
| <b>Age Restrictions</b>             | For endometriosis/fibroids/ovarian cancer: at least 18 years of age or older. For CPP: younger than 12 years old if female and less than 13 years old if male.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>            | Prostate CA/breast CA/ CPP: plan year. Endometriosis/ovarian cancer: 6 months. Fibroids: 3 months.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

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| <b>Prior Authorization Group</b>    | MOZOBIL                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                   | MOZOBIL                                                                                                                                                                                                                                                                                      |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b> | Mozobil will be used to mobilize hematopoietic stem cells for collection prior to autologous transplantation and used in combination with granulocyte-colony stimulating factor (ie, filgrastim or pegfilgrastim). Patient diagnosed with either non-Hodgkin's lymphoma or multiple myeloma. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>            | 6 months                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                              |

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| <b>Prior Authorization Group</b>    | NEUPOGEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                   | NEUPOGEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D., prophylaxis of chemotherapy-induced febrile neutropenia (FN) or other dose-limiting neutropenic events in intermediate and low risk patients, treatment of chemotherapy-induced FN, acute lymphocytic leukemia (ALL), leukemic relapse, myelodysplastic syndromes (MDS)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>           | E. coli protein hypersensitivity. Use of Neupogen within 24 hours preceding or following chemotherapy or radiotherapy. When Neupogen is used for treatment of acute FN: patient received prophylactic Neulasta during the current chemotherapy cycle.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b> | Complete blood counts with differential and platelet counts will be monitored at baseline and regularly throughout therapy. For prophylaxis of FN or other dose-limiting neutropenic events: 1) patient has a non-myeloid cancer and is currently receiving or will be receiving myelosuppressive anti-cancer drugs, AND 2) meets one of the following: a) patient has experienced FN or a dose-limiting neutropenic event with a previous cycle of chemotherapy, OR b) patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing FN based on chemotherapy regimen and patient's risk factors, OR c) patient is at low risk (less than 10%) for developing FN based on chemotherapy regimen and patient's risk factors AND chemotherapy is intended to be curative or adjuvant AND patient is at significant risk for serious medical consequences of FN. For treatment of acute FN: 1) patient has a non-myeloid cancer and is currently or will be receiving myelosuppressive anti-cancer drugs AND 2) meets one of the following: a) patient received prophylactic filgrastim or sargramostim during the current chemotherapy cycle, OR b) patient is at risk for infection-associated complications or poor clinical outcomes of FN. For acute myeloid leukemia and ALL: Neupogen will be used following induction or consolidation chemotherapy. For leukemic relapse: Neupogen will be used as an alternative or adjunct to donor leukocyte infusions after allogeneic stem cell transplant. For MDS: 1) patient has neutropenia and recurrent or resistant infections, OR 2) patient has symptomatic anemia and Neupogen will be used in combination with epoetin or darbepoetin. Neupogen is used for one of the following reasons: 1) mobilization of peripheral blood progenitor cells (PBPC), 2) use following PBPC transplant, 3) use following bone marrow transplant, or 4) severe chronic neutropenia. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>            | 6 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |



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| <b>Prior Authorization Group</b>    | NEXAVAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                   | NEXAVAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), gastrointestinal stromal tumors, angiosarcoma.                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b> | For RCC, patient has advanced RCC. For HCC, patient has unresectable HCC. For follicular, papillary, or Hurthle cell thyroid carcinoma: patient has clinically progressive or symptomatic metastatic disease with nonradioiodine-responsive tumors at sites other than central nervous system. For medullary thyroid carcinoma: patient has disseminated symptomatic disease with progression on vandetanib or vandetanib is not appropriate. For GIST: patient has progressive disease with an inadequate response to imatinib or sunitinib. For angiosarcoma: Nexavar will be used as a single agent. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

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| <b>Prior Authorization Group</b>    | NITROFURANTOIN                                                                                                      |
| <b>Drug Names</b>                   | MACRODANTIN, NITROFURANTOIN MACROCRYST, NITROFURANTOIN MONOHYDRAT                                                   |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                    |
| <b>Exclusion Criteria</b>           |                                                                                                                     |
| <b>Required Medical Information</b> | Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older. |
| <b>Age Restrictions</b>             |                                                                                                                     |
| <b>Prescriber Restrictions</b>      |                                                                                                                     |
| <b>Coverage Duration</b>            | Plan Year                                                                                                           |
| <b>Other Criteria</b>               |                                                                                                                     |

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| <b>Prior Authorization Group</b>    | NUEDEXTA                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                   | NUEDEXTA                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>           | A. Concomitantly taking other drugs containing quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong QT interval and are metabolized by CYP2D6. B. Patient has a prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or heart failure. C. Patient has complete atrioventricular (AV) block without implanted pacemaker or is at high risk of complete AV block. |
| <b>Required Medical Information</b> | Patient has amyotrophic lateral sclerosis (ALS) OR multiple sclerosis (MS).                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

OCTREOTIDE

OCTREOTIDE ACETATE

All FDA-approved indications not otherwise excluded from Part D, atypical lung carcinoids, islet cell tumors, multiple endocrine neoplasia type 1 (MEN 1), primary CNS tumors, thymic carcinoma.

**Exclusion Criteria**

**Required Medical Information**

For initiation of acromegaly therapy, patients meets the following: 1) Clinical evidence of acromegaly, 2) Pre-treatment high IGF-1 level for age/gender, 3) Patient has had an inadequate or partial response to surgery and/or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy (e.g., medically unstable conditions, patient is at high risk for complications of anesthesia because of airway difficulties, lack of an available skilled surgeon, patient refuses surgery or prefers the medical option over surgery, major systemic manifestations of acromegaly including cardiomyopathy, severe hypertension and uncontrolled diabetes). For continuation of acromegaly therapy, the IGF-1 level decreased or normalized. For atypical lung carcinoids, use in combination with chemotherapy. For islet cell tumors, patient has insulinoma, glucagonoma, or VIPoma. For MEN 1, patient meets one of the following: 1) Patient has insulinoma, glucagonoma, or VIPoma OR 2) Patient has pituitary adenoma and is symptomatic or has significant tumor burden. For primary CNS tumors, patient has recurrent meningiomas AND unresectable tumors. For thymic carcinoma, patient has locally advanced, unresectable disease AND receiving octreotide injection post-radiation.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Plan Year

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| <b>Prior Authorization Group</b>    | ORAL TESTOSTERONES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                   | ANDROXY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>           | Male patients who have carcinoma of the breast or known or suspected prostate cancer.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b> | A. For female patients being treated for inoperable metastatic breast cancer who are 1 to 5 years postmenopausal (either naturally or surgically) and who have had an incomplete response to other therapies for metastatic breast cancer. B. For male patients being treated for primary hypogonadism (congenital or acquired) or secondary (hypogonadotropic) hypogonadism (e.g., idiopathic gonadotropin, or LHRH deficiency), before the start of testosterone therapy patient had (or patient currently has) a confirmed low testosterone level (i.e., morning total testosterone less than 300 ng/dL, morning free testosterone less than 9 ng/dL) or absence of endogenous testosterone. C. For male patients being treated for delayed puberty, bone development must be checked at least every 6 months. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>               | Patients who have tried and failed or unable to tolerate non-oral forms of testosterone supplementation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

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| <b>Prior Authorization Group</b>    | ORAL-INTRANASAL FENTANYL                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                   | FENTANYL CITRATE ORAL TRA, LAZANDA                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>           | Patients taking strong or moderate cytochrome P450 3A4 inhibitor(s), who will not be carefully monitored and will not have dosing adjustments made if necessary.                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b> | A. Long-Acting opioid is being prescribed for around-the clock treatment of the cancer pain. B. The patient is opioid tolerant (Patients are considered opioid tolerant if they have been taking at least 60 mg of oral morphine per day, 25 mcg of transdermal fentanyl/hr, 30 mg of oral oxycodone daily, 8 mg of oral hydromorphone daily, 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer). |
| <b>Age Restrictions</b>             | 16 years of age or older (Actiq), 18 years of age or older all others                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>            | 6 Months                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                              |

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| <b>Prior Authorization Group</b>    | PEGASYS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                   | PEGASYS, PEGASYS PROCLICK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia patient (pt) who is unable to tolerate a tyrosine kinase inhibitor (eg, Gleevec, Sprycel, Tasigna) or who is post-transplant without remission or with relapse.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>           | Decompensated liver disease, autoimmune hepatitis, uncontrolled major depression or severe mental illness.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b> | Chronic HCV: 1) HCV genotype (G), detectable viral load (VL) prior to starting treatment (tx), 2) For G2,3: max 24 wks. HCV coinfecting with HIV (all genotypes): Max 48 wks. Tx naïve and retreatment (re-tx) with Pegasys, Ribavirin (RBV) + Victrelis (G1): 1) 4 wks of Pegasys and RBV prior to starting Victrelis, 2) VL at wks 4, 8, 12, 24, 3) VL less than 100 IU/mL at wk 12, 4) undetectable (UD) VL at wk 24, 5) Max 28 wks for tx naïve pts with UD VL at wk 8, 6) Max 36 wks for re-tx pts with UD VL at wk 8, 7) Max 48 wks for: a) Pts with cirrhosis, b) Poorly IFN-responsive (less than 1-log drop in VL at wk 4 of tx), c) Null responders with prior tx (less than 2-log drop in VL at wk 12 of prior tx), d) Pts with detectable VL at wk 8. Tx naïve and re-tx with Pegasys, RBV + Incivek (G1): 1) VL at wks 4, 12, 24, 2) VL less than or equal to 1,000 IU/mL at wks 4, 12, 3) UD VL at wk 24, 4) Max 24 wks for tx naïve or relapsers with UD VL at wks 4 AND 12, 5) Max 48 wks for: a) Pts with cirrhosis (tx naïve or relapsers), b) Pts with detectable VL at wks 4 and/or 12 (tx naïve or relapsers), c) Prior nonresponders (including partial/null response). Treatment naïve, dual therapy with RBV (G1,4): 1) UD VL at wk 12, OR at least a 2 log decrease in VL from baseline at wk 12 plus UD VL at wk 24, 2) Max 48 wks if UD VL at wk 12, 3) Max 48 wks for G4 if UD VL at wk 24, 4) Max 72 wks for G1 if UD VL at wk 24. Re-tx with dual therapy with RBV (all genotypes): 1) Must be used with RBV, 2) Max 1 time re-tx with PEG-IFN + RBV as dual tx, 3) UD VL at wk 12, OR at least a 2 log decrease in VL from baseline at wk 12 plus UD VL at wk 24, 4) Max 48 wks if UD VL at wk 12, 5) Max 48 wks for G4 if UD VL at wk 24, 6) Max 72 wks for G1 if UD VL at wk 24. Treatment naïve, monotherapy (all genotypes): 1) Must have a contraindication or intolerance to RBV, 2) UD VL at wk 12, OR at least a 2 log decrease in VL from baseline at wk 12 plus UD VL at wk 24, 3) Max 48 wks if UD VL at wk 12 or 24. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>            | HCV=Based on genotype and response 12 to 72wks for dual tx. 6 to 48wks for triple tx. HBV,CML=48wks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>               | Chronic HBV: Patients with cirrhosis: 1) HBsAg+ for at least 6 months AND, 2) HBV-DNA at least 10,000 copies/mL or at least 2,000 IU/mL regardless of HBeAg status. Patients without cirrhosis: 1) HBsAg+ for at least 6 months AND, 2) Persistent or intermittently elevated ALT greater than 2 times ULN or liver biopsy showing chronic hepatitis with moderate to severe necroinflammation AND, 3) If HBeAg+, pt has HBV-DNA greater than 100,000 copies/mL or greater than 20,000 IU/mL OR, 4) If HBeAg negative, pt has HBV-DNA greater than 10,000 copies/mL or greater than 2,000 IU/mL.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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| <b>Prior Authorization Group</b>    | PEGINTRON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                   | PEG-INTRON, PEG-INTRON REDIPEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia patient (pt) who is unable to tolerate a tyrosine kinase inhibitor (eg, Gleevec, Sprycel, Tasigna) or who is post-transplant without remission or with relapse.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>           | Decompensated liver disease, autoimmune hepatitis, uncontrolled major depression or severe mental illness.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b> | Chronic HCV: 1) HCV genotype (G), detectable viral load (VL) prior to starting treatment (tx) 2) G2,3: max 24 wks. HCV coinfectd with HIV (regardless of genotypes): Max 48 wks. Tx naive and retreatment (re-tx) with PegIntron, ribavirin (RBV) + Victrelis (G1): 1) Receive 4 wks of PegIntron + RBV prior to starting Victrelis, 2) VL at wks 4, 8, 12, and 24, 3) VL less than 100 IU/mL at wk 12, 4) undetectable (UD) VL at wk 24, 5) max 28 wks for tx naive pts with UD VL at wk 8, 6) Max 36 weeks for re-tx pts with UD VL at wk 8 of tx, 7) Max 48 wks for: a) Pts with cirrhosis, b) Poorly IFN-responsive (less than 1-log drop in VL at wk 4) c) Null responders with prior tx (less than 2-log drop in VL at wk 12 of prior tx) d) Pts with detectable VL at wk 8. Tx naive and re-tx with PegIntron, RBV + Incivek (G1): 1) VL at wks 4, 12, 24, 2) VL less than or equal to 1,000 IU/mL at wks 4 and 12, 3) UD VL at wk 24, 4) Max 24 wks for tx naive or relapsers with UD VL at wks 4 AND 12, 5) Max 48 weeks for: a) Pts with cirrhosis (tx naive or relapsers), b) Pts with detectable VL at wks 4 and/or 12 (tx naive or relapsers), c) Prior nonresponders (including partial/null response). Tx naive, dual tx with RBV (G1,4): 1) UD VL at wk 12, OR at least a 2 log decrease in VL from baseline at wk 12 plus UD VL at wk 24 2) Max 48 wks if UD VL at wk 12, 3) Max 48 wks if UD VL at wk 24. Re-tx with dual tx with RBV (all genotypes): 1) Must be used in combination with RBV, 2) Allow only 1x re-tx with PEG-IFN + RBV as dual tx, 3) UD VL at wk 12, OR at least a 2 log decrease in VL from baseline at wk 12 plus UD VL at wk 24, 4) Max 48 wks if UD VL at wk 12, 5) Max 48 wks if UD VL at wk 24. Tx naive, monotherapy (all genotypes): 1) Must have CI or intolerance to RBV, 2) UD VL at wk 12, OR at least a 2 log decrease in VL from baseline at wk 12 plus UD VL at wk 24, 3) Max 48 wks if UD VL at wk 12 or 24. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>            | HCV=Based on genotype and response 12 to 48 wks for dual tx. 6 to 48 wks for triple tx. CML=48 wks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

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| <b>Prior Authorization Group</b>    | PRIVIGEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                   | PRIVIGEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, CLL, Kawasaki syndrome, CIDP, and pure red cell aplasia (PRCA).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>           | IgA deficiency with antibodies to IgA and a history of hypersensitivity, history of anaphylaxis or severe systemic reaction to human immune globulin or product components, and hyperprolinemia.                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b> | Coverage is provided for: 1) ITP. 2) Confirmed diagnosis of CIDP. 3) CLL with a serum IgG less than 500 mg/dL or a history of recurrent bacterial infections. 4) Kawasaki syndrome in conjunction with high-dose aspirin. 5) PRCA secondary to parvovirus B19 infection. For all indications, patients with any of the following risk factors for acute renal failure must receive the minimum concentration available of IGIV and the minimum infusion rate practicable: pre-existing renal insufficiency, diabetes mellitus, age over 65 years, volume depletion, sepsis, paraproteinemia, or receiving concomitant nephrotoxic drugs. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>               | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

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| <b>Prior Authorization Group</b>    | PROMACTA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                   | PROMACTA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b> | <p>Patient has chronic or persistent ITP and meets the following criteria: For new starts: 1) Patient has been evaluated for other causes of thrombocytopenia, 2) Patient has had an insufficient response or intolerance to corticosteroids, immunoglobulins, or splenectomy, 3) Platelet (Plt) count at time of diagnosis is: less than 30,000/mcL OR less than or equal to 50,000/mcL with significant mucous membrane bleeding or risk factors for bleeding. For continuation of therapy: 1) Plt count response to Promacta: Plt count increased to at least 50,000/mcL OR Plt count increased to a level sufficient to avoid clinically important bleeding after at least 4 weeks of Promacta at a maximal dose, 2) If Plt counts rise above 200,000/mcL with Promacta, therapy will be adjusted to maintain the minimal count needed to reduce the patient's risk for bleeding. Patient has thrombocytopenia associated with chronic hepatitis C and meets the following criteria: 1) Promacta is used for initiation and maintenance of interferon-based therapy, 2) Plt count at time of diagnosis is less than 75,000/mcL.</p> |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>            | <p>ITP Initial 6 mos, Renewal Plan yr if adequate Plt response, 3 mo w/out Plt response.<br/>Hep C 6 mos.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>               | <p>Alanine aminotransferase levels must not be greater than or equal to 3 times the upper limit of normal or greater than or equal to 3 times baseline in a patient with pre-treatment elevations in transaminases with any of the following characteristics: progressive, persistent, accompanied by increased bilirubin or symptoms of liver injury or evidence of hepatic decompensation. Liver function must be assessed pretreatment and regularly throughout therapy.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |



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| <b>Prior Authorization Group</b>    | PROVIGIL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                   | MODAFINIL, PROVIGIL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b> | A. If diagnosis is narcolepsy confirmed by Sleep Lab Evaluation. B. If diagnosis is OSA confirmed by polysomnography and patient is currently utilizing CPAP or CPAP is contraindicated or has been tried and found to be ineffective. C. If diagnosis of Shift Work Sleep Disorder (work the night shift (at least 6 hours between the hours of 10pm and 8am permanently or work the night shift (at least 6 hours between the hours of 10pm and 8am) frequently (5 times or more per month) and experience excessive sleepiness while working. D. If diagnosis of mild obstructive sleep apnea patient is using and compliant with an oral appliance. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <br>                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization Group</b>    | RANEXA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                   | RANEXA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>           | A. Patients with clinically significant hepatic impairment B. Patient is receiving a strong CYP3A inhibitor that prolongs the QT interval.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b> | A. The patient has tried, failed and/or been intolerant (continues to have angina symptoms that limits daily activities) to a 30-day trial of the following: a nitrate PLUS a beta blocker or a calcium channel blocker. OR B. If the patient has received prior treatment with Ranexa, the patient experienced a decrease in angina frequency since initiating treatment.                                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>      | Cardiologist or affiliated with a cardiology practice                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>            | 3 months initial, Plan Year renewal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

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| <b>Prior Authorization Group</b>    | REGRANEX                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                   | REGRANEX                                                                                                                                                                                                                                                                                                                         |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>           | Neoplasm(s) at site(s) of application.                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b> | A. Treatment of lower-extremity diabetic ulcers AND B. The ulcer extends into subcutaneous tissue or beyond AND C. The ulcer has adequate blood supply AND D. Good ulcer care practices including ALL of the following: a. Debridement b. Pressure relief c. Infection control will be performed concurrently with Regranex gel. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>            | 20 weeks                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                  |

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| <b>Prior Authorization Group</b>    | RELISTOR                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                   | RELISTOR                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>           | Known or suspected mechanical gastrointestinal obstruction.                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b> | A. Relistor is being requested for the treatment of opioid-induced constipation in a patient with advanced illness who is receiving palliative care. AND B. Patient demonstrated an inadequate treatment response or intolerance to a drug regimen of polyethylene glycol 3350 (PEG 3350) OR C. Patient has a documented contraindication to polyethylene glycol 3350 (PEG 3350). |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>            | 4 Months                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                   |

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| <b>Prior Authorization Group</b>    | REMICADE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                   | REMICADE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>           | Active infection (including TB). Murine protein hypersensitivity. Unstable moderate to severe heart failure. NYHA Class III or IV. Combination therapy with other biologic agent(s).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b> | Latent TB screening with TB skin test or interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to Remicade request. For positive latent TB, patient must have completed or is receiving treatment for LTBI prior to initiating Remicade. For those at risk for Hepatitis B (HBV) infection, HBV has been ruled out or treatment has been initiated. For moderately to severely active RA, Remicade will be used with MTX or leflunomide, unless contraindicated or intolerant to such therapies AND inadequate response or intolerance to Humira or Enbrel OR contraindication to Humira or Enbrel and one of the following: 1) Inadequate response to MTX OR 2) inadequate response to another nonbiologic DMARD such as leflunomide, hydroxychloroquine, sulfasalazine if contraindicated or intolerant to MTX OR 3) intolerance or contraindication to at least 2 nonbiologic DMARDs OR 4) Remicade will be used as first-line therapy with MTX for severely active RA. For Crohn's disease, fistulizing disease OR inadequate response or intolerance to Humira OR contraindication to Humira and inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine) unless contraindicated or intolerant to such therapies. For ankylosing spondylitis, inadequate response, intolerance, or contraindication to Humira or Enbrel. For plaque psoriasis, at least 5% BSA affected or crucial body areas (e.g., feet, hands, face, neck and/or groin) affected AND inadequate response or intolerance to Humira or Enbrel OR contraindication to Humira or Enbrel and an inadequate response to either phototherapy or a conventional systemic therapy, unless contraindicated or intolerant to such therapies. For ulcerative colitis, inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine) unless contraindicated or intolerant to such therapies. (Step therapy applies to new starts only). |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>            | Initial: 14 weeks for IBD. Plan year for all other indications. Renewal: plan year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>               | For renewal, patient's condition must have improved or stabilized.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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| <b>Prior Authorization Group</b>    | REVATIO                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                   | REVATIO, SILDENAFIL CITRATE                                                                                                                                                                                                                                                                                                                  |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>           | Patient requires nitrate therapy on a regular or intermittent basis.                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b> | NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: patient has had an inadequate response or intolerance to Adcirca (tadalafil). For Revatio injection: patient was previously receiving Revatio tablets but is now temporarily unable to take oral medications. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>            | Plan year for Revatio tablets. 3 months for Revatio injection.                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                              |

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

REVLIMID

REVLIMID

All FDA-approved indications not otherwise excluded from Part D, chronic lymphocytic leukemia (CLL), myelodysplastic syndromes (MDS) without the deletion 5q, progressive solitary plasmacytoma or smoldering myeloma that has progressed to active/symptomatic myeloma, systemic light chain amyloidosis, and the following subtypes of non-Hodgkin's lymphomas (NHL): AIDS-related diffuse large B-cell lymphoma (DLBCL), AIDS-related lymphoma associated with Castleman's disease, AIDS-related primary effusion lymphoma, DLBCL, follicular lymphoma (FL), gastric mucosa associated lymphoid tissue (MALT) lymphoma, mantle cell lymphoma (MCL), nodal marginal zone lymphoma, nongastric MALT lymphoma, primary cutaneous B-cell lymphoma (PCBCL), and splenic marginal zone lymphoma.

**Exclusion Criteria**

**Required Medical Information**

Pregnancy.

1) For active/symptomatic myeloma or progressive solitary plasmacytoma, Revlimid is warranted in any of the following settings: a) Revlimid is used as primary induction therapy in combination with dexamethasone or both melphalan and prednisone, b) Revlimid is used as maintenance monotherapy for patients responding to primary induction therapy or for patients with stable or responsive disease following stem cell transplant, c) Revlimid is used as salvage or palliative therapy. 2) For low or intermediate-1 risk MDS, Revlimid is warranted in any of the following settings: a) In those with a 5q deletion, patients have transfusion-dependent anemia (i.e., greater than 2 units of red blood cells in the previous 8 weeks) or symptomatic anemia, b) In those without a 5q deletion and symptomatic anemia, patients have pretreatment serum erythropoietin level greater than 500 mU/mL or both a pretreatment serum erythropoietin level less than or equal to 500 mU/mL and have failed a trial of epoetin or darbepoetin. 3) For NHL, Revlimid is warranted in any of the following settings: a) Revlimid is used in relapsed or refractory disease in patients with CLL, b) Revlimid is used as monotherapy or in combination with rituximab for relapsed, refractory, or progressive disease in the following subtypes of NHL: i) AIDS-related DLBCL, ii) AIDS-related lymphoma associated with Castleman's disease, iii) AIDS-related primary effusion lymphoma, iv) DLBCL, v) FL, vi) gastric MALT lymphoma, vii) MCL, viii) nodal marginal zone lymphoma, ix) nongastric MALT lymphoma, x) PCBCL, xi) splenic marginal zone lymphoma. 4) For systemic light chain amyloidosis, Revlimid is used in combination with dexamethasone as primary therapy. 5) For female patients of child-bearing potential, pregnancy is excluded by two negative serum or urine pregnancy tests. 6) Complete blood counts are regularly evaluated for hematological toxicity.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Plan Year

All patients are monitored for signs and symptoms of thromboembolism. Female patients of child-bearing potential and male patients are instructed on the importance and proper utilization of appropriate contraceptive methods.

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

RIBAVIRIN

REBETOL, RIBAPAK, RIBASPHERE, RIBAVIRIN

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

Pregnancy (self or partner) or unwilling to use adequate contraception (self or partner), hemoglobinopathy, hemoglobin less than 8.5 g/dL, poorly controlled or deteriorating cardiac disease, coadministration with didanosine in HIV coinfecting patients.

Chronic Hepatitis C (HCV): HCV genotype (G), detectable viral load (VL) prior to starting treatment (tx). HCV coinfecting with HIV: Max 48 wk. Tx naive and retreatment (re-tx) with PEG-IFN, Victrelis + ribavirin (RBV) (G1): 1) Receive 4 wks of PEG-IFN + RBV prior to starting Victrelis, 2) VL at wks 4, 8, 12, 24, 3) VL is less than 100 IU/mL at wk 12, 4) undetectable (UD) VL at wk 24, 5) Max 28 wks for tx naive pts with UD VL at wk 8, 6) Max 36 wks for re-tx pts with UD VL at wk 8, 7) Allow up to 48 weeks for: a) Pts with cirrhosis, b) Poorly IFN-responsive (less than 1.0-log drop in VL at wk 4), b) Null responders with prior tx (less than 2-log drop in VL at wk 12 of prior tx), c) Pts with detectable VL at wk 8. Tx naive and re-tx with PEG-IFN, Incivek + RBV (G1): 1) VL at wks 4, 12, 24, 2) VL less than or equal to 1,000 IU/mL at wks 4, 12, 2) UD VL at wk 24, 3) Max 24 wks for tx naive or relapsers with UD VL wks 4 AND 12, 4) Allow up to 48 weeks for: a) Pts with cirrhosis (tx naive or relapsers), b) Pts with detectable VL at wks 4 and/or 12 of tx (tx naive or relapsers), c) Prior nonresponders (including partial and null response). Tx naive, dual tx with PEG-IFN + ribavirin (G2,3): Max 24 weeks. Tx naive, dual tx with PEG-IFN + ribavirin (G1,4): 1) UD VL at wk 12, OR at least a 2 log decrease in VL from baseline at wk 12 plus UD VL at wk 24, 2) Max 48 wks if UD VL at wk 12, 3) Max 48 wks if UD VL at wk 24. Re-tx with dual tx with PEG-IFN + RBV: 1) Allow only 1x re-tx with PEG-IFN + RBV as dual tx, 2) UD VL at wk 12, OR at least 2 log decrease in VL from baseline at wk 12 plus UD VL at wk 24, 3) Max 48 wks if UD VL at wk 12, 4) Max 48 wks if UD VL at wk 24. Tx naive or re-tx, with a non-pegylated IFN + RBV: 1) Must have documented adverse reaction (ADR) or is at higher risk for an ADR with a PEG-IFN, 2) Max 48 wks.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Based on genotype and response, 12 to 48 wks for dual tx and 6 to 48 wks for triple tx. Patient is instructed to practice effective contraception during therapy and for 6 months after stopping ribavirin. For all patients with CrCl less than 50 mL/minute: will be treated with reduced doses of both RBV and IFN with careful monitoring by a specialist.

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| <b><i>Prior Authorization Group</i></b>    | RISPERDAL CONSTA                                                                                                                                                                                                                                                                                                      |
| <b><i>Drug Names</i></b>                   | RISPERDAL CONSTA                                                                                                                                                                                                                                                                                                      |
| <b><i>Covered Uses</i></b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                      |
| <b><i>Exclusion Criteria</i></b>           | Dementia-related psychosis.                                                                                                                                                                                                                                                                                           |
| <b><i>Required Medical Information</i></b> | A. The patient has a history of non-compliance and/or refuses to utilize oral medications.<br>B. The patient must have a history of 3 test doses of oral Risperdal (risperidone). C. If the patient is increasing the dose of Risperdal Consta the patient has a history of two prior injections of Risperdal Consta. |
| <b><i>Age Restrictions</i></b>             |                                                                                                                                                                                                                                                                                                                       |
| <b><i>Prescriber Restrictions</i></b>      | Psychiatrist or receiving input from psychiatry practice                                                                                                                                                                                                                                                              |
| <b><i>Coverage Duration</i></b>            | Plan Year                                                                                                                                                                                                                                                                                                             |
| <b><i>Other Criteria</i></b>               |                                                                                                                                                                                                                                                                                                                       |

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

RITUXAN

RITUXAN

All FDA-approved indications not otherwise excluded from Part D. Primary CNS lymphoma. Metastatic CNS cancer with lesions. Lymphocyte-predominant Hodgkin lymphoma when Rituxan will be used as primary treatment. Marginal zone lymphomas (nodal, splenic, and MALT). Mantle cell lymphoma in combination with other agents or chemotherapy. Burkitt lymphoma in combination with chemotherapy. Lymphoblastic lymphoma in combination with chemotherapy. AIDS-related B-cell lymphoma. Small lymphocytic lymphoma. Post-transplant lymphoproliferative disorder (PTLD). Primary cutaneous B-cell lymphoma. Acute lymphoblastic leukemia in combination with hyperCVAD chemotherapy. Acquired blood factor VIII deficiency. Autoimmune hemolytic anemia. Chronic graft-versus-host disease. Relapsed or refractory Hairy cell leukemia. Multicentric Castleman's disease with HIV. Refractory immune or idiopathic thrombocytopenia purpura (ITP). Waldenstroms macroglobulinemia/ lymphoplasmacytic lymphoma.

**Exclusion Criteria**

Severe, active infection. Concomitant use of another biologic agent. History of severe skin or infusion reactions with prior Rituxan use that cannot be appropriately managed.

**Required Medical Information**

Prior to initiating therapy, the prescriber has assessed the patient's risk of hepatitis B, and if appropriate, ruled out or initiated treatment of hepatitis B. For RA: used in combination with methotrexate for the treatment of moderately to severely active RA in patients who have an inadequate response or intolerance/contraindication to Enbrel or Humira (Step therapy applies to new starts only). For Wegener's Granulomatosis and Microscopic Polyangiitis, Rituxan is used in combination with glucocorticoids. Hematologic malignancies must be CD20-positive. For DLBCL, patient meets one of the following: 1) previously untreated DLBCL in combination with chemotherapy OR 2) previously treated DLBCL in combination with chemotherapy for a patient who is a candidate for autologous stem cell transplant OR 3) previously treated DLBCL in a patient who is not a candidate for autologous stem cell transplant.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Plan Year

For continuation of therapy for RA: improvement in clinical symptoms is required from the last treatment course, which was at least 16 weeks earlier. Patient monitored for pulmonary toxicity.



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| <b>Prior Authorization Group</b>    | SABRIL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                   | SABRIL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b> | Vision is assessed by an ophthalmologist at baseline or within 4 weeks of starting Sabril and will continue to be assessed every 3 months during therapy except patients exempted from vision testing (e.g., pre-existing blindness). For infantile spasms only: Sabril is used as monotherapy. For complex partial seizures (CPS) only: patient had an inadequate response to 2 alternative therapies (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine) for CPS and Sabril is used as adjunctive therapy. |
| <b>Age Restrictions</b>             | Initial treatment infantile spasms, 1 month to 2 years. CPS, 16 years of age and older                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>            | 12 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

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| <b>Prior Authorization Group</b>    | SANDOSTATIN LAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                   | SANDOSTATIN LAR DEPOT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, atypical lung carcinoids, islet cell tumors, multiple endocrine neoplasia type 1 (MEN 1).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b> | For initiation of acromegaly therapy, patient meets the following: 1) Clinical evidence of acromegaly, 2) Pre-treatment high IGF-1 level for age/gender, 3) Patient has had an inadequate or partial response to surgery and/or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy (e.g., medically unstable conditions, patient is at high risk for complications of anesthesia because of airway difficulties, lack of an available skilled surgeon, patient refuses surgery or prefers the medical option over surgery, major systemic manifestations of acromegaly including cardiomyopathy, severe hypertension and uncontrolled diabetes). For continuation of acromegaly therapy, the IGF-1 level decreased or normalized. For atypical lung carcinoids, use in combination with chemotherapy. For islet cell tumors, patient has insulinoma, glucagonoma, or VIPoma. For MEN 1, patient meets one of the following: 1) Patient has insulinoma, glucagonoma, or VIPoma OR 2) Patient has pituitary adenoma and is symptomatic or has significant tumor burden. Patient received at least 2 weeks of initial treatment with Sandostatin Injection (not the Depot formulation) and treatment with Sandostatin Injection was effective and tolerable. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

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

**Prior Authorization Group** SOMATULINE DEPOT  
**Drug Names** SOMATULINE DEPOT  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information** Patient meets the following criteria for initiation of therapy: 1) Clinical evidence of acromegaly, 2) Pre-treatment high IGF-1 level for age/gender, and 3) Patient has had an inadequate or partial response to surgery and/or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy (e.g., medically unstable conditions, patient is at high risk for complications of anesthesia because of airway difficulties, lack of an available skilled surgeon, patient refuses surgery or prefers the medical option over surgery, major systemic manifestations of acromegaly including cardiomyopathy, severe hypertension and uncontrolled diabetes). For continuation of therapy, the IGF-1 level decreased or normalized.  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria**

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| <b>Prior Authorization Group</b>    | SOMAVERT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                   | SOMAVERT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b> | Patient meets the following criteria for initiation of therapy: 1) Clinical evidence of acromegaly, 2) Pre-treatment high IGF-1 level for age/gender, 3) Patient has had an inadequate or partial response to octreotide or lanreotide OR patient is intolerant to or has a contraindication to octreotide or lanreotide, and 4) Patient has had an inadequate or partial response to surgery and/or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy (e.g., medically unstable conditions, patient is at high risk for complications of anesthesia because of airway difficulties, lack of an available skilled surgeon, patient refuses surgery or prefers the medical option over surgery, major systemic manifestations of acromegaly including cardiomyopathy, severe hypertension and uncontrolled diabetes). For continuation of therapy, the IGF-1 level decreased or normalized. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

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| <b>Prior Authorization Group</b>    | SORIATANE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                   | SORIATANE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, Prevention of non-melanoma skin cancers in high risk individuals                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>           | A. Severely impaired liver function. B. Severely impaired kidney function. C. Chronic abnormally elevated blood lipid values. D. Currently taking methotrexate or tetracycline.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b> | A. If the patient is female and able to bear children (e.g., no hysterectomy, not reached menopause, has achieved menses). AND B. The patient is unresponsive to other therapies for the covered diagnoses OR the other therapies for the treatment of the covered diagnoses are contraindicated due to the clinical condition of the patient. AND C. Pregnancy has been excluded as confirmed by 2 negative urine or serum pregnancy tests with a sensitivity of at least 25 mIU/mL. AND D. the patient has chosen to use any of the following methods of contraception: one primary form (e.g., tubal ligation, partner's vasectomy, intrauterine devices, birth control pills, injectable/implantable/insertable/topical hormonal birth control products) plus one secondary form (e.g., diaphragms, latex condoms, cervical caps) used in combination with a spermicide OR absolute abstinence. AND E. The patient has agreed to use her chosen form of contraception for at least 1 month before initiation of Soriatane therapy, during Soriatane therapy, and for at least 3 years after discontinuation of therapy. AND F. The patient has been advised that ethanol must not be ingested by female patients during Soriatane treatment and for 2 months following therapy. AND G. The patient will have a negative pregnancy test on a monthly basis. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>               | Female patient or guardian signed a Patient Agreement/Informed Consent.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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| <b>Prior Authorization Group</b>    | SPRYCEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                   | SPRYCEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, gastrointestinal stromal tumor (GIST)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b> | For ALL and newly diagnosed CML, patient must be positive for the Ph chromosome or BCR-ABL gene. For ALL, patient meets one of the following: 1) ALL is newly diagnosed and Sprycel is used in combination with chemotherapy, OR 2) resistance or intolerance to prior therapy. For CML, patient meets one of the following: 1) newly diagnosed in chronic phase, 2) resistance or intolerance/toxicity to imatinib or nilotinib, 3) relapse after hematopoietic stem cell transplant or 4) advanced phase (accelerated or blast phase). GIST in patients with disease progression on imatinib or sunitinib. |
| <b>Age Restrictions</b>             | 18 years or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <br>                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>    | STIVARGA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                   | STIVARGA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b> | Patient with mCRC must have been previously treated with the following: fluoropyrimidine-, oxaliplatin- and irinotecan-based regimen, an anti-VEGF agent, and an anti-EGFR agent if KRAS wild type. Patient with GIST must have been previously treated with imatinib or sunitinib.                                                                                                                                                                                                                                                                                                                          |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

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| <b>Prior Authorization Group</b>    | SUTENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                   | SUTENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), lung neuroendocrine tumors, angiosarcoma, solitary fibrous tumor, and hemangiopericytoma.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>           | Clinical manifestations of congestive heart failure (CHF).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b> | For RCC, patient has advanced RCC. For GIST: patient had disease progression on imatinib or was intolerant to imatinib. For PNETs: patient has well differentiated tumors and progressive unresectable locally advanced or metastatic disease. For LNETs: tumors are low or intermediate grade (typical or atypical carcinoid) and patient has unresectable or advanced disease (stage IIIb-IV). For follicular, papillary, or Hurthle cell thyroid carcinoma: patient has clinically progressive or symptomatic metastatic disease with nonradioiodine-responsive tumors at sites other than central nervous system. For medullary thyroid carcinoma: patient has disseminated symptomatic disease with progression on vandetanib or vandetanib is not appropriate. For angiosarcoma, solitary fibrous tumor, or hemangiopericytoma: Sutent will be used as a single agent. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>               | Patient will be monitored for signs and symptoms of CHF. Liver function test monitoring at initiation of therapy and throughout treatment. Sutent therapy will be interrupted for serious hepatic adverse events and discontinued if serious hepatic adverse events do not resolve.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <br>                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>    | SYLATRON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                   | SYLATRON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia (CML)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>           | Autoimmune hepatitis. Decompensated hepatic disease. Uncontrolled major depression or severe mental illness.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b> | For Melanoma: must have microscopic or gross nodal involvement and had a surgical resection of the tumor including complete lymphadenectomy. For CML: patient unable to tolerate a tyrosine kinase inhibitor (eg, imatinib, dasatinib, or nilotinib) or post-transplant patient without remission or with relapse.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <br>                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>               | Patients will be monitored and evaluated for signs and symptoms of depression and other psychiatric symptoms throughout treatment. For melanoma, Sylatron must be requested within 84 days (12 weeks) of the surgical resection.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

**Prior Authorization Group** SYMLIN  
**Drug Names** SYMLINPEN 120, SYMLINPEN 60  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** A. Severe hypoglycemia that required assistance during the past 6 months. B. Gastroparesis. C. Patient requires drug therapy to stimulate gastrointestinal motility. D. Hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia). E. HbA1c level greater than 9 percent.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Plan Year

A. If patient received Symlin in previous 3 months, patient demonstrated an expected reduction in HbA1c since starting Symlin therapy. OR B. The patient has inadequate glycemic control (HbA1c greater than 7percent). AND C. Patient is currently receiving optimal mealtime insulin therapy.

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

TARCEVA

TARCEVA

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

Non-small cell lung cancer (NSCLC) is locally advanced or metastatic. If used for first line treatment of NSCLC, patient has a known active epidermal growth factor receptor (EGFR) mutation or amplification of the EGFR gene. If used for second or third line treatment of NSCLC, Tarceva is used as monotherapy. If used for maintenance treatment of NSCLC, the following criteria are met: 1) patient responded to or remains stable after four cycles of platinum-based chemotherapy, AND 2) Tarceva is being used as monotherapy. For pancreatic cancer, the following criteria are met: 1) pancreatic cancer is locally advanced, unresectable or metastatic, AND 2) Tarceva is used as first line treatment, AND 3) Tarceva is used in combination with gemcitabine.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Plan Year

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| <b>Prior Authorization Group</b>    | TARGRETIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                   | TARGRETIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, Mycosis fungoides, Sezary Syndrome (Capsules only), Adult T-cell leukemia/lymphoma (Gel only), and primary cutaneous B-cell lymphoma (Gel only)                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>           | Pregnancy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b> | Targretin Capsule: Patient must meet one of following criteria: received prior systemic therapy for CTCL OR advanced-stage MF (stage IIB, III or IV) or SS OR early-stage MF (stage IA, IB or IIA) with folliculotropic/large cell transformation OR early-stage MF (stage IA, IB or IIA) refractory to skin directed therapy. Targretin Gel: Patient must meet one of following criteria for CTCL: early-stage MF (stage IA, IB, or IIA) OR stage IIB or III MF in combination with systemic therapy. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Other Criteria</b>               | Patient has been instructed on the importance and proper utilization of appropriate contraceptive methods.                                                                                                                                                                                                                                                                                                                                                                                             |

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| <b>Prior Authorization Group</b>    | TASIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                   | TASIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D, acute lymphoblastic leukemia (ALL), gastrointestinal stromal tumor (GIST).                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>           | Uncorrected hypokalemia or hypomagnesemia, long QT syndrome.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b> | ECG monitored at baseline, 7 days after initiation, and periodically during treatment. For ALL and newly diagnosed CML, patient must be positive for the Ph chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) newly diagnosed CML and Tasigna is used for first line treatment, OR 2) resistance to imatinib or dasatinib, OR 3) intolerance to imatinib or dasatinib, OR 4) relapse after hematopoietic stem cell transplant. For ALL, patient has relapsed or refractory ALL. For GIST, disease progression on imatinib or sunitinib. |
| <b>Age Restrictions</b>             | 18 years or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>               | Patient has been instructed to take Tasigna 1 hour before or 2 hours after a meal. Drugs known to prolong the QT interval or any strong CYP 3A4 inhibitors should be avoided. If patient has hepatic impairment, a lower starting dose will be considered.                                                                                                                                                                                                                                                                                                        |



**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

THALOMID

THALOMID

All FDA-approved indications not otherwise excluded from Part D, myelofibrosis with myeloid metaplasia, progressive solitary plasmacytoma or smoldering myeloma that has progressed to active/symptomatic myeloma, systemic light chain amyloidosis, and Waldenstrom's macroglobulinemia.

Pregnancy.

1) For ENL, Thalomid is used for maintenance therapy or as part of a combination regimen in a patient with moderate to severe neuritis for acute therapy. 2) For active/symptomatic myeloma or progressive solitary plasmacytoma, Thalomid is warranted in any of the following settings: a) Thalomid is used in combination with dexamethasone or both melphalan and prednisone as primary induction therapy, b) Thalomid is used as maintenance monotherapy for patients responding to primary induction therapy or for patients with stable or responsive disease following stem cell transplant, c) Thalomid is used as salvage or palliative therapy. 3) Use for treatment of myelofibrosis with myeloid metaplasia. 4) For systemic light chain amyloidosis, Thalomid is used as primary treatment in combination with dexamethasone. 5) For Waldenstrom's macroglobulinemia, Thalomid is used as monotherapy or in combination with rituximab. 6) In females of childbearing potential, pregnancy is excluded as confirmed by a negative serum or urine pregnancy test.

Plan Year

All patients are monitored for signs and symptoms of thromboembolism. Female patients of child-bearing potential and male patients are instructed on the importance and proper utilization of appropriate contraceptive methods for Thalomid use.

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| <b>Prior Authorization Group</b>    | TOPICAL IMMUNOSUPPRESSANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                   | ELIDEL, PROTOPIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b> | A. For Elidel, the diagnosis of mild to moderate atopic dermatitis (eczema). For Protopic, the diagnosis of moderate to severe atopic dermatitis (eczema). B. Patient completed a documented trial and failure of at least one medium or higher potency topical steroid or has a documented intolerance or unresponsiveness to medium or higher potency topical steroids. C. Patients have been advised that Elidel and Protopic should only be used to treat the immediate problem and then should be stopped when the condition improves. |
| <b>Age Restrictions</b>             | 2 years of age or older, unless Protopic 0.1% 16 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

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| <b>Prior Authorization Group</b>    | TOPICAL TESTOSTERONES                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                   | ANDROGEL, ANDROGEL PUMP, TESTIM                                                                                                                                                                                                                               |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>           | A. Female. B. Carcinoma of the breast or known or suspected prostate cancer.                                                                                                                                                                                  |
| <b>Required Medical Information</b> | Before the start of testosterone therapy patient had (or patient currently has) a confirmed low testosterone level (i.e., morning total testosterone less than 300 ng/dL, morning free testosterone less than 9 ng/dL) or absence of endogenous testosterone. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                               |

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| <b>Prior Authorization Group</b>    | TRACLEER                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                   | TRACLEER                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>           | Pregnancy. Concomitant use with cyclosporine or glyburide. For initial therapy: alanine aminotransferase (ALT)/aspartate aminotransferase (AST) level greater than 3 times the upper limit of normal (ULN). For continuation of therapy: ALT/AST level greater than 3 times ULN that is accompanied by one of the following: 1) signs or symptoms of liver dysfunction, 2) bilirubin level greater than or equal to 2 times ULN. |
| <b>Required Medical Information</b> | NYHA Functional Class II to IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy and will be excluded monthly during therapy, AND 2) Patient will use reliable contraception during treatment and for one month after stopping treatment.                                                        |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                                                                  |

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| <b>Prior Authorization Group</b>    | TRELSTAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                   | TRELSTAR DEPOT MIXJECT, TRELSTAR LA MIXJECT                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>           | Use as neoadjuvant ADT for radical prostatectomy.                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b> | Prostate cancer, must meet one of the following: 1) Locally advanced, recurrent or metastatic disease (including palliative treatment) , OR 2) Use as neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with intermediate or high risk of recurrence, OR 3) Use as neoadjuvant therapy in conjunction with brachytherapy in patients with a large prostate to shrink the prostate to an acceptable size for brachytherapy. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>               | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                                                                                                                                                                                                                                              |

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

VICTRELIS

VICTRELIS

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

Failed previous therapy with a treatment regimen that includes a protease inhibitor (eg, Incivek, Victrelis). Concomitant administration with a drug that is highly dependent on CYP3A4/5 for clearance or is a potent CYP3A4/5 inducer (ie, alfuzosin, carbamazepine, cisapride, drospirenone, dihydroergotamine, ergonovine, ergotamine, methylergonovine, lovastatin, oral midazolam, phenobarbital, phenytoin, pimozone, rifampin, simvastatin, St. John's wort, triazolam, Adcirca or Revatio when used for PAH). Concomitant use of any of the following ritonavir-boosted HIV protease inhibitors: atazanavir, lopinavir, or darunavir for new starts.

**Required Medical Information**

Diagnosis of chronic hepatitis C and meets the following criteria: 1) Detectable viral load prior to starting therapy for all patients, 2) HCV Genotype 1, 3) Must be given in combination with PEG-IFN (ie, Pegasys or PegIntron) and ribavirin, 4) Patient will receive 4 weeks of PEG-IFN and ribavirin prior to starting Victrelis, 5) Assess viral load at weeks 4, 8, 12, and 24 of Victrelis triple therapy, 6) Viral load less than 100 IU/mL at week 12, 7) Undetectable viral load at week 24, 8) Allow up to 24 weeks for treatment naïve patients with undetectable viral load at week 8, 9) Allow up to 32 weeks for treatment naïve patients with detectable viral load at week 8, 10) Allow up to 32 weeks for retreatment patients with detectable or undetectable viral load at week 8, 11) Allow up to 44 weeks for: a) Patients with cirrhosis, b) Poorly IFN-responsive (less than 1.0-log drop in viral load at week 4 of treatment), c) Null responders with prior therapy (less than 2-log drop in viral load at week 12 of prior treatment).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Initial: 10 weeks. Continuation of therapy: up to 44 weeks

Patients who are already taking Victrelis and one of the following ritonavir-boosted HIV protease inhibitors: atazanavir, lopinavir, or darunavir will be monitored closely by the prescriber for HCV treatment response and for potential HCV and HIV virologic rebound.

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| <b>Prior Authorization Group</b>    | VPRIV                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                   | VPRIV                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>           | Concomitant therapy with miglustat                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b> | Patient has a diagnosis of type 1 Gaucher disease. Diagnosis of Gaucher disease is confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity. Therapy is initiated for a patient with one or more of the following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.                                  |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                 |
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| <b>Prior Authorization Group</b>    | XALKORI                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                   | XALKORI                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>           |                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b> | Patient has a diagnosis of locally advanced or metastatic non-small cell lung cancer that is ALK-positive as detected by an FDA-approved test.                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                 |
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| <b>Prior Authorization Group</b>    | XENAZINE                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                   | XENAZINE                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>           | Patients who are actively suicidal or have untreated or inadequately treated depression. Impaired hepatic function. Use of Xenazine in combination with a monoamine oxidase inhibitor (MAOI) or it has been less than 14 days since the MAOI was discontinued. Use of Xenazine in combination with reserpine or it has been less than 20 days since reserpine was discontinued. |
| <b>Required Medical Information</b> | Patient has chorea associated with Huntington's disease.                                                                                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>               |                                                                                                                                                                                                                                                                                                                                                                                 |

**Prior Authorization Group** XIFAXAN  
**Drug Names** XIFAXAN  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions** 18 years of age or older  
**Prescriber Restrictions**  
**Coverage Duration** Hepatic encephalopathy - 6 months  
**Other Criteria** The recommended dose of two 550 mg tablets daily will not be exceeded.

**Prior Authorization Group** XOLAIR  
**Drug Names** XOLAIR  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information** Xolair will be used in combination with other medications for long-term control of asthma, and patient will have a short-acting beta2-agonist available for rescue therapy. For initial Xolair therapy, patient meets all the following: 1) Positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Baseline IgE level at or above 30 IU/mL, 3) Asthma is inadequately controlled despite use of inhaled corticosteroid at the optimal dose, 4) Patient is using a long-acting inhaled beta2-agonist, leukotriene modifier, or theophylline, and 5) Patient has been adherent with prescribed asthma treatments. To continue Xolair therapy, patient must have improved asthma control OR have a documented clinical reason for lack of improvement (e.g., patient has received less than 6 months of Xolair therapy, patient was not receiving appropriate dose of IgE level and weight, or patient was nonadherent with therapy, but will be adherent going forward).  
**Age Restrictions** 12 years of age or older  
**Prescriber Restrictions** Pulmonologist, allergist, or immunologist  
**Coverage Duration** Plan Year  
**Other Criteria** Xolair will be administered in a controlled healthcare setting with access to emergency medications (e.g., anaphylaxis kit) and appropriate observation following administration. Patient will be provided with an epinephrine self-injection pen for use in the event of a delayed allergic/anaphylactic reaction outside of a controlled healthcare setting.

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| <b>Prior Authorization Group</b>    | XTANDI                                                                                                               |
| <b>Drug Names</b>                   | XTANDI                                                                                                               |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                     |
| <b>Exclusion Criteria</b>           |                                                                                                                      |
| <b>Required Medical Information</b> | Patient must have metastatic, castration-resistant prostate cancer. Patient must have previously received docetaxel. |
| <b>Age Restrictions</b>             |                                                                                                                      |
| <b>Prescriber Restrictions</b>      |                                                                                                                      |
| <b>Coverage Duration</b>            | Plan Year                                                                                                            |
| <b>Other Criteria</b>               |                                                                                                                      |

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| <b>Prior Authorization Group</b>    | XYREM                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                   | XYREM                                                                                                                                                                                                                                            |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>           | If the patient is taking alcohol (ethanol), sedative/hypnotic drugs, or other CNS depressants.                                                                                                                                                   |
| <b>Required Medical Information</b> | A. Patient has a diagnosis of narcolepsy and experiences episodes of cataplexy OR B. Patient has a diagnosis of narcolepsy and experiences excessive daytime sleepiness with symptoms that limit the ability to perform normal daily activities. |
| <b>Age Restrictions</b>             |                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>            | 3 months                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>               | If the patient has received prior treatment with Xyrem, the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.                                                            |

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| <b>Prior Authorization Group</b>    | ZELBORAF                                                                                                                                                  |
| <b>Drug Names</b>                   | ZELBORAF                                                                                                                                                  |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                                                          |
| <b>Exclusion Criteria</b>           |                                                                                                                                                           |
| <b>Required Medical Information</b> | Patient has a diagnosis of unresectable or metastatic melanoma and the tumor is positive for the BRAF V600E mutation as detected by an FDA-approved test. |
| <b>Age Restrictions</b>             |                                                                                                                                                           |
| <b>Prescriber Restrictions</b>      |                                                                                                                                                           |
| <b>Coverage Duration</b>            | Plan Year                                                                                                                                                 |
| <b>Other Criteria</b>               |                                                                                                                                                           |

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| <b>Prior Authorization Group</b>    | ZYTIGA                                                                                                                  |
| <b>Drug Names</b>                   | ZYTIGA                                                                                                                  |
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.                                                        |
| <b>Exclusion Criteria</b>           |                                                                                                                         |
| <b>Required Medical Information</b> | Patient must have metastatic, castration-resistant prostate cancer. Zytiga will be used in combination with prednisone. |
| <b>Age Restrictions</b>             |                                                                                                                         |
| <b>Prescriber Restrictions</b>      |                                                                                                                         |
| <b>Coverage Duration</b>            | Plan Year                                                                                                               |
| <b>Other Criteria</b>               |                                                                                                                         |