



## **PA Criteria**

### ***Prior Authorization Group***

ACITRETIN

### ***Drug Names***

ACITRETIN

### ***Covered Uses***

All FDA-approved indications not otherwise excluded from Part D, Prevention of non-melanoma skin cancers in high risk individuals.

### ***Exclusion Criteria***

Severely impaired liver function or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracycline.

### ***Required Medical Information***

#### ***Age Restrictions***

#### ***Prescriber Restrictions***

#### ***Coverage Duration***

Plan Year

#### ***Other Criteria***

If the patient is able to bear children, the patient and/or guardian signed a Patient Agreement/Informed Consent (e.g., Do Your P.A.R.T) which includes confirmation of 2 negative pregnancy tests.

### ***Prior Authorization Group***

ACTIMMUNE

### ***Drug Names***

ACTIMMUNE

### ***Covered Uses***

All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, atopic dermatitis.

### ***Exclusion Criteria***

### ***Required Medical Information***

For chronic granulomatous disease, Actimmune is used for reducing the frequency and severity of serious infections associated with chronic granulomatous disease. For atopic dermatitis, the condition is resistant to conservative treatments (e.g., topical medications, phototherapy).

#### ***Age Restrictions***

#### ***Prescriber Restrictions***

#### ***Coverage Duration***

Plan Year

#### ***Other Criteria***

<i>Prior Authorization Group</i>	ADAGEN
<i>Drug Names</i>	ADAGEN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Severe combined immunodeficiency disease (SCID) is due to adenosine deaminase (ADA) deficiency. Condition failed to respond to bone marrow transplantation or patient is not currently a suitable candidate for bone marrow transplantation.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	ADCIRCA
<i>Drug Names</i>	ADCIRCA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	Treatment with nitrate therapy on a regular or intermittent basis. Concomitant treatment with a guanylate cyclase stimulator (e.g., Adempas).
<i>Required Medical Information</i>	PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	ADEMPAS
<i>Drug Names</i>	ADEMPAS
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	Treatment with a nitrate or nitric oxide donor medication (e.g., amyl nitrite) on a regular or intermittent basis. Concomitant treatment with a phosphodiesterase inhibitor (e.g., sildenafil, tadalafil, vardenafil, dipyridamole, theophylline).
<i>Required Medical Information</i>	For pulmonary arterial hypertension (PAH) (WHO Group 1): 1) PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI) or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
<i>Age Restrictions</i>	18 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<b>Prior Authorization Group</b>	AFINITOR
<b>Drug Names</b>	AFINITOR, AFINITOR DISPERZ
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangiomyomatosis.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Breast cancer: 1) The patient has advanced hormone receptor positive, HER2 negative disease, AND 2) Afinitor will be used in combination with exemestane, AND 3) The patient's disease a) has progressed within 12 months prior to starting Afinitor, OR b) was previously treated with a nonsteroidal aromatase inhibitor, OR c) was previously treated with tamoxifen. Renal cell carcinoma: 1) The disease is relapsed or medically unresectable, AND 2) For disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. Classical Hodgkin lymphoma: 1) The disease is relapsed or refractory AND 2) Afinitor will be used as a single agent. Thymomas and Thymic carcinomas: 1) The disease has progressed on a platinum-based chemotherapy regimen AND 2) Afinitor will be used as a single agent. Soft tissue sarcoma: 1) The patient has one of the following subtypes of STS: a) perivascular epithelioid cell tumors (PEComa), or b) angiomyolipoma, or c) lymphangiomyomatosis, AND 2) Afinitor will be used as a single agent. Subependymal giant cell astrocytoma associated with tuberous sclerosis complex (TSC): The patient is not a candidate for curative surgical resection. Renal angiomyolipoma associated with TSC: The patient does not require immediate surgery.

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

Plan Year

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

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

The diagnosis of mucopolysaccharidosis I is confirmed by either an enzyme assay showing a deficiency of alpha-L-iduronidase enzyme activity or by DNA testing. Patients with Scheie syndrome must have moderate to severe symptoms.

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

Plan Year

**Prior Authorization Group** ALECENSA  
**Drug Names** ALECENSA  
**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** ALGLUCOSIDASE  
**Drug Names** LUMIZYME  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information** Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by DNA testing that identifies mutations in the GAA gene.  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria**

**Prior Authorization Group** ALOSETRON  
**Drug Names** ALOSETRON HYDROCHLORIDE  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** Patient has a history of any of the following conditions: Chronic or severe constipation or sequelae from constipation. Intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions. Ischemic colitis. Impaired intestinal circulation, thrombophlebitis or hypercoagulable state. Crohn's disease or ulcerative colitis. Diverticulitis. Severe hepatic impairment.  
**Required Medical Information** 1) Lotronex is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) chronic IBS symptoms lasting at least 6 months AND 3) gastrointestinal tract abnormalities have been ruled out AND 4) inadequate response to conventional therapy.  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria**

<b>Prior Authorization Group</b>	ALPHA1-PROTEINASE INHIBITOR
<b>Drug Names</b>	ARALAST NP, PROLASTIN-C, ZEMAIRA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Patients must have clinically evident emphysema. Patients must have a pretreatment serum alpha1-proteinase inhibitor level less than 11 micromoles/L (80 mg/dl). Patients must have a pretreatment post-bronchodilation FEV1 greater than, or equal to, 25 percent and less than, or equal to, 80 percent of predicted.

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

<b>Prior Authorization Group</b>	ALUNBRIG
<b>Drug Names</b>	ALUNBRIG
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	

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

<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>	
<b>Required Medical Information</b>	For new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment and 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.

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

<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, Cachexia associated with AIDS (HIV-wasting) or due to chronic disease or Turner's syndrome.
<b>Exclusion Criteria</b>	Pregnancy. Known or suspected carcinoma of the prostate or breast in male patients. Carcinoma of the breast in females with hypercalcemia. Nephrosis, the nephrotic phase of nephritis. Hypercalcemia.
<b>Required Medical Information</b>	Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	ANADROL
<b>Drug Names</b>	ANADROL-50
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting), Fanconi's anemia.
<b>Exclusion Criteria</b>	Pregnancy. Carcinoma of the prostate or breast in male patients. Carcinoma of the breast in women with hypercalcemia. Nephrosis or the nephrotic phase of nephritis. Severe hepatic dysfunction.
<b>Required Medical Information</b>	Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 Months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	APOKYN
<b>Drug Names</b>	APOKYN
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concomitant treatment with a serotonin 5HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, and alosetron).
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<b><i>Prior Authorization Group</i></b>	ARCALYST
<b><i>Drug Names</i></b>	ARCALYST
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D. Prevention of gout flares in patients initiating or continuing urate-lowering therapy.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (new starts): all of the following criteria must be met: 1) serum uric acid concentration greater than or equal to 445 micromol/L (7.5 mg/dL) prior to initiating Arcalyst, 2) two or more gout flares within the previous 12 months, 3) inadequate response, intolerance or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, and 4) concurrent use with urate-lowering therapy (i.e., allopurinol or febuxostat). For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (continuation): 1) Member must have achieved or maintain a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline and 2) have continued use of urate-lowering therapy concurrently with Arcalyst.
<b><i>Age Restrictions</i></b>	CAPS: 12 years of age or older. Gout: 18 years of age or older.
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	For prevention of gout flares: 4 months. Other: Plan Year
<b><i>Other Criteria</i></b>	Abbreviation: CAPS = Cryopyrin-Associated Periodic Syndromes.

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



**Prior Authorization Group**

**Drug Names**

**Covered Uses**

AVASTIN

AVASTIN

All FDA-approved indications not otherwise excluded from Part D, breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, endometrial cancer, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma subtypes: angiosarcoma, solitary fibrous tumor, and hemangiopericytoma, malignant pleural mesothelioma, choroidal neovascularization associated with: ocular histoplasmosis, pathologic myopia, angioid streaks, inflammatory conditions, or of idiopathic etiology, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema due to retinal vein occlusion, diabetic macular edema, ocular neovascularization of the choroid, retina, or iris associated with proliferative diabetic retinopathy, neovascular glaucoma, and retinopathy of prematurity.

**Exclusion Criteria**

**Required Medical Information**

For CRC, Avastin (AV) will be used with a fluoropyrimidine- or irinotecan-based regimen (i.e., capecitabine, CapeOx, FOLFIRI, FOLFOX, FOLFOXIRI, or 5-FU with leucovorin) for: 1) perioperative (neoadjuvant/adjuvant/postoperative) therapy for advanced or metastatic disease or 2) treatment (tx) of unresectable advanced or metastatic disease. For NSCLC, the disease is unresectable, locally advanced, recurrent, or metastatic for patients with tumors of non-squamous cell histology, and no hx of recent hemoptysis and 1) AV will be used as first-line therapy or as subsequent therapy after prior therapy with erlotinib, afatinib, gefitinib or crizotinib a) AV will be used with cisplatin- or carboplatin-based regimens and b) Patient has distant mets or locoregional recurrence with evidence of disseminated disease, OR 2) AV will be used as a continuation maintenance tx (i.e., continuation of AV as first-line therapy beyond 4-6 cycles in the absence of disease progression) for tumor that is negative or unknown for both EGFR and ALK mutations and a) AV will be used alone or in combination with pemetrexed if previously used with a firstline pemetrexed/platinum chemotherapy regimen and b) Patient has achieved tumor response or stable disease following first-line chemotherapy. For malignant sex cord-stromal tumors, AV is used for clinical relapse in patient with granulosa cell tumors. For breast CA, 1) HER2-negative recurrent or metastatic disease and 2) AV is used with paclitaxel. For endometrial CA, AV is used alone for patients who progressed on prior cytotoxic chemotherapy.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Colorectal cancer perioperative therapy: 3 months. Other: Plan Year.

### *Other Criteria*

For angiosarcoma, Avastin is used as a single-agent. For solitary fibrous tumor or hemangiopericytoma, Avastin is used with temozolomide. For malignant pleural mesothelioma, Avastin is used with pemetrexed and cisplatin. For RCC, 1) relapsed or for surgically unresectable RCC and 2) Avastin is used as a) first-line tx with interferon alfa-2 for disease with clear cell histology or b) first-line tx as a single-agent for disease with non-clear cell histology, or c) subsequent tx as a single-agent for disease with predominant clear cell histology following prior cytokine tx. 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*

B VS. D

ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ADRUCIL, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMIFOSTINE, AMINOSYN, AMINOSYN 7%/ELECTROLYTES, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 8.5%/ELECTROL, AMINOSYN M, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-PF 7%, AMINOSYN-RF, AMPHOTERICIN B, APREPITANT, AZACITIDINE, AZATHIOPRINE, BENDEKA, BICNU, BLEOMYCIN SULFATE, BUDESONIDE, BUSULFAN, BUSULFEX, CALCITONIN-SALMON, CALCITRIOL, CARBOPLATIN, 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%, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DACARBAZINE, DAUNORUBICIN HCL, DEPO-PROVERA, DEXRAZOXANE, DIPHTHERIA/TETANUS TOXOID, DOCEFREZ, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HCL LIPOSOME, DRONABINOL, DURAMORPH, ELITEK, EMEND, EMEND TRIPACK, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FLUDARABINE PHOSPHATE, FLUOROURACIL, FORTICAL, FREAMINE HBC 6.9%, FREAMINE III, FUSILEV, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, HYDROXYPROGESTERONE CAPRO, IDARUBICIN HCL, IFEX, IFOSFAMIDE, INTRALIPID, INTRON A, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTODAX (OVERFILL), KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVOCARNITINE, LEVOLEUCOVORIN, LEVOLEUCOVORIN CALCIUM, LIDOCAINE HCL, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MIACALCIN, MITOMYCIN, MITOXANTRONE HCL, MORPHINE SULFATE, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEBUPENT, NEORAL, NEPHRAMINE, NIPENT, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISON, PREDNISON INTENSOL, PREMASOL, PROCALAMINE, PROGRAF, PROLEUKIN, PROSOL, RAPAMUNE, RECOMBIVAX HB, SANDIMMUNE, SIROLIMUS, TACROLIMUS, TAXOTERE, TENIVAC, TETANUS/DIPHTHERIA TOXOID, TOPOSAR, TOPOTECAN HCL, TPN ELECTROLYTES, TRAVASOL, TREANDA, TRISENOX, TROPHAMINE, VINBLASTINE SULFATE, VINCASAR PFS, VINCRIStINE SULFATE, VINOReLBINE TARTRATE, XATMEP, ZOLEDRONIC ACID, ZORTRESS

<i>Covered Uses</i>	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.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	N/A
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	BANZEL
<i>Drug Names</i>	BANZEL
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	The patient has Familial Short QT Syndrome.
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	1 year of age or older.
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	BELEODAQ
<i>Drug Names</i>	BELEODAQ
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<b><i>Prior Authorization Group</i></b>	BENLYSTA
<b><i>Drug Names</i></b>	BENLYSTA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	Severe active lupus nephritis. Severe active central nervous system lupus.
<b><i>Required Medical Information</i></b>	Diagnosis of active, autoantibody-positive systemic lupus erythematosus (SLE). Member is currently receiving standard therapy for SLE (eg, corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) or has tried and had an inadequate response or intolerance to standard therapy for SLE.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Initial: 6 months. Renewal: Plan Year.
<b><i>Other Criteria</i></b>	For renewals, member is benefiting from Benlysta therapy (eg, reduction of steroid dose, decrease in pain medications).

<b><i>Prior Authorization Group</i></b>	BETASERON
<b><i>Drug Names</i></b>	BETASERON
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Have a relapsing form of MS (e.g., 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.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<p><b>Prior Authorization Group</b></p> <p><b>Drug Names</b></p> <p><b>Covered Uses</b></p>	<p>BEXAROTENE</p> <p>BEXAROTENE, TARGRETIN</p> <p>All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).</p>
<p><b>Exclusion Criteria</b></p> <p><b>Required Medical Information</b></p>	<p>For capsule formulation: Patient has any of the following types of cutaneous T-cell lymphomas: mycosis fungoides, Sezary syndrome, primary cutaneous anaplastic large cell lymphoma, lymphomatoid papulosis. For primary cutaneous anaplastic large cell lymphoma and lymphomatoid papulosis: 1) The disease is CD30-positive, and 2) bexarotene will be used as a single agent. For gel formulation: For cutaneous T-cell lymphoma, patient has a diagnosis of stage I to III mycosis fungoides. For primary cutaneous B-cell lymphoma, patient has either primary cutaneous marginal zone lymphoma or primary cutaneous follicle center lymphoma.</p>
<p><b>Age Restrictions</b></p> <p><b>Prescriber Restrictions</b></p> <p><b>Coverage Duration</b></p> <p><b>Other Criteria</b></p>	<p>Plan Year</p>
<p><b>Prior Authorization Group</b></p> <p><b>Drug Names</b></p> <p><b>Covered Uses</b></p> <p><b>Exclusion Criteria</b></p> <p><b>Required Medical Information</b></p>	<p>BOSENTAN</p> <p>TRACLEER</p> <p>All FDA-approved indications not otherwise excluded from Part D.</p> <p>Patient has had NYHA Functional Class II to IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.</p>
<p><b>Age Restrictions</b></p> <p><b>Prescriber Restrictions</b></p> <p><b>Coverage Duration</b></p> <p><b>Other Criteria</b></p>	<p>Plan Year</p>

<b><i>Prior Authorization Group</i></b>	BOSULIF
<b><i>Drug Names</i></b>	BOSULIF
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Diagnosis of CML was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets any of the following: 1) Patient has chronic phase CML and meets one of the following conditions: a) experienced intolerance or toxicity to a prior tyrosine kinase inhibitor (TKI) (eg, imatinib, dasatinib, nilotinib, ponatinib), or b) experienced resistance to a prior TKI and is negative for T315I mutation, OR 2) Patient has accelerated or blast phase CML and meets one of the following: a) has not received prior therapy with a TKI, b) experienced intolerance or toxicity to a prior TKI, or c) experienced resistance to a prior TKI and is negative for T315I mutation, OR 3) Patient received a hematopoietic stem cell transplant.
<b><i>Age Restrictions</i></b>	18 years of age or older
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

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

<b>Prior Authorization Group</b>	BUPRENORPHINE
<b>Drug Names</b>	BUPRENORPHINE HCL
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	1) The drug is being prescribed for the treatment of opioid dependence AND 2) If the patient is pregnant and being prescribed buprenorphine for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) If buprenorphine is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) If buprenorphine is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone.

<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Induction 3 months, Maintenance Plan Year, Pregnancy 10 months
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	BUPRENORPHINE-NALOXONE
<b>Drug Names</b>	BUPRENORPHINE HCL/NALOXON, SUBOXONE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	CABOMETYX
<b>Drug Names</b>	CABOMETYX
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	The disease expresses clear cell histology and is advanced or metastatic. The patient has received and progressed on or after prior treatment with a vascular endothelial growth factor receptor targeting tyrosine kinase inhibitor.

<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	



**Prior Authorization Group** CAPRELSA  
**Drug Names** CAPRELSA  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D, differentiated thyroid cancer subtypes: papillary, follicular, Hurthle cell.

**Exclusion Criteria**

**Required Medical Information** For medullary thyroid cancer: 1) disease is symptomatic or progressive and 2) patient has unresectable locoregional or metastatic disease. For differentiated thyroid cancer: 1) histologic subtype is papillary, follicular, or Hurthle cell, 2) disease is symptomatic and/or progressive, 3) disease is iodine-refractory, and 4) patient has unresectable recurrent or persistent locoregional disease OR metastatic disease.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

**Prior Authorization Group** CARBAGLU  
**Drug Names** CARBAGLU  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D, methylmalonic acidemia, propionic acidemia.

**Exclusion Criteria**

**Required Medical Information** Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

**Prior Authorization Group** CAYSTON  
**Drug Names** CAYSTON  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

**Required Medical Information** The diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Pseudomonas aeruginosa is present in the cultures of the airway.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan year

**Other Criteria**

<b>Prior Authorization Group</b>	CERDELGA
<b>Drug Names</b>	CERDELGA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	CYP2D6 extensive metabolizers or intermediate metabolizers taking a strong or moderate CYP2D6 inhibitor (e.g., paroxetine, terbinafine) concomitantly with a strong or moderate CYP3A inhibitor (e.g., ketoconazole, fluconazole). CYP2D6 intermediate metabolizers or poor metabolizers taking a strong CYP3A inhibitor (e.g., ketoconazole). CYP2D6 indeterminate metabolizers (i.e., CYP2D6 genotype cannot be determined). CYP2D6 ultra-rapid metabolizers. Use concomitantly with enzyme replacement therapy.
<b>Required Medical Information</b>	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. Member is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	CEREZYME
<b>Drug Names</b>	CEREZYME
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, type 3 Gaucher disease
<b>Exclusion Criteria</b>	Concomitant therapy with miglustat (Zavesca) or eliglustat (Cerdelga)
<b>Required Medical Information</b>	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. For Type 1 Gaucher disease, the patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. For Type 3 Gaucher disease, the patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, splenomegaly, developmental delay, or ophthalmoplegia (gaze palsy).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<b><i>Prior Authorization Group</i></b>	CHANTIX
<b><i>Drug Names</i></b>	CHANTIX, CHANTIX CONTINUING MONTH, CHANTIX STARTING MONTH PA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	6 Months
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	CINRYZE
<b><i>Drug Names</i></b>	CINRYZE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Diagnostic laboratory testing for HAE has been performed (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels). For patients with HAE with C1 inhibitor deficiency, C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test. For patients with HAE with normal C1 inhibitor, other causes of angioedema have been ruled out (eg, drug-induced) and EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b>Prior Authorization Group</b>	CLORAZEPATE
<b>Drug Names</b>	CLORAZEPATE DIPOTASSIUM
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) (e.g., escitalopram, sertraline) or a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., duloxetine, venlafaxine ER) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal AND 4) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Anxiety Disorders-4 Months, All other Diagnoses-Plan Year

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

CLOZAPINE ODT

CLOZAPINE ODT

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

History of clozapine-induced agranulocytosis or severe granulocytopenia. Dementia-related psychosis.

The patient is unwilling or unable to take tablets or capsules orally or is at high risk for non-compliance.

Plan Year

<b><i>Prior Authorization Group</i></b>	COMETRIQ
<b><i>Drug Names</i></b>	COMETRIQ
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Medullary thyroid cancer which meets one of the following: 1) Unresectable locoregional disease that is symptomatic or structurally progressive, 2) Asymptomatic distant metastases if structurally progressive and unresectable, 3) Symptomatic or progressive metastatic disease
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	COTELLIC
<b><i>Drug Names</i></b>	COTELLIC
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	CYSTAGON
<b><i>Drug Names</i></b>	CYSTAGON
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	CYSTARAN
<b><i>Drug Names</i></b>	CYSTARAN
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Diagnosis of cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing. The patient has corneal cystine crystal accumulation.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	DAKLINZA
<b><i>Drug Names</i></b>	DAKLINZA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, chronic hepatitis C genotype 2 or 4 infection.
<b><i>Exclusion Criteria</i></b>	Use with a strong inducer of CYP3A, including phenytoin, carbamazepine, rifampin and St. John's wort
<b><i>Required Medical Information</i></b>	Chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants (eg, NS3 Q80K polymorphism) where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Criteria will be applied consistent with current AASLD-IDSa guidance
<b><i>Other Criteria</i></b>	For HCV/HIV coinfection, patient meets criteria for requested regimen.

<b>Prior Authorization Group</b>	DEFERASIROX
<b>Drug Names</b>	EXJADE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L. For chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes: A) For initiation of the deferasirox therapy: Pretreatment liver iron concentration (LIC) is at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw) AND pretreatment serum ferritin levels are greater than 300 mcg/L on 2 consecutive measurements 1 month apart. B) For continuation of the deferasirox therapy: Current LIC is greater than 3 mg Fe/g dw or the deferasirox therapy will be withheld until the LIC reaches above 5 mg Fe/g dw.
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	DIAZEPAM
<b>Drug Names</b>	DIAZEPAM, DIAZEPAM INTENSOL
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) (e.g., escitalopram, sertraline) or a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., duloxetine, venlafaxine ER) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of skeletal muscle spasms OR 4) For adjunctive therapy in the treatment of convulsive disorders AND 5) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
<b>Other Criteria</b>	

**Prior Authorization Group** ELIQUIS  
**Drug Names** ELIQUIS  
**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** EMSAM  
**Drug Names** EMSAM  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** Pheochromocytoma.  
**Required Medical Information** 1) Patient will be monitored closely for suicidal thoughts and behavior and clinical worsening AND 2) Patient experienced an inadequate treatment response to any one of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (SNRIs (e.g., venlafaxine)), selective serotonin reuptake inhibitors (SSRIs (e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline)), tricyclic or tetracyclic antidepressants (e.g., amitriptyline, nortriptyline) OR 3) Patient is unable to swallow oral formulations.  
**Age Restrictions** 18 years of age or older  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria**



<b><i>Prior Authorization Group</i></b>	EPCLUSA
<b><i>Drug Names</i></b>	EPCLUSA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current prescribing information and AASLD treatment guidelines.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Criteria will be applied consistent with current AASLD-IDSa guidance.
<b><i>Other Criteria</i></b>	For HCV and HIV coinfection, patient meets the criteria for approval for the requested regimen above. Patient will not receive treatment with efavirenz, etravirine or nevirapine. Patient will not receive treatment with tipranavir.

<b><i>Prior Authorization Group</i></b>	EPO
<b><i>Drug Names</i></b>	PROCRIT
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa).
<b><i>Exclusion Criteria</i></b>	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer. Use to facilitate preoperative autologous blood donation.
<b><i>Required Medical Information</i></b>	For all uses except surgery: 1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL (less than 9 g/dL for anemia in CHF only). 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 anemia due to myelosuppressive cancer chemotherapy: 1) For initial therapy, at least 2 more months of chemotherapy is expected. 2) For reauthorizations, current Hgb is less than 11 g/dL. Additional requirements for CKD not on dialysis reauthorization: 1) Current Hgb is less than or equal to 10 g/dL OR Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) Patient has symptomatic anemia AND 2) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL. 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR 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 per week. 2) For initial therapy, pretreatment serum erythropoietin level is less than or equal to 500 mU/mL. 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for anemia due to CHF, RA, hepatitis C treatment, or patients whose religious beliefs forbid blood transfusions: 1) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery. 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	16 weeks
<b><i>Other Criteria</i></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 (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion.

<b><i>Prior Authorization Group</i></b>	ERIVEDGE
<b><i>Drug Names</i></b>	ERIVEDGE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Patient meets one of the following criteria: 1) patient has nodal or distant metastatic basal cell carcinoma (BCC), OR 2) patient has residual or recurrent disease and further surgery and radiation are contraindicated or not appropriate, OR 3) patient cannot achieve negative margins by Mohs surgery or more extensive surgical procedures.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	ESBRIET
<b><i>Drug Names</i></b>	ESBRIET
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Initial Review Only: The patient does not have a known etiology for interstitial lung disease. The patient has completed a high-resolution computed tomography study of the chest which reveals the usual interstitial pneumonia pattern. If the study reveals the possible usual interstitial pneumonia pattern, the diagnosis is supported by surgical lung biopsy. If a surgical lung biopsy has not been conducted, the diagnosis is supported by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis. For initial and continuation: Esbriet will not be used in combination with Ofev.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Initial: 6 months, Renewal: Plan Year
<b><i>Other Criteria</i></b>	For continuation only: The patient has experienced a reduction in disease progression.

<b><i>Prior Authorization Group</i></b>	FABRAZYME
<b><i>Drug Names</i></b>	FABRAZYME
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by DNA testing. Patient has clinical signs and symptoms of Fabry disease.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	FARYDAK
<b><i>Drug Names</i></b>	FARYDAK
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	The patient has received at least two prior regimens, including bortezomib and an immunomodulatory agent (eg, lenalidomide, thalidomide, pomalidomide). Farydak will be used in combination with bortezomib and dexamethasone. The patient does not have a baseline QTc interval greater than, or equal to, 450 ms. The patient will be monitored for severe diarrhea.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	FENTANYL PATCH
<b><i>Drug Names</i></b>	FENTANYL
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	Significant respiratory depression. Known or suspected paralytic ileus.
<b><i>Required Medical Information</i></b>	1) The patient has been evaluated and will be monitored regularly for the development of addiction, abuse, or misuse of fentanyl patch AND 2) The patient can safely take the requested dose based on their current opioid use history. [Note: Fentanyl patch is indicated for use in opioid-tolerant patients. Patients considered opioid-tolerant are those who are taking, for one week or longer, at least 60mg of morphine daily, or at least 30mg of oral oxycodone daily, or at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid.] AND 3) Fentanyl patch is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

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

<b><i>Prior Authorization Group</i></b>	FILGRASTIM
<b><i>Drug Names</i></b>	GRANIX, NEUPOGEN
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL), leukemic relapse following allogeneic stem cell transplantation, myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia.
<b><i>Exclusion Criteria</i></b>	Use of a G-CSF product within 24 hours prior to or following chemotherapy or radiotherapy. For treatment of chemotherapy-induced FN, patient received prophylactic pegylated G-CSF (e.g., Neulasta) during the current chemotherapy cycle.
<b><i>Required Medical Information</i></b>	For prophylaxis of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For the treatment of anemia in MDS patients must meet all of the following: 1) Patient has symptomatic anemia, 2) The requested G-CSF product will be used in combination with epoetin or darbepoetin, 3) Patient has MDS with a low or intermediate-1 risk stratification, 4) The serum erythropoietin level is less than, or equal to, 500 mU/ml. For neutropenia in MDS: 1) Member is neutropenic, 2) Patient experiences recurrent or resistant infections.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	6 months
<b><i>Other Criteria</i></b>	For prevention of neutropenia: Patient will not receive chemotherapy and radiotherapy concurrently

<b><i>Prior Authorization Group</i></b>	FIRAZYR
<b><i>Drug Names</i></b>	FIRAZYR
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, ACE inhibitor-induced angioedema.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For hereditary angioedema (HAE): Diagnostic laboratory testing for HAE has been performed (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels). For patients with HAE with C1 inhibitor deficiency, C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test. For patients with HAE with normal C1 inhibitor: Other causes of angioedema have been ruled out (eg, drug induced) and EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema.
<b><i>Age Restrictions</i></b>	18 years of age or older
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	For HAE, Firazyr is being requested for the treatment of acute HAE attacks.

<i>Prior Authorization Group</i>	FORTEO
<i>Drug Names</i>	FORTEO
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For postmenopausal osteoporosis (OP): 1) A hx of fragility fractures, OR 2) Patient (pt) has ONE of the following (a. or b.): a) A pre-treatment (pre-tx) T-score of less than or equal to -2.5, OR b) a pre-tx T-score of less than or equal to -1 but greater than -2.5 with a pre-tx FRAX score of either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture AND pt has ONE of the following (i. or ii.): i) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR ii) Pt has failed prior treatment with or is intolerant to previous OP therapy (oral bisphosphonates or injectable antiresorptive agents). For primary or hypogonadal OP: Pt has a) a hx of an osteoporotic vertebral or hip fracture OR b) a pre-tx T-score of less than or equal to -2.5 OR c) a pre-tx T-score of less than or equal to -1 but greater than -2.5 AND a pre-tx FRAX score of either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. For glucocorticoid-induced OP: Pt has had an oral bisphosphonate trial of at least 1-year duration unless contraindicated or intolerant to an oral bisphosphonate AND meets EITHER of the following (1. or 2.): 1) Postmenopausal women and men 50 years of age or older: i) Pt is currently receiving or will be initiating glucocorticoid therapy, and ii) Pt has a) a hx of fragility fracture OR b) a pre-tx T-score of less than or equal to -2.5 OR c) a pre-tx FRAX score of either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture, OR 2) Premenopausal women and men less than 50 years of age: i) Pt is currently receiving or will be initiating glucocorticoid therapy, and ii) The anticipated glucocorticoid length of therapy is at least 3 months, and iii) Pt has a hx of a fragility fracture.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	24 months (lifetime)
<i>Other Criteria</i>	



<b><i>Prior Authorization Group</i></b>	FYCOMPA
<b><i>Drug Names</i></b>	FYCOMPA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	The patient and caregivers will be advised to contact the healthcare provider immediately if any serious psychiatric or behavioral reactions are observed.
<b><i>Age Restrictions</i></b>	12 years of age or older.
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	GATTEX
<b><i>Drug Names</i></b>	GATTEX
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Patient was dependent on parenteral support for at least 12 months prior to initiation of therapy with Gattex. For continuation: requirement for parenteral support has decreased from baseline while on Gattex therapy.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	GILENYA
<b><i>Drug Names</i></b>	GILENYA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses).
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	GILOTRIF
<b><i>Drug Names</i></b>	GILOTRIF
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For non-small cell lung cancer (NSCLC), patient meets either of the following: 1) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) Patient had EGFR mutation testing and is positive for exon 19 deletions or exon 21 (L858R) substitution mutations AND Gilotrif is prescribed for use as any of the following: a) First-line therapy as a single agent for recurrent or metastatic disease (EGFR mutation discovered prior to first-line chemotherapy or during first-line chemotherapy), or b) Subsequent therapy as a single agent for recurrent or metastatic disease following disease progression on afatinib or erlotinib.

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

Plan Year

<b><i>Prior Authorization Group</i></b>	GLATIRAMER
<b><i>Drug Names</i></b>	COPAXONE, GLATOPA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, first clinical episode of MS.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Have a relapsing form of MS (e.g., 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.

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

Plan Year

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

GROWTH HORMONE

NORDITROPIN FLEXPRO

All FDA-approved indications not otherwise excluded from Part D (including pediatric growth hormone deficiency (GHD), Turner syndrome (TS), Noonan syndrome (NS), chronic kidney disease (CKD), small for gestational age (SGA), Prader-Willi syndrome (PWS), idiopathic short stature (ISS), short stature homeobox-containing gene deficiency (SHOXD), adult GHD), HIV-associated wasting/cachexia, short bowel syndrome (SBS).

**Exclusion Criteria**

Active malignancy. Closed epiphyses (except PWS, adult GHD, HIV-associated wasting/cachexia and SBS).

**Required Medical Information**

Pediatric GHD, TS, CKD, SHOXD, NS: 1) younger than 2.5 yrs old, when applicable: pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity, 2) 2.5 yrs old or older: pre-tx 1-year ht velocity more than 2 SD below mean OR pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) failed 2 growth hormone (GH) stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) patient is a neonate or was diagnosed with GHD as a neonate. TS: confirmed by karyotyping. Growth failure associated with CKD: not post-kidney transplant. SGA: 1) birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2. PWS: confirmed by one of the following: 1) deletion in the chromosomal 15q11.2-q13 region, OR 2) maternal uniparental disomy in chromosome 15, OR 3) imprinting defects or translocations involving chromosome 15. SHOXD: confirmed by molecular or genetic testing. ISS: 1) pediatric GHD ruled out with appropriate provocative test more than 10 ng/mL AND 2) pre-tx ht more than 2.25 SD below mean AND 3) adult ht prediction below 63 inches for boys, 59 inches for girls. Adult GHD: 1) failed 2 GH stimulation tests (peak below 5 ng/mL) prior to starting tx, OR 2) structural abnormality of the hypothalamus/pituitary and 3 or more pituitary hormone deficiencies, OR 3) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary, OR 4) low pre-tx IGF-1 and failed 1 GH stimulation test (peak below 5 ng/mL) prior to starting tx. SGA: 2 years of age or older. NS and SHOXD: 3 years of age or older.

**Age Restrictions**

**Prescriber Restrictions**

Endocrinologist, Geneticist, Pediatric nephrologist, Infectious disease specialist, Gastroenterologist/Nutritional support specialist.

**Coverage Duration**

HIV-associated wasting: 12 wks. All other indications: Plan Year.

**Other Criteria**

HIV-associated wasting/cachexia: 1) on antiretroviral treatment, AND 2) suboptimal response to at least 1 other therapy for wasting or cachexia (eg, megestrol, dronabinol, cyproheptadine, or testosterone therapy if hypogonadal) OR contraindication or intolerance to alternative therapies, AND 3) prior to starting GH tx, body mass index (BMI) less than 18.5 kg/m<sup>2</sup> AND experienced unintentional weight loss greater than 5 percent of body weight in the previous 6 months. SBS: Used in conjunction with optimal management of SBS. Renewal for pediatric GHD, TS, NS, CKD, SGA, PWS patients with open epiphyses, ISS, or SHOXD: patient is experiencing improvement. Also for renewal for PWS only: body composition and psychomotor function have improved or stabilized. Renewal for PWS patients with closed epiphyses: current IGF-1 level is not elevated for age and gender. Renewal for adult GHD patients: current IGF-1 level is normal for age and gender (does not apply to patients with: a) structural abnormality of the hypothalamus/pituitary and 3 or more pituitary hormone deficiencies, and b) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary). Renewal for HIV-associated wasting: demonstrated response to GH therapy (ie, BMI has improved or stabilized).

**Prior Authorization Group**

HAEGARDA

**Drug Names**

HAEGARDA

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

This medication is being used for the prevention of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

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

***Prior Authorization Group***

***Drug Names***

***Covered Uses***

HERCEPTIN

HERCEPTIN

All FDA-approved indications not otherwise excluded from Part D, esophageal and esophagogastric junction cancer, leptomeningeal metastases from HER2-positive breast cancer

***Exclusion Criteria***

***Required Medical Information***

For HER2-positive breast cancer, Herceptin is used either: 1) For neoadjuvant treatment in combination with chemotherapy, OR 2) For adjuvant treatment in combination with chemotherapy for tumors at least 0.6cm or node positive, OR 3) For recurrent or metastatic disease in combination with aromatase inhibition for hormone-receptor positive disease, OR 4) For recurrent or metastatic disease in patients without previous treatment with Herceptin for recurrent or metastatic disease who meet 4a or 4b. 4a) Patients are hormone-receptor negative or are hormone-receptor positive and endocrine refractory, have symptomatic visceral disease, or visceral crisis. 4b) Patients use Herceptin as a single agent, in combination with chemotherapy, in combination with pertuzumab and docetaxel or paclitaxel, OR 5) For recurrent or metastatic disease in patient with previous treatment with Herceptin for recurrent or metastatic disease who meet 5a or 5b. 5a) Patients are hormone-receptor negative or are hormone-receptor positive and endocrine refractory, have symptomatic visceral disease, or visceral crisis, OR 5b) Patients use Herceptin in combination with capecitabine, in combination with lapatinib without chemotherapy, in combination with pertuzumab with or without chemotherapy and the patient previous received chemotherapy and Herceptin in the absence of pertuzumab. For esophageal, gastric, or esophagogastric junction cancer: 1) The disease is locally advanced or metastatic, AND 2) Herceptin is used with cisplatin and fluorouracil or cisplatin and capecitabine.

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration***

***Other Criteria***

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.

<b>Prior Authorization Group</b>	HETLIOZ
<b>Drug Names</b>	HETLIOZ
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For initial therapy and continuation of HetlioZ therapy:1) diagnosis of Non-24 Hour Sleep-Wake Disorder, AND 2) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas), AND 3) unable to perceive light in both eyes. For patients currently on HetlioZ therapy, must meet at least one of the following: 1) increased total nighttime sleep OR 2) decreased daytime nap duration
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Initiation: 3 Months, Renewal: Plan Year
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	HIGH RISK MEDICATION
<b>Drug Names</b>	CYPROHEPTADINE HCL, DISOPYRAMIDE PHOSPHATE, GUANFACINE ER, NORPACE CR, SCOPOLAMINE, TRANSDERM-SCOP
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

***Prior Authorization Group***

***Drug Names***

***Covered Uses***

***Exclusion Criteria***

***Required Medical Information***

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration***

***Other Criteria***

HRM-ANTICONVULSANTS

PHENOBARBITAL, PHENOBARBITAL SODIUM

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

Plan Year

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



**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

HRM-ANTIDEPRESSANTS TCA

AMITRIPTYLINE HCL, DOXEPIN HCL, IMIPRAMINE HCL, TRIMIPRAMINE MALEATE

All FDA-approved indications not otherwise excluded from Part D, Neuropathic pain for amitriptyline or imipramine.

Plan Year

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Depression: 1) Two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Neuropathic pain for amitriptyline or imipramine: Two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

HRM-ANTIPARKINSON

BENZTROPINE MESYLATE

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

Plan Year

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) EPS: 1) One non-HRM alternative formulary drug amantadine has not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug amantadine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug amantadine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug amantadine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Parkinson's: Two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole have not been tried. AND 2) The patient has a contraindication to two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

***Prior Authorization Group***

***Drug Names***

***Covered Uses***

***Exclusion Criteria***

***Required Medical Information***

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration***

***Other Criteria***

HRM-ANTIPSYCHOTICS

THIORIDAZINE HCL

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

Plan Year

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone. AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone. AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

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

**Prior Authorization Group** HRM-DIGOXIN  
**Drug Names** DIGITEK, DIGOX, DIGOXIN  
**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** This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Reduction in dose is inappropriate AND 2) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

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

***Prior Authorization Group***

***Drug Names***

***Covered Uses***

***Exclusion Criteria***

***Required Medical Information***

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration***

***Other Criteria***

HRM-HYDROXYZINE

HYDROXYZINE HCL, HYDROXYZINE PAMOATE

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

Plan Year

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

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

HRM-HYDROXYZINE INJ

HYDROXYZINE HCL

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

Plan Year

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Alcohol Withdrawal Syndrome:1) One non-HRM alternative formulary drug clorazepate or lorazepam have not been tried AND 2) The patient has a contraindication to one non-HRM alternative formulary drug clorazepate or lorazepam AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative formulary drug clorazepate or lorazepam have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug clorazepate or lorazepam AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient Anxiety: 1)Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER have not been tried AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 7) If being requested for nausea/vomiting, prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

**Prior Authorization Group** HRM-HYPNOTICS  
**Drug Names** ZOLPIDEM TARTRATE  
**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** This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

**Prior Authorization Group** HRM-MEGESTROL AC  
**Drug Names** MEGESTROL ACETATE  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D, oral suspension - palliative treatment of advanced carcinoma of the breast or endometrium (i.e., recurrent, inoperable, or metastatic disease).  
**Exclusion Criteria**  
**Required Medical Information**  
**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria** This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.



***Prior Authorization Group***

***Drug Names***

***Covered Uses***

***Exclusion Criteria***

***Required Medical Information***

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration***

***Other Criteria***

HRM-NITROFURANTOIN

NITROFURANTOIN MACROCRYST, NITROFURANTOIN MONOHYDRAT

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

Plan Year

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

***Prior Authorization Group***

***Drug Names***

***Covered Uses***

***Exclusion Criteria***

***Required Medical Information***

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration***

***Other Criteria***

HRM-PROMETHAZINE

PHENADOZ, PHENERGAN, PROMETHAZINE HCL, PROMETHEGAN

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

Plan Year

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Rhinitis: 1) One non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal have not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient Urticaria: 1) One non-HRM alternative formulary drug levocetirizine have not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug levocetirizine have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 7) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 8) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient

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

**Prior Authorization Group**

**Drug Names**

HUMIRA

HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CROHNS DISEASE, HUMIRA PEN-PSORIASIS STAR

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis, uveitis.

**Exclusion Criteria**

**Required Medical Information**

Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Humira (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response to at least a 3-month trial of methotrexate (MTX) despite adequate dosing (i.e., titrated to 25 mg/week), 2) Intolerance or contraindication to MTX, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD or a targeted synthetic DMARD (e.g., Xeljanz), 4) Intolerance to a prior biologic DMARD or a targeted synthetic DMARD, 5) Severely active RA. For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): Patient meets ANY of the following criteria: 1) Inadequate response to at least a 3-month trial of MTX, 2) Intolerance or contraindication to MTX, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD, 4) Intolerance to a prior biologic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to at least a 4-week NSAID trial at maximum recommended or tolerated dose OR intolerance and/or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to immunosuppressant therapy (e.g., corticosteroids, azathioprine, mercaptopurine) or intolerance or contraindication to immunosuppressant therapy, AND 2) Patient is naive to TNF inhibitor therapy or patient lost response to previous TNF inhibitor therapy due to antibody formation. For active psoriatic arthritis (PsA) (new starts only): Patient meets ANY of the following: 1) Inadequate response to at least a 3-month trial of MTX, sulfasalazine, or leflunomide, 2) Intolerance or contraindication to MTX, sulfasalazine, or leflunomide, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD, 4) Intolerance to a prior biologic DMARD, 5) Severely active PsA as evidenced by ANY of the following: a) multiple swollen joints, b) structural damage in the presence of inflammation, c) clinically relevant extra-articular manifestations (e.g., extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), 6) Active enthesitis and/or dactylitis (i.e., sausage finger), 7) Predominant axial disease (i.e., extensive spinal involvement).

**Prior Authorization Group**

HYPNOTIC BENZODIAZEPINES

**Drug Names**

TEMAZEPAM

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has not been tried. AND 2) The patient has a contraindication to two non-HRM alternative drugs Silenor (3mg or 6mg) and trazodone. AND 3) Prescriber must acknowledge that medication benefits outweigh potential risk in a patient 65 years of age or older. OR 4) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug Silenor (3mg or 6mg) or trazodone. AND 6) Prescriber must acknowledge that medication benefits outweigh potential risk in a patient 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

<b><i>Prior Authorization Group</i></b>	IBRANCE
<b><i>Drug Names</i></b>	IBRANCE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D. Single-agent therapy for the treatment of well-differentiated/dedifferentiated liposarcoma for retroperitoneal sarcomas.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	ICLUSIG
<b><i>Drug Names</i></b>	ICLUSIG
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For CML or Ph+ ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
<b><i>Age Restrictions</i></b>	18 years of age or older
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	IDHIFA
<b><i>Drug Names</i></b>	IDHIFA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	IMATINIB
<b><i>Drug Names</i></b>	IMATINIB MESYLATE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, Ph+ lymphoblastic lymphoma, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, and melanoma.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For CML or Ph+ ALL/lymphoblastic lymphoma, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor (eg, dasatinib, nilotinib, bosutinib, ponatinib). For melanoma, c-Kit mutation is positive.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	IMBRUVICA
<b><i>Drug Names</i></b>	IMBRUVICA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, small lymphocytic lymphoma, lymphoplasmacytic lymphoma.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For Waldenstrom's macroglobulinemia and lymphoplasmacytic lymphoma (WM/LPL): Imbruvica is used as a single agent.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	INCRELEX
<b><i>Drug Names</i></b>	INCRELEX
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	Closed epiphyses
<b><i>Required Medical Information</i></b>	Must meet all of the following prior to beginning Increlex therapy (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) stimulation test showing a normal or elevated growth hormone level. For renewal, patient is experiencing improvement AND the current IGF-1 level is normal for age and gender.

<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	Endocrinologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	INLYTA
<b><i>Drug Names</i></b>	INLYTA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, papillary, Hurthle cell, or follicular thyroid carcinoma.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For renal cell carcinoma: 1) Inlyta will be used as a single agent and 2) the disease is relapsed or medically unresectable. For disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. For thyroid carcinoma: 1) The disease has papillary, Hurthle cell, or follicular histology, 2) Nexavar is not an appropriate option for the patient, 3) the disease is unresectable or metastatic, 4) the disease is radioiodine refractory, and 5) the disease is progressive or symptomatic.

<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	



**Prior Authorization Group** IRESSA  
**Drug Names** IRESSA  
**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** ISOTRETINOIN  
**Drug Names** AMNESTEEM, CLARAVIS, MYORISAN, ZENATANE  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D, Cutaneous T-cell Lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), Keratosis follicularis (Darier Disease), Lamellar ichthyosis, Neuroblastoma, Pityriasis rubra pilaris, Transient acantholytic dermatosis (Grover Disease), severe refractory Rosacea, refractory Acne, Reduction of the development of skin cancer (squamous cell cancers) in high risk patients.

**Exclusion Criteria**  
**Required Medical Information** For acne (severe recalcitrant nodular or refractory) or severe refractory rosacea and patient had inadequate treatment responses to any topical acne product and an oral antibiotic [Note: topical products include salicylic acid, benzoyl peroxide, azelaic acid, adapalene, tretinoin, tazarotene, clindamycin, erythromycin, or metronidazole for rosacea] [Note: oral antibiotics include minocycline, doxycycline, tetracycline, erythromycin, trimethoprim-sulfamethoxazole, trimethoprim, azithromycin].

**Age Restrictions**  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria** For acne (severe recalcitrant nodular or refractory) or severe refractory rosacea treatment will be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course.

<b><i>Prior Authorization Group</i></b>	ITRACONAZOLE
<b><i>Drug Names</i></b>	ITRACONAZOLE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, Coccidioidomycosis, Cryptococcosis, Sporotrichosis, Penicilliosis, Microsporidiosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea manuum/Tinea pedis.
<b><i>Exclusion Criteria</i></b>	Current use of certain drugs metabolized by CYP3A4. If the patient has the diagnosis of onychomycosis, evidence of ventricular dysfunction, such as congestive heart failure (CHF).
<b><i>Required Medical Information</i></b>	1) If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed with a fungal diagnostic test OR 2) Pityriasis versicolor or Tinea versicolor OR 3) If for the treatment of tinea corporis, tinea cruris, tinea manuum, tinea pedis, the patient has experienced either an inadequate treatment response, adverse event, intolerance, or contraindication to griseofulvin OR 4) Diagnosis of blastomycosis, histoplasmosis, aspergillosis, coccidioidomycosis, cryptococcosis, sporotrichosis, penicilliosis, microsporidiosis.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Onychomycosis, Versicolor (pityriasis or tinea), Tinea-3mo, Systemic infection-6mo
<b><i>Other Criteria</i></b>	Criteria apply to capsule dosage form only.

<b><i>Prior Authorization Group</i></b>	IVIG
<b><i>Drug Names</i></b>	BIVIGAM, CARIMUNE NANOFILTERED, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, primary immunodeficiency, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, idiopathic thrombocytopenic purpura, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
<b><i>Exclusion Criteria</i></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><i>Required Medical Information</i></b>	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL OR 2) History of recurrent bacterial infections, patient is not able to take combination antiretroviral therapy, and antibiotic prophylaxis was not effective. For dermatomyositis and polymyositis: standard first-line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For myasthenia gravis: IVIG is requested for worsening weakness, acute exacerbation or use in preparation for surgery. PRCA is secondary to parvovirus B19 infection.
<b><i>Age Restrictions</i></b>	For pediatric HIV infection: age 12 years or younger
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></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.

<i>Prior Authorization Group</i>	JAKAFI
<i>Drug Names</i>	JAKAFI
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For polycythemia vera, patient has had an inadequate response to or is intolerant of hydroxyurea.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<b><i>Prior Authorization Group</i></b>	JUXTAPID
<b><i>Drug Names</i></b>	JUXTAPID
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), 2) Prior to initiation of treatment with Juxtapid, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin, rosuvastatin), fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, 3) Prior to initiation of treatment with Juxtapid, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated LDL-C greater than 160 mg/dL. For renewal of therapy: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	Lipid specialist, cardiometabolic specialist, cardiologist, or endocrinologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, b) Diagnosis of definite FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of definite FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, 2) Simon-Broome Diagnostic Criteria for definite FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or 3) Dutch Lipid Clinic Network Criteria for definite FH: Total score greater than 8 points.

<b><i>Prior Authorization Group</i></b>	KALYDECO
<b><i>Drug Names</i></b>	KALYDECO
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	Use in combination with Orkambi
<b><i>Required Medical Information</i></b>	The patient has a diagnosis of cystic fibrosis. The patient has one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data.
<b><i>Age Restrictions</i></b>	Granules: 2 years of age and older, Tablets: 6 years of age and older
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	KETOCONAZOLE
<b><i>Drug Names</i></b>	KETOCONAZOLE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, Cushing's syndrome
<b><i>Exclusion Criteria</i></b>	Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozone, cisapride, methadone, disopyramide, dronedarone, ranolazine.
<b><i>Required Medical Information</i></b>	The patient's liver status will be assessed prior to therapy and as needed during therapy.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	6 months
<b><i>Other Criteria</i></b>	1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, and paracoccidioidomycosis AND other antifungal therapies are ineffective, unavailable, or not tolerated OR 2) Ketoconazole (Nizoral) is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative.

<b><i>Prior Authorization Group</i></b>	KEYTRUDA
<b><i>Drug Names</i></b>	KEYTRUDA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For melanoma: Patient has unresectable or metastatic disease. Keytruda will be used as a single agent. Keytruda is used for first-line therapy OR Keytruda is used for second-line therapy and patient meets both of the following criteria: 1) Patient has experienced disease progression, AND 2) Patient has not received Keytruda previously. For HNSCC, patient has recurrent or metastatic disease and the patient has experienced disease progression on or after platinum-containing chemotherapy.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	KISQALI
<b><i>Drug Names</i></b>	KISQALI, KISQALI FEMARA 200 DOSE, KISQALI FEMARA 400 DOSE, KISQALI FEMARA 600 DOSE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	KORLYM
<b><i>Drug Names</i></b>	KORLYM
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Korlym is being used to control hyperglycemia secondary to hypercortisolism in a patient with endogenous Cushing's syndrome who has type 2 diabetes mellitus or glucose intolerance. Patient has had surgery that was not curative or the patient is not a candidate for surgery.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	Endocrinologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<i>Prior Authorization Group</i>	KUVAN
<i>Drug Names</i>	KUVAN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For patients who have not yet received a therapeutic trial of Kuvan: a) patients less than or equal to 12 years of age have a baseline blood Phe level greater than 6 mg/dL OR b) patients greater than 12 years of age have a baseline blood Phe level greater than 10 mg/dL. For patients for whom this is the first treatment after a therapeutic trial of Kuvan: a) patient must have experienced a reduction in blood Phe level of greater than or equal to 30 percent from baseline OR b) patient has demonstrated an improvement in neuropsychiatric symptoms.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Initial: 2 months. Continuation of treatment: Plan Year.
<i>Other Criteria</i>	



<b><i>Prior Authorization Group</i></b>	KYNAMRO
<b><i>Drug Names</i></b>	KYNAMRO
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), 2) Prior to initiation of treatment with Kynamro, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin, rosuvastatin), fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, 3) Prior to initiation of treatment with Kynamro, patient is/was experiencing an inadequate response to such combination regimen, as demonstrated by treated LDL-C greater than 160 mg/dL. For renewal of therapy, 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	Lipid specialist, cardiometabolic specialist, cardiologist, or endocrinologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, b) Diagnosis of definite FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, sudden premature cardiac death. Diagnosis of definite FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, 2) Simon-Broome Diagnostic Criteria for definite FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or 3) Dutch Lipid Clinic Network Criteria for definite FH: Total score greater than 8 points.

<b><i>Prior Authorization Group</i></b>	LENVIMA
<b><i>Drug Names</i></b>	LENVIMA 10 MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For differentiated thyroid cancer: 1) histologic subtype is papillary, follicular, or Hurthle cell, 2) disease is symptomatic and/or progressive, 3) disease is iodine-refractory, and 4) patient has unresectable recurrent or persistent locoregional disease OR metastatic disease.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

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

<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, prevention and treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL) or acute myeloid leukemia (AML), neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia.
<b>Exclusion Criteria</b>	Use of Leukine within 24 hours prior to or following chemotherapy or radiotherapy. For treatment of chemotherapy-induced FN, patient received prophylactic pegylated G-CSF (eg, Neulasta) during the current chemotherapy cycle.
<b>Required Medical Information</b>	For prophylaxis of myelosuppressive chemotherapy-induced FN the patient must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN the patient must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For MDS: Patient has neutropenia and experiences recurrent or resistant infections.

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

6 months  
For prevention of neutropenia: Patient will not receive chemotherapy and radiotherapy concurrently

<b>Prior Authorization Group</b>	LIDOCAINE PATCHES
<b>Drug Names</b>	LIDOCAINE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g. neuropathy associated with radiation treatment or chemotherapy]).

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

Plan Year

<i>Prior Authorization Group</i>	LONSURF
<i>Drug Names</i>	LONSURF
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For metastatic colorectal cancer, KRAS (with or without NRAS) mutation testing is performed on either the primary tumor or metastases to confirm RAS mutation status. The patient must have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if KRAS or NRAS wild type, an anti-EGFR therapy.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<b>Prior Authorization Group</b>	LUPRON
<b>Drug Names</b>	LEUPROLIDE ACETATE, LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH), LUPRON DEPOT-PED (1-MONTH, LUPRON DEPOT-PED (3-MONTH
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, in combination with growth hormone for children with growth failure and advancing puberty (leuprolide acetate only), breast cancer (Lupron Depot 3.75mg only), malignant sex cord-stromal tumors (Lupron 3.75mg and 11.25 mg only), epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer (Lupron Depot 3.75mg only), preoperative use for uterine leiomyomata (Lupron Depot 3.75mg and 11.25mg only).
<b>Exclusion Criteria</b>	Undiagnosed abnormal vaginal bleeding (Lupron 3.75mg and 11.25mg only). Pregnancy (Lupron 3.75mg and 11.25mg only). Breast feeding (Lupron 3.75mg and 11.25mg only).
<b>Required Medical Information</b>	For central precocious puberty (CPP), patients not currently receiving therapy must meet ALL of the following criteria: 1) Diagnosis of CPP confirmed by: a) A pubertal response to a GnRH agonist OR a pubertal level of a third generation LH assay AND, b) Assessment of bone age versus chronological age AND, c) Appropriate diagnostic imaging of the brain to exclude an intracranial tumor. 2) The onset of sexual characteristics occurred prior to eight years of age for female patients OR prior to nine years of age for male patients. For prostate cancer (PC): If the patient has regional disease as initial ADT, metastatic disease as initial ADT, progressive castration-naive disease, or recurrent disease as defined as a biochemical failure after previous therapy, then no further information is required. If the patient has lymph node-positive disease found during pelvic lymph node dissection (PLND), then Lupron Depot must be used without external beam radiation therapy (EBRT) as adjuvant therapy. If the patient has none of the abovementioned criteria and has intermediate risk stratification (IRS), then Lupron Depot must be used with EBRT as initial ADT. If the patient has none of the abovementioned criteria and has high or very high risk stratification, then Lupron Depot must be used with EBRT or EBRT and docetaxel as initial ADT. If the patient has none of the abovementioned criteria and has very high risk stratification and is not a candidate for definitive therapy, Lupron Depot may be used without EBRT as initial ADT. For endometriosis (ENDO) retreatment patient must meet all of the following: 1) Patient has had a recurrence of symptoms, 2) Patient will be receiving add-back therapy (e.g., norethindrone), AND 3) Bone mineral density is within normal limits.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	For PC with IRS: 6 months (MO). Fibroids: 3 MO: Max 6 MO. ENDO: 6 MO: max 12 MO. Others: Plan Year.

**Other Criteria**

For prostate cancer: Use as neoadjuvant therapy prior to radical prostatectomy is not approvable. For uterine fibroids patient must meet one of the following: 1) Diagnosis of anemia (e.g., hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) Lupron Depot will be used in the preoperative setting to facilitate surgery. For uterine fibroids retreatment, bone mineral density is within normal limits. For epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: Lupron (3.75mg only) will be used as a single agent AND disease is persistent or recurrent. For breast cancer (3.75mg only) patient must meet all of the following: 1) Premenopausal woman, 2) Hormone receptor positive disease.

**Prior Authorization Group**

LYNPARZA

**Drug Names**

LYNPARZA

**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**

MAVYRET - PENDING CMS REVIEW

**Drug Names**

MAVYRET

**Covered Uses**

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

**Exclusion Criteria**

Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)

**Required Medical Information**

Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants where applicable, liver transplantation status if applicable. Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

8-16 weeks per package insert or Criteria will be applied consistent w/ current AASLD-IDSA guidance

**Other Criteria**

<b>Prior Authorization Group</b>	MEGESTROL
<b>Drug Names</b>	MEGESTROL ACETATE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	MEKINIST
<b>Drug Names</b>	MEKINIST
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Mekinist will be used as a single agent or in combination with Tafinlar for patients with a diagnosis of unresectable or metastatic melanoma AND tumor is positive for BRAF V600E or V600K mutation. For non-small cell lung cancer, tumor is positive for BRAF V600E mutation.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	MEMANTINE
<b>Drug Names</b>	MEMANTINE HCL, MEMANTINE HYDROCHLORIDE, NAMENDA XR, NAMENDA XR TITRATION PACK
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	The drug is being prescribed for the treatment of moderate to severe dementia of the Alzheimer's type.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This edit only applies to patients less than 30 years of age.

*Prior Authorization Group* MOZOBIL  
*Drug Names* MOZOBIL  
*Covered Uses* All FDA-approved indications not otherwise excluded from Part D.  
*Exclusion Criteria*  
*Required Medical Information*  
*Age Restrictions*  
*Prescriber Restrictions*  
*Coverage Duration* 6 months  
*Other Criteria*

*Prior Authorization Group* NAGLAZYME  
*Drug Names* NAGLAZYME  
*Covered Uses* All FDA-approved indications not otherwise excluded from Part D  
*Exclusion Criteria*  
*Required Medical Information* Diagnosis of mucopolysaccharidosis VI (MPS VI) disease was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by DNA testing  
*Age Restrictions*  
*Prescriber Restrictions*  
*Coverage Duration* Plan Year  
*Other Criteria*



<b><i>Prior Authorization Group</i></b>	NATPARA
<b><i>Drug Names</i></b>	NATPARA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	Acute postsurgical hypoparathyroidism (within 6 months of surgery). Hypoparathyroidism due to calcium-sensing receptor mutations. Any of the following risk factors for osteosarcoma: Paget's disease of bone, unexplained elevations of alkaline phosphatase, open epiphyses (ie, children or young adults), hereditary disorder that predisposes to osteosarcoma, history of external beam or implant radiation therapy involving the skeleton.
<b><i>Required Medical Information</i></b>	Natpara is prescribed to control hypocalcemia associated with hypoparathyroidism. Natpara will be used in conjunction with calcium supplements with or without calcitriol (activated vitamin D). For initial therapy only: 1) total serum calcium levels are inadequately controlled despite treatment with optimized doses of calcium supplements and calcitriol, 2) total serum calcium level (albumin-corrected) is above 7.5 mg/dL, 3) serum 25-hydroxyvitamin D level is within the normal range, and 4) serum magnesium level is within the normal range. For continuation of therapy only: 1) total serum calcium level (albumin-corrected) is within the low-normal range (generally between 8 mg/dL and 9 mg/dL) OR the dose of Natpara, calcitriol, or calcium supplement is being adjusted to achieve total serum calcium levels within the low-normal range, and 2) serum 25-hydroxyvitamin D level is within the normal range.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Initial: 6 months Renewal: Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	NERLYNX
<b><i>Drug Names</i></b>	NERLYNX
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	The patient has early stage HER2-positive breast cancer. Nerlynx is initiated within two years after completing adjuvant trastuzumab based therapy.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	NEXAVAR
<b><i>Drug Names</i></b>	NEXAVAR
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, osteosarcoma, soft tissue sarcoma subtypes: angiosarcoma, desmoid tumors (aggressive fibromatosis), gastrointestinal stromal tumor (GIST), medullary thyroid carcinoma, acute myeloid leukemia.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For hepatocellular carcinoma: 1) Nexavar will be used as a single agent and 2) the disease is a) metastatic, OR b) unresectable and the patient is not a candidate for liver transplantation, OR c) the patient is not a candidate for surgery due to performance status or comorbidities. For renal cell carcinoma: 1) The patient has relapsed or medically unresectable disease, 2) Nexavar will be used as a single agent, and 3) for disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) The disease is unresectable or metastatic, 2) the disease is radioiodine-refractory, and 3) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For osteosarcoma: Nexavar will be used as a single agent. For gastrointestinal stromal tumor: The disease has progressed after treatment with imatinib, sunitinib, or regorafenib. For acute myeloid leukemia: 1) The disease is relapsed or refractory, 2) the patient has FLT3-ITD mutation-positive disease, 3) the patient cannot tolerate more aggressive regimens, and 4) Nexavar will be used in combination with azacitidine or decitabine.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	NINLARO
<b><i>Drug Names</i></b>	NINLARO
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b>Prior Authorization Group</b>	NORTHERA
<b>Drug Names</b>	NORTHERA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Prior to initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing, supported by serial blood pressure measurements. Northera will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) Dopamine beta hydroxylase deficiency, OR 3) Non-diabetic autonomic neuropathy
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	Patients currently on Northera must experience a sustained decrease in dizziness to continue on therapy.

<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>	Patient is currently using quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong the QT interval and are metabolized by CYP2D6 (examples: thioridazine and pimozide). Patient has a prolonged QT interval or congenital long QT syndrome (LQTS), or heart failure or a history suggestive of torsades de pointes (TdP). Patient has complete atrioventricular (AV) block without an implanted pacemaker or is at high risk of complete AV block.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<b><i>Prior Authorization Group</i></b>	NUPLAZID
<b><i>Drug Names</i></b>	NUPLAZID
<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 that is unrelated to the hallucinations and delusions associated with Parkinson's disease psychosis.
<b><i>Required Medical Information</i></b>	The diagnosis of Parkinson's disease was made prior to the onset of psychotic symptoms.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	NUVIGIL
<b><i>Drug Names</i></b>	ARMODAFINIL
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography OR 3) Diagnosis is Shift Work Disorder (SWD).
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

OCTREOTIDE

OCTREOTIDE ACETATE, SANDOSTATIN LAR DEPOT

All FDA-approved indication not otherwise covered under Part D, meningiomas, thymomas and thymic carcinomas, adrenal gland neuroendocrine tumors (NETs), NETs of the gastrointestinal (GI) tract, thymus, and lung, pancreatic NETs, and poorly differentiated (high-grade)/large or small cell NETs.

**Exclusion Criteria**

**Required Medical Information**

Meningiomas: 1) Patient has recurrent or progressive disease (dx), 2) Dx is unresectable, 3) Dx is refractory to radiation therapy, and 4) Somatostatin receptor status (SRS) is positive. Thymomas and thymic carcinomas: 1) Patient has locally advanced, advanced, or recurrent dx, 2) Dx is unresectable OR patient has residual dx following resection, 3) Patient has progressed on at least one prior chemotherapy regimen, and 4) SRS is positive OR patient has symptoms of carcinoid syndrome. NETs of GI tract: Patient has 1) distant metastases OR 2) unresectable dx, OR 3) primary site of tumor is gastric, tumor is less than or equal to 2 cm, AND patient has hypersecretion of gastrin. NETs of thymus: Patient has distant metastases OR unresectable dx. NETs of lung: 1) Patient has distant metastases OR 2) Patient has a) NET that is low-grade (typical carcinoid) or intermediate-grade (atypical carcinoid), AND b) Stage IIIB dx that is T4 due to multiple lung nodules or Stage IV dx, AND c) SRS is positive or patient has symptoms of carcinoid syndrome. Pancreatic NETs: 1) For gastrinoma, glucagonoma, and VIPoma, patient's SRS is positive OR patient has hormone-related symptoms, OR 2) For insulinoma, non-functioning pancreatic tumor, somatostatinoma, pancreatic polypeptidoma, cholecystikininoma, ACTH-secreting pancreatic NET, and parathyroid hormone-related protein-secreting pancreatic NET, patient has a) distant metastases or unresectable dx AND b) SRS is positive OR patient has hormone-related symptoms. Adrenal gland NETs: 1) Patient has a diagnosis of non-ACTH dependent Cushing's syndrome, and 2) Cortisol production is symmetric, and 3) Tumors are less than 4 cm, and 4) SRS is positive. Poorly differentiated (high-grade)/large or small cell NETs (excluding lung): 1) Patient has metastatic or unresectable dx, 2) SRS is positive, and 3) Patient has hormone-related symptoms.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Plan Year

Acromegaly: Patient has 1) clinical evidence of acromegaly, 2) a high pre-treatment IGF-1 level for age and/or gender, and 3) an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why patient has not had surgery or radiotherapy. For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

<b>Prior Authorization Group</b>	ODOMZO
<b>Drug Names</b>	ODOMZO
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Member has a diagnosis of locally advanced basal cell carcinoma (BCC). Member experienced disease recurrence following surgery or radiation therapy OR member is not a candidate for surgery or radiation therapy. For females of reproductive potential, pregnancy has been ruled out with a negative pregnancy test result.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

**Prior Authorization Group**

**Drug Names** OFEV

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

**Exclusion Criteria**

**Required Medical Information** Initial Review Only: The patient does not have a known etiology for interstitial lung disease. The patient has completed a high-resolution computed tomography study of the chest which reveals the usual interstitial pneumonia pattern. If the study reveals the possible usual interstitial pneumonia pattern, the diagnosis is supported by surgical lung biopsy. If a surgical lung biopsy has not been previously conducted, the diagnosis is supported by a multidisciplinary discussion between a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis. For initial and continuation: Ofev will not be used in combination with Esbriet.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Initial: 6 months, Renewal: Plan Year

**Other Criteria** For continuation only: The patient has experienced a reduction in disease progression.

**Prior Authorization Group**

**Drug Names** ONFI

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions** 2 years of age or older.

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

<b>Prior Authorization Group</b>	OPSUMIT
<b>Drug Names</b>	OPSUMIT
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

<b>Prior Authorization Group</b>	ORAL-INTRANASAL FENTANYL
<b>Drug Names</b>	FENTANYL CITRATE ORAL TRA, FENTORA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Significant respiratory depression. Known or suspected paralytic ileus.
<b>Required Medical Information</b>	1) The patient has CANCER related pain AND 2) The ICD diagnosis code provided supports the CANCER RELATED diagnosis [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER RELATED diagnosis.] AND 3) The drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain AND 4) The patient can safely take the requested dose based on their current opioid use history. [Note: The TIRF (Transmucosal Immediate-Release Fentanyl) products (Abstral, Actiq, Fentora, Lazanda, Onsolis, and Subsys) are indicated for opioid- tolerant patients. Patients considered opioid tolerant are those who are taking at least: 60 mg of oral morphine/day, 25 mcg of transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of another opioid for a week or longer.]

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

<i>Prior Authorization Group</i>	ORFADIN
<i>Drug Names</i>	ORFADIN
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) and appropriate clinical picture of the patient, or 2) DNA testing (mutation analysis).
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<i>Prior Authorization Group</i>	ORKAMBI
<i>Drug Names</i>	ORKAMBI
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	Use in combination with Kalydeco
<i>Required Medical Information</i>	The patient is positive for the F508del mutation on both alleles of the CFTR gene.
<i>Age Restrictions</i>	6 years of age or older
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	



<b><i>Prior Authorization Group</i></b>	PEGASYS
<b><i>Drug Names</i></b>	PEGASYS, PEGASYS PROCLICK
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia (CML), giant cell tumor of the bone (GCTB).
<b><i>Exclusion Criteria</i></b>	Decompensated cirrhosis (Child Turcotte Pugh class B or C)
<b><i>Required Medical Information</i></b>	For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines. For chronic hepatitis B: 1) For pt with cirrhosis, must have been HBsAg positive for at least 6 months AND must have serum HBV-DNA greater than or equal to 10,000 copies/mL or greater than or equal to 2,000 IU/mL regardless of HBeAg status. 2) For pts without cirrhosis, must have been HBsAg positive for at least 6 months. If HBeAg positive, pt must have serum HBV-DNA greater than 100,000 copies/mL or greater than 20,000 IU/mL. If HBeAg negative, pt must have serum HBV-DNA greater than 10,000 copies/mL or greater than 2,000 IU/mL. Must have persistent or intermittently elevated ALT greater than 2 times the upper limit of normal OR liver biopsy showing chronic hepatitis with moderate to severe inflammation or significant fibrosis.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	HCV=12 to 48 wks depending on treatment regimen. HBV=48 wks. CML and GCTB=Plan Year.
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	PHENYLBUTYRATE
<b><i>Drug Names</i></b>	BUPHENYL, SODIUM PHENYLBUTYRATE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing. Buphenyl will be used for chronic management of UCD.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<i>Prior Authorization Group</i>	POMALYST
<i>Drug Names</i>	POMALYST
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For multiple myeloma: 1) The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent (ie, thalidomide, lenalidomide) AND a proteasome inhibitor (ie, bortezomib, carfilzomib), 2) Pomalyst will be used as a single agent or in combination with dexamethasone, and 3) the patient will be monitored for thromboembolism. For systemic light chain amyloidosis: 1) Pomalyst will be used in combination with dexamethasone and 2) the patient will be monitored for thromboembolism.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<b>Prior Authorization Group</b>	PRALUENT
<b>Drug Names</b>	PRALUENT
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member must have one of the following conditions (new starts and continuation): 1) Prior clinical atherosclerotic cardiovascular disease (ASCVD) or cardiovascular event (see Other Criteria), or 2) Heterozygous familial hypercholesterolemia (HeFH): Definite diagnosis of FH (See Other Criteria). For new starts: For members with prior clinical ASCVD or cardiovascular event, at least one of the following requirements is met: 1) Current LDL-C level 70 mg/dL or greater after treatment with a high-intensity statin (eg, atorvastatin, rosuvastatin), 2) Current LDL-C level 70 mg/dL or greater with intolerance to a high-intensity statin AND is taking a maximally tolerated dose of any statin, 3) Current LDL-C level 70 mg/dL or greater with contraindication to statin (see Other Criteria) OR intolerance to any dose of two statins, or 4) Recent treatment (ie, within the last 120 days) with another PCSK9 inhibitor. For members with HeFH, at least one of the following requirements is met: 1) With ASCVD: See requirements for members with prior ASCVD above, 2) Current LDL-C level 100 mg/dL or greater after treatment with a high-intensity statin (eg, atorvastatin, rosuvastatin), 3) Current LDL-C level 100 mg/dL or greater with intolerance to a high-intensity statin AND is taking a maximally tolerated dose of any statin, 4) Current LDL-C level 100 mg/dL or greater with contraindication to statin (see Other Criteria) OR intolerance to any dose of two statins, or 5) Recent treatment (ie, within the last 120 days) with another PCSK9 inhibitor. For continuation: Response to therapy as demonstrated by a reduction in LDL-C.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Clinical ASCVD or cardiovascular event defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure [eg, PTCA, CABG], stroke of presumed atherosclerotic origin, transient ischemic attack, peripheral arterial disease of presumed atherosclerotic origin, findings from CT angiogram or catheterization consistent with clinical ASCVD). Diagnosis of FH must be confirmed by one of the following: 1) Genetic confirmation: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, 2) Simon-Broome Diagnostic Criteria for definite FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or 3) Dutch Lipid Clinic Network Criteria for definite FH: Total score greater than 8 points. Contraindication to statin must be due to one of the following: 1) Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (eg, ALT level at least 3 times ULN), 2) Women who are pregnant or may become pregnant, or 3) Nursing mothers.

<b><i>Prior Authorization Group</i></b>	PRIVIGEN
<b><i>Drug Names</i></b>	PRIVIGEN
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
<b><i>Exclusion Criteria</i></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. Hyperprolinemia.
<b><i>Required Medical Information</i></b>	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections, patient is not able to take combination antiretroviral therapy, and antibiotic prophylaxis was not effective. For dermatomyositis and polymyositis: standard first-line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For myasthenia gravis: IVIG is requested for worsening weakness, acute exacerbation or use in preparation for surgery. PRCA is secondary to parvovirus B19 infection.
<b><i>Age Restrictions</i></b>	For pediatric HIV infection: age 12 years or younger
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></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.

<i>Prior Authorization Group</i>	PROMACTA
<i>Drug Names</i>	PROMACTA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For chronic or persistent immune thrombocytopenia (ITP): For new starts: a) Patient has had an inadequate response or is intolerant to corticosteroids, immunoglobulins or splenectomy, AND b) Untransfused platelet count at time of diagnosis is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. For continuation of therapy, platelet (plt) count response to Promacta: a) Current plt count is 50,000-200,000/mcL OR b) Current plt count is less than 50,000/mcL and sufficient to avoid clinically important bleeding OR c) Current plt count is less than 50,000/mcL and patient has not received a maximal dose of Promacta for at least 4 weeks OR d) Current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: For new starts: a) Promacta is used for initiation and maintenance of interferon-based therapy, AND b) Untransfused platelet count at time of diagnosis is less than 75,000/mcL. For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): For new starts: a) Patient has had an inadequate response to immunosuppressive therapy, AND b) Untransfused platelet count at time of diagnosis is less than or equal to 30,000/mcL. For continuation of therapy, plt count response to Promacta: a) Current plt count is 50,000-200,000/mcL OR b) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks OR c) Current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. Adequate platelet response = APR. Inadequate platelet response = IRP
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	HCV:6mo, ITP/AA initial:6mo, ITP/AA APR reauth: Plan Yr, ITP IPR reauth:3mo, AA IPR reauth:16wks
<i>Other Criteria</i>	

<b>Prior Authorization Group</b>	PULMOZYME
<b>Drug Names</b>	PULMOZYME
<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 cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
<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.

<b>Prior Authorization Group</b>	QUININE SULFATE
<b>Drug Names</b>	QUININE SULFATE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, Babesiosis, uncomplicated Plasmodium vivax malaria
<b>Exclusion Criteria</b>	Prolonged QT interval. Glucose-6-phosphate dehydrogenase (G6PD) deficiency. Myasthenia gravis. Optic neuritis.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	RAVICTI
<b>Drug Names</b>	RAVICTI
<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 urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing. Ravicti will be used for chronic management of UCD. Patient has experienced intolerance to prior Buphenyl therapy OR patient has not tried Buphenyl because of a comorbid condition that prohibits a trial due to its sodium content (e.g., heart failure, hypertension, renal impairment, edema).
<b>Age Restrictions</b>	2 months of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

**Prior Authorization Group** REGRANEX  
**Drug Names** REGRANEX  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** Neoplasm(s) at site(s) of application.  
**Required Medical Information** 1) For the treatment of lower extremity diabetic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply AND 2) Good ulcer care practices including initial sharp debridement, pressure relief, and infection control will be performed.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** 20 weeks

**Other Criteria**

**Prior Authorization Group** RELISTOR

**Drug Names** RELISTOR

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

**Exclusion Criteria** Known or suspected mechanical gastrointestinal obstruction. At increased risk of recurrent obstruction due to the potential for gastrointestinal perforation.

**Required Medical Information** 1) Relistor is being prescribed for opioid-induced constipation in an adult patient with advanced illness who is receiving palliative care when response to laxative therapy has not been sufficient OR 2) Relistor is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried. (Note: Examples are Amitiza or Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: Examples are Amitiza or Movantik) OR 6) The patient has a contraindication to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: Examples are Amitiza or Movantik).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** 4 Months

**Other Criteria**

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

REMICADE

REMICADE

All FDA-approved indications not otherwise excluded from Part D. Axial spondyloarthritis. Behcet's syndrome. Granulomatosis with polyangiitis (Wegener's granulomatosis). Hidradenitis suppurativa. Juvenile idiopathic arthritis. Pyoderma gangrenosum. Sarcoidosis. Takayasu's arteritis. Uveitis.

**Exclusion Criteria**

**Required Medical Information**

Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Remicade (or other biologic). For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) Inadequate response to at least a 3-month trial of self-injectable TNF inhibitor (eg, Cimzia, Humira) OR 3) Intolerance to a self-injectable TNF inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (eg, corticosteroids, sulfasalazine, azathioprine, mesalamine) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Remicade will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (eg, Cimzia, Humira) or intolerance to a self-injectable TNF inhibitor. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to at least a 4-week NSAID trial at maximum recommended or tolerated dose OR intolerance and/or contraindication to NSAIDs.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year



**Other Criteria**

For active psoriatic arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of MTX, sulfasalazine, or leflunomide OR 2) Intolerance or contraindication to MTX, sulfasalazine, or leflunomide OR 3) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (eg, Humira, Cimzia), OR 4) Intolerance to a self-injectable TNF inhibitor, OR 5) Severely active PsA as evidenced by ANY of the following: a) multiple swollen joints, b) structural damage in the presence of inflammation, c) clinically relevant extra-articular manifestations (eg, extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), OR 6) Active enthesitis and/or dactylitis (ie, sausage finger) OR 7) Predominant axial disease (ie, extensive spinal involvement). For chronic moderate to severe plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (e.g., feet, hands, face, neck and/or groin) are affected AND 2) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (e.g., Humira) or intolerance to a self-injectable TNF inhibitor. For juvenile idiopathic arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (e.g., Humira) OR 2) Intolerance to a self-injectable TNF inhibitor. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis (e.g., methotrexate, azathioprine, or mycophenolate mofetil).

**Prior Authorization Group**

REMODULIN

**Drug Names**

REMODULIN

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

Patient has had NYHA Functional Class II, III, or IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

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

***Prior Authorization Group***

***Drug Names***

***Covered Uses***

REVLIMID

REVLIMID

All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, classical Hodgkin lymphoma, non-Hodgkin's lymphoma with the following subtypes: chronic lymphocytic leukemia/small lymphocytic lymphoma, AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, lymphoma associated with Castleman's disease, diffuse large B-cell lymphoma, follicular lymphoma, nongastric/gastric MALT lymphoma, primary cutaneous B-cell lymphoma, splenic marginal zone lymphoma, multicentric Castleman's disease.

***Exclusion Criteria***

***Required Medical Information***

For all indications: The patient will be monitored for thromboembolism. For multiple myeloma: Revlimid is prescribed for primary, maintenance, or salvage therapy. For primary therapy: 1) The prescribed regimen includes dexamethasone, OR 2) The prescribed regimen is Revlimid, melphalan, and prednisone for a patient who is not a stem cell transplant candidate. For myelodysplastic syndrome (MDS): 1) Patient must have low- to intermediate-1 risk MDS with symptomatic anemia. For multicentric Castleman's disease: 1) The disease has progressed following treatment of relapsed, refractory, or progressive disease AND 2) Revlimid will be used as monotherapy. For all subtypes of NHL except Castleman's disease: 1) The disease is relapsed, refractory, or progressive AND 2) Revlimid will be used as monotherapy or in combination with rituximab. For systemic light chain amyloidosis: Revlimid will be used with either: a) dexamethasone OR b) dexamethasone AND cyclophosphamide.

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration***

***Other Criteria***

Plan Year

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

RITUXAN

RITUXAN

All FDA-approved indications not otherwise excluded from Part D, primary CNS lymphoma, leptomeningeal metastases from lymphomas, Hodgkin's lymphoma (lymphocyte-predominant), non-Hodgkin's lymphoma subtypes [marginal zone lymphomas (splenic, MALT), Mantle cell lymphoma, Burkitt lymphoma, AIDS-related B-cell lymphoma, relapsed/refractory hairy cell leukemia, small lymphocytic lymphoma (SLL), post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma, lymphoblastic lymphoma, Castleman's disease], acute lymphoblastic leukemia, refractory immune or idiopathic thrombocytopenic purpura (ITP), acquired blood factor VIII deficiency, autoimmune hemolytic anemia, chronic graft-versus-host disease (GVHD), Waldenstrom's macroglobulinemia, lymphoplasmacytic lymphoma, Sjogren syndrome, thrombotic thrombocytopenic purpura, and prevention of Epstein-Barr virus (EBV)-related PTLD.

**Exclusion Criteria**

**Required Medical Information**

Prior to initiating therapy, patient has been screened for hepatitis B virus (HBV) infection with Hepatitis B serologic assays. For moderately to severely active rheumatoid arthritis (new starts only): 1) Rituxan is used in combination with methotrexate unless methotrexate is contraindicated or not tolerated and 2) member has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor. Hematologic malignancies must be CD20-positive. For Burkitt lymphoma and ALL, Rituxan is used as a component of a chemotherapy regimen. For diffuse large B-cell lymphoma (DLBCL), patient meets one of the following conditions: 1) has relapsed or refractory disease and will use Rituxan as a component of a chemotherapy regimen if patient is a candidate for high dose therapy with autologous stem cell rescue, 2) has relapsed or refractory disease and is not a candidate for high dose therapy with autologous stem cell rescue OR 3) does not have relapsed or refractory disease and will use Rituxan as a component of a chemotherapy regimen. For Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA), Rituxan will be used in combination with glucocorticoids.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Plan Year

<b><i>Prior Authorization Group</i></b>	RITUXAN HYCELA
<b><i>Drug Names</i></b>	RITUXAN HYCELA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

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

<b><i>Prior Authorization Group</i></b>	RYDAPT
<b><i>Drug Names</i></b>	RYDAPT
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For newly diagnosed FLT3 mutation-positive AML, Rydapt is/was used in combination with standard cytarabine with daunorubicin or idarubicin induction followed by cytarabine consolidation chemotherapy.
<b><i>Age Restrictions</i></b>	18 years of age or older
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	SABRIL
<b><i>Drug Names</i></b>	SABRIL, VIGABATRIN
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For infantile spasms (IS): The requested drug is used as a single agent in the treatment of IS. For complex partial seizures (CPS): 1) patient had an inadequate response to at least 2 alternative therapies for CPS (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine), AND 2) The requested drug is used as adjunctive therapy.
<b><i>Age Restrictions</i></b>	Initial treatment of infantile spasms: 1 month to 2 years. CPS: 10 years of age or older.
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	SIGNIFOR
<b><i>Drug Names</i></b>	SIGNIFOR
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Patient has had pituitary surgery that was not curative or the patient is not a candidate for surgery. Patient must have controlled blood glucose levels or is receiving optimized antidiabetic therapy. Fasting plasma glucose and/or hemoglobin A1c levels must be obtained at baseline. For continuation of therapy, patient must show a clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	Endocrinologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	SILDENAFIL
<b><i>Drug Names</i></b>	REVATIO, SILDENAFIL
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	Treatment with a nitrate therapy on a regular or intermittent basis. Concomitant treatment with a guanylate cyclase stimulator (e.g., Adempas).
<b><i>Required Medical Information</i></b>	PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	SIRTURO
<b><i>Drug Names</i></b>	SIRTURO
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	Sirturo being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis (e.g. central nervous system), or infection caused by the non-tuberculous mycobacteria (NTM).
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	6 Months
<b><i>Other Criteria</i></b>	

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

SOMATULINE DEPOT

SOMATULINE DEPOT

All FDA-approved indications not otherwise excluded from Part D, adrenal gland neuroendocrine tumors (NETs), NETs of the gastrointestinal (GI) tract, thymus, and lung, pancreatic NETs, and poorly differentiated (high-grade)/large or small cell NETs.

**Exclusion Criteria**

**Required Medical Information**

Acromegaly: Patient has 1) clinical evidence of acromegaly, AND 2) a high pre-treatment IGF-1 level for age and/or gender, AND 3) had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. NETs of the GI tract: Patient has 1) distant metastases, OR 2) unresectable disease, OR 3) primary site of the tumor is gastric, tumor is less than or equal to 2 centimeters, AND the patient has hypersecretion of gastrin. NETs of the thymus: Patient has distant metastases OR unresectable disease. NETs of the lung: Patient has distant metastases OR unresectable disease. Pancreatic NETs: 1) For gastrinoma, glucagonoma, and VIPoma, patient's somatostatin receptor status is positive OR patient has hormone-related symptoms, OR 2) For insulinoma, non-functioning pancreatic tumor, somatostatinoma, pancreatic polypeptidoma, cholecystokininoma, ACTH-secreting pancreatic NET, and parathyroid hormone-related protein-secreting pancreatic NET, patient has a) distant metastases or unresectable disease AND b) somatostatin receptor status is positive OR patient has hormone-related symptoms. Adrenal Gland NETs: 1) Patient has a diagnosis of non-ACTH dependent Cushing's syndrome, AND 2) The cortisol production is symmetric, AND 3) Tumors are less than 4 centimeters, AND 4) Somatostatin receptor status is positive. Poorly differentiated (high-grade)/large or small cell NETs (excluding lung): 1) Patient has metastatic or unresectable disease, AND 2) Somatostatin receptor status is positive, AND 3) Patient has hormone-related symptoms.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

Plan Year

For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

<b><i>Prior Authorization Group</i></b>	SOMAVERT
<b><i>Drug Names</i></b>	SOMAVERT
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Patient must meet all of the following: 1) Patient has clinical evidence of acromegaly, AND 2) Patient has a high pre-treatment IGF-1 level for age and/or gender, AND 3) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy, AND 4) Patient had an inadequate or partial response to a) octreotide (Sandostatin or Sandostatin LAR), or b) lanreotide (Somatuline Depot), or c) pasireotide (Signifor LAR) OR patient is intolerant or has a contraindication to a) octreotide, or b) lanreotide, or c) pasireotide.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	For continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.



<b><i>Prior Authorization Group</i></b>	SOVALDI
<b><i>Drug Names</i></b>	SOVALDI
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, chronic hepatitis C genotype 5 or 6 infection.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants (eg, NS3 Q80K polymorphism) where applicable, liver transplantation status if applicable. For patients with genotype 1, 2, 3, or 4 infection and hepatocellular carcinoma awaiting liver transplantation: must meet MILAN criteria. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Criteria will be applied consistent with current AASLD-IDSa guidance
<b><i>Other Criteria</i></b>	For HCV/HIV coinfection, patient meets criteria for requested regimen and will not receive treatment with tipranavir. For patients prescribed a treatment regimen that includes Olysio, no prior treatment failure with an HCV protease inhibitor (eg, telaprevir, simeprevir, boceprevir, paritaprevir) despite adequate dosing and duration of therapy. MILAN criteria defined as: 1) tumor size 5 cm or less in diameter in pts with single hepatocellular carcinoma OR 3 tumor nodules or less, each 3 cm or less in diameter in pts with multiple tumors, and 2) no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor.

<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 CML or Ph+ ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) high or intermediate risk for disease progression, or b) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have PDGFRA D842V mutation and disease progression on imatinib, sunitinib, or regorafenib.
<b>Age Restrictions</b>	15 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<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>	For unresectable advanced or metastatic colorectal cancer, KRAS/NRAS mutation testing is performed on either the primary tumor or metastases to confirm RAS mutation status. The patient must have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, and, if KRAS or NRAS wild type, an anti-EGFR therapy. Stivarga must be used as a single agent. For locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST), the patient 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>	

<b><i>Prior Authorization Group</i></b>	SUTENT
<b><i>Drug Names</i></b>	SUTENT
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), angiosarcoma, solitary fibrous tumor, hemangiopericytoma, chordoma (bone cancer), lung neuroendocrine tumor, thymic carcinoma.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For renal cell carcinoma: 1) The disease is relapsed or medically unresectable and 2) Sutent will be used as a single agent. For gastrointestinal stromal tumor: The patient experienced disease progression on imatinib or was intolerant to imatinib. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) Nexavar is not an appropriate option for the patient, 2) the disease is unresectable or metastatic, 3) the disease is radioiodine-refractory, and 4) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For thymic carcinoma: 1) Sutent will be used as a single agent and 2) the disease has progressed on a platinum-based chemotherapy regimen.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	SYLATRON
<b><i>Drug Names</i></b>	SYLATRON
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, giant cell tumor of the bone.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For giant cell tumor of the bone, patient has unresectable disease OR surgical resection is likely to result in severe morbidity.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	For melanoma, Sylatron must be requested within 84 days (12 weeks) of the surgical resection.

<b><i>Prior Authorization Group</i></b>	SYMLIN
<b><i>Drug Names</i></b>	SYMLINPEN 120, SYMLINPEN 60
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	Recurrent severe hypoglycemia that required assistance during the past 6 months. Gastroparesis. Patient requires drug therapy to stimulate gastrointestinal motility. Hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia). HbA1c level greater than 9 percent.
<b><i>Required Medical Information</i></b>	1) The patient is currently receiving optimal mealtime insulin therapy AND 2) The patient has experienced an inadequate treatment response to insulin AND 3) The patient has a diagnosis of type 1 or type 2 diabetes mellitus
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	1) If the patient has been receiving Symlin for at least 3 months, patient demonstrated a reduction in HbA1c since starting Symlin therapy
<b><i>Prior Authorization Group</i></b>	SYNRIBO
<b><i>Drug Names</i></b>	SYNRIBO
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For CML, the patient has experienced resistance, toxicity or intolerance to prior therapy with at least two tyrosine kinase inhibitors (TKIs) (eg, imatinib, dasatinib, nilotinib, bosutinib, ponatinib).
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	TAFINLAR
<b><i>Drug Names</i></b>	TAFINLAR
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, CNS metastases, and non-small cell lung cancer.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For unresectable or metastatic melanoma: 1) Tafinlar will be used in combination with Mekinist for patients with a diagnosis of BRAF V600E or V600K mutation positive disease OR 2) Tafinlar will be used as a single agent for BRAF V600E or V600K mutation positive disease AND clinical deterioration is anticipated in less than or equal to 12 weeks. For CNS metastases: Tafinlar has activity against the primary tumor (melanoma) AND Tafinlar will be used as a single agent. For NSCLC: The tumor is positive for the BRAF V600E mutation
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

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

***Prior Authorization Group***

TARCEVA

***Drug Names***

TARCEVA

***Covered Uses***

All FDA-approved indications not otherwise excluded from Part D, chordoma, renal cell carcinoma (RCC).

***Exclusion Criteria***

***Required Medical Information***

For locally advanced, recurrent or metastatic non-small cell lung cancer (NSCLC) with positive EGFR mutation (exon 19 deletions or exon 21 L858R substitution mutations), Tarceva is prescribed for use as ANY of the following: 1) First-line therapy as a single agent (EGFR mutation discovered prior to first-line chemotherapy or during first-line chemotherapy), 2) Subsequent therapy as a single agent following disease progression on erlotinib, 3) Subsequent therapy in combination with chemotherapy following disease progression on afatinib or erlotinib, or 4) Subsequent therapy as a single agent following progression on a cytotoxic regimen for metastatic disease in members who have not previously received erlotinib. For metastatic NSCLC with negative or unknown EGFR mutation, Tarceva is prescribed for use as subsequent therapy as a single agent following progression on a cytotoxic regimen in a patient who has not previously received erlotinib. For pancreatic cancer, Tarceva is prescribed in combination with gemcitabine for locally advanced unresectable or metastatic pancreatic cancer. For chordoma, Tarceva is prescribed as a single agent for recurrent disease. For RCC, Tarceva is prescribed as a single agent for relapsed or unresectable stage IV disease with non-clear cell histology.

***Age Restrictions***

***Prescriber Restrictions***

***Coverage Duration***

Plan Year

***Other Criteria***

<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, Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST).
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For CML or Ph+ ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) high or intermediate risk for disease progression, or b) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For Ph+ ALL, 1) patient has relapsed or refractory Ph+ ALL, OR 2) patient has received hematopoietic stem cell transplant after achieving complete response to induction chemotherapy. If patient relapsed after or is refractory to initial tyrosine kinase inhibitor-containing therapy for ALL, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	
<b>Prior Authorization Group</b>	TAZORAC
<b>Drug Names</b>	TAZAROTENE, TAZORAC
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	1) For patients being treated for plaque psoriasis the requested drug must be applied to less than 20 percent of the patient's body surface area AND 2) For patients being treated for plaque psoriasis a trial of at least one topical corticosteroid (e.g., clobetasol, fluocinonide, mometasone, triamcinolone) (patient may still be using a corticosteroid product in addition to the requested drug) OR 3) patient experienced an adverse event, intolerance, or contraindication to topical corticosteroids.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	For patients who are able to bear children, the pregnancy status of the patient has been evaluated and the patient made aware of the potential risks of fetal harm and importance of birth control while using the requested drug.

**Prior Authorization Group** TECENTRIQ  
**Drug Names** TECENTRIQ  
**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** TESTOSTERONE CYPIONATE INJ  
**Drug Names** TESTOSTERONE CYPIONATE  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D, Gender Identity Disorder in Female-to-Male transgender  
**Exclusion Criteria**  
**Required Medical Information** 1) Drug is being prescribed for a male patient with congenital or acquired primary hypogonadism (i.e., testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchidectomy) who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values OR 2) Drug is being prescribed for a male patient with congenital or acquired hypogonadotropic hypogonadism (i.e., gonadotropin or luteinizing hormone-releasing hormone [LHRH] deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation) who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values OR 3) Drug is being prescribed for female-to-male gender reassignment in a patient who is 14 years of age or older and able to make an informed, mature decision to engage in therapy  
**Age Restrictions** 14 years of age or older (female-to-male gender reassignment)  
**Prescriber Restrictions**  
**Coverage Duration** Plan Year  
**Other Criteria**



<b><i>Prior Authorization Group</i></b>	TESTOSTERONE ENANTHATE INJ
<b><i>Drug Names</i></b>	TESTOSTERONE ENANTHATE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	1) Drug is being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal and who has had an incomplete response to other therapy for metastatic breast cancer OR 2) Drug is being prescribed for a pre-menopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor OR 3) Drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 4) Drug is being prescribed for delayed puberty in a male patient.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	TETRABENAZINE
<b><i>Drug Names</i></b>	TETRABENAZINE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, chronic tics associated with Tourette's syndrome, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
<b><i>Exclusion Criteria</i></b>	Active suicide ideation. Untreated or inadequately treated depression.
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

**Prior Authorization Group** THALOMID  
**Drug Names** THALOMID  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, HIV-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, myelofibrosis with myeloid metaplasia, multicentric Castleman's disease.

**Exclusion Criteria**  
**Required Medical Information** For all indications: The patient will be monitored for thromboembolism. For cachexia: Cachexia must be due to cancer or HIV-infection. For Kaposi's sarcoma: The patient has HIV infection.

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

**Prior Authorization Group** TOBRAMYCIN  
**Drug Names** TOBRAMYCIN  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D, non-cystic fibrosis bronchiectasis.

**Exclusion Criteria**  
**Required Medical Information** The patient has a diagnosis of cystic fibrosis that is confirmed by appropriate diagnostic or genetic testing OR the patient has a diagnosis of non-cystic fibrosis bronchiectasis. Pseudomonas aeruginosa is present in the patient's airway cultures OR the patient has a history of pseudomonas aeruginosa infection or colonization in the airways.

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

<b>Prior Authorization Group</b>	TOPICAL LIDOCAINE
<b>Drug Names</b>	LIDOCAINE, LIDOCAINE HCL, LIDOCAINE HCL JELLY, LIDOCAINE/PRILOCAINE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 Months
<b>Other Criteria</b>	1) The prescribed quantity falls within the manufacturer's published dosing guidelines. 2) If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use. 3) 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.

<b>Prior Authorization Group</b>	TOPICAL TESTOSTERONES
<b>Drug Names</b>	ANDRODERM, AXIRON, TESTOSTERONE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	TOPICAL TRETINOIN
<b>Drug Names</b>	AVITA, TRETINOIN
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<b><i>Prior Authorization Group</i></b>	TRELSTAR
<b><i>Drug Names</i></b>	TRELSTAR MIXJECT
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, adjuvant therapy for prostate cancer, initial ADT for prostate cancer, progressive, metastatic, and recurrent prostate cancer.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	If the patient has regional disease as initial ADT, metastatic disease as initial ADT, progressive castration-naïve disease, or recurrent disease as defined as a biochemical failure after previous therapy, then no further information is required. If the patient has lymph node-positive disease found during pelvic lymph node dissection (PLND), then Trelstar must be used without external beam radiation therapy (EBRT) as adjuvant therapy. If the patient has none of the abovementioned criteria and has intermediate risk stratification, then Trelstar must be used with EBRT as initial ADT. If the patient has none of the abovementioned criteria and has high or very high risk stratification, then Trelstar must be used with EBRT or EBRT and docetaxel as initial ADT. If the patient has none of the abovementioned criteria and has very high risk stratification and is not a candidate for definitive therapy, Trelstar may be used without EBRT as initial ADT.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	For immediate risk stratification: 6 months. Others: Plan Year.
<b><i>Other Criteria</i></b>	Use as neoadjuvant therapy prior to radical prostatectomy is not approvable.

<b><i>Prior Authorization Group</i></b>	TYKERB
<b><i>Drug Names</i></b>	TYKERB
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, metastatic CNS lesions.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For advanced, recurrent, or metastatic HER2-positive breast cancer, Tykerb will be used in combination with: 1) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) for a postmenopausal woman with hormone receptor-positive disease, or 2) capecitabine or trastuzumab (without cytotoxic therapy) for a patient who has received prior trastuzumab-containing regimen. For metastatic CNS lesions, 1) member has recurrent HER2-positive breast cancer, 2) Tykerb is active against the primary tumor (breast), and 3) Tykerb will be used in combination with capecitabine in a patient with recurrent HER2-positive breast cancer.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	TYSABRI
<b><i>Drug Names</i></b>	TYSABRI
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Use as monotherapy. For Crohn's disease (CD), patient must have an inadequate response, intolerance or contraindication to one conventional CD therapy (eg, corticosteroid, azathioprine, mesalamine) and one TNF-inhibitor (eg, Humira, Cimzia).
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	UPTRAVI
<b><i>Drug Names</i></b>	UPTRAVI
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than or equal to 5 Wood units OR pretreatment pulmonary vascular resistance is greater than 3 Wood units for members who are experiencing clinical deterioration/worsening on current PAH therapy at maximum tolerated doses.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	VALCHLOR
<b><i>Drug Names</i></b>	VALCHLOR
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, adult T-cell leukemia/lymphoma, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Lymphomatoid papulosis: Valchlor will be used as a single agent
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan year
<b><i>Other Criteria</i></b>	

<b><i>Prior Authorization Group</i></b>	VELCADE
<b><i>Drug Names</i></b>	VELCADE
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For multiple myeloma: Velcade is prescribed for primary, maintenance, or salvage therapy. For primary therapy: 1) the prescribed regimen includes dexamethasone, OR 2) the prescribed regimen is Velcade, melphalan, and prednisone for a patient who is not a stem cell transplant candidate. For multicentric Castleman's disease: 1) The disease has progressed following treatment of relapsed, refractory, or progressive disease, and 2) Velcade will be prescribed as monotherapy or in combination with rituximab.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></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.

<b><i>Prior Authorization Group</i></b>	VENCLEXTA
<b><i>Drug Names</i></b>	VENCLEXTA, VENCLEXTA STARTING PACK
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<b>Prior Authorization Group</b>	VENTAVIS
<b>Drug Names</b>	VENTAVIS
<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 had NYHA Functional Class III or IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
<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.

<b>Prior Authorization Group</b>	VERSACLOZ
<b>Drug Names</b>	VERSACLOZ
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	History of clozapine-induced agranulocytosis or severe granulocytopenia. Dementia-related psychosis.
<b>Required Medical Information</b>	The patient is unwilling or unable to take tablets or capsules orally or is at high risk for non-compliance.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<b>Prior Authorization Group</b>	VOLTAREN GEL
<b>Drug Names</b>	DICLOFENAC SODIUM
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Use during the peri-operative period in the setting of coronary artery bypass graft (CABG) surgery. Experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDS.
<b>Required Medical Information</b>	The patient is unable to tolerate or not a suitable candidate for oral NSAID therapy (e.g., bleeding ulcer, etc.).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<b><i>Prior Authorization Group</i></b>	VOSEVI - PENDING CMS REVIEW
<b><i>Drug Names</i></b>	VOSEVI
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
<b><i>Required Medical Information</i></b>	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	12 weeks or Criteria will be applied consistent with current AASLD-IDSA guidance.
<b><i>Other Criteria</i></b>	



**Prior Authorization Group**

VOTRIENT

**Drug Names**

VOTRIENT

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, dermatofibrosarcoma protuberans, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma.

**Exclusion Criteria**

**Required Medical Information**

For renal cell carcinoma: 1) The disease is relapsed or medically unresectable and 2) Votrient will be used as a single agent. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma and 2) the patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk sarcoma. For GIST, the disease has progressed on treatment with imatinib, sunitinib, or regorafenib. For angiosarcoma or pleomorphic rhabdomyosarcoma, Votrient will be used as a single agent. For retroperitoneal/intra-abdominal sarcoma or extremity/superficial trunk sarcoma, Votrient will be used as a single agent for progressive, unresectable, or metastatic disease. For uterine sarcoma: 1) Votrient will be used as a single agent and 2) for stage I disease, the disease is medically inoperable. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) Nexavar is not an appropriate option for the patient, 2) the disease is unresectable or metastatic, 3) the disease is radioiodine-refractory, and 4) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For dermatofibrosarcoma protuberans: 1) The disease is metastatic and 2) Votrient will be used as a single agent.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

<b><i>Prior Authorization Group</i></b>	XALKORI
<b><i>Drug Names</i></b>	XALKORI
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer (NSCLC) with MET amplification, inflammatory myofibroblastic tumors (IMT).
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For NSCLC, patient meets all of the following: 1) Tumor is ALK-positive, ROS1-positive, or demonstrates MET amplification, and 2) Patient has recurrent or metastatic disease, and 3) Xalkori is being used as a single agent. For IMT, the tumor is ALK-positive and Xalkori is being used as a single agent.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	XELJANZ
<b><i>Drug Names</i></b>	XELJANZ, XELJANZ XR
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	Combination therapy with a potent immunosuppressant such as azathioprine or cyclosporine
<b><i>Required Medical Information</i></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 initiating Xeljanz/Xeljanz XR or previous biologic DMARD. For moderately to severely active rheumatoid arthritis (new starts only), patient meets at least one of the following criteria: 1) Inadequate response to at least a 3-month trial of methotrexate (MTX) despite adequate dosing (i.e., titrated to 25 mg/week), 2) Intolerance or contraindication to MTX, 3) Inadequate response to at least a 3-month trial of any prior biologic DMARD (eg, adalimumab), 4) Intolerance to any prior biologic DMARD.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

**Prior Authorization Group** XGEVA  
**Drug Names** XGEVA  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria**  
**Required Medical Information** For bone metastases from prostate cancer (solid tumor), patient has castration-recurrent disease. For giant cell tumor of the bone, patient has unresectable disease or surgical resection is likely to result in severe morbidity. For hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy (eg, zoledronic acid, pamidronate) defined as albumin-corrected serum calcium level of greater than 12.5 mg/dL despite IV bisphosphonate therapy.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Hypercalcemia of malignancy: initial = 2 months, renewal = Plan Year. All other dx = Plan Year.

**Other Criteria**

For hypercalcemia of malignancy renewal requests: patient has demonstrated a response to Xgeva therapy defined as albumin-corrected serum calcium level of 12.5 mg/dL or less. 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**

XIFAXAN

**Drug Names**

XIFAXAN

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Reduction in risk of overt HE recurrence-6 Months, IBS-D-Plan Year

**Other Criteria**

<b><i>Prior Authorization Group</i></b>	XOLAIR
<b><i>Drug Names</i></b>	XOLAIR
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For allergic asthma: 1) Xolair is used in combination with other medications for long-term control of asthma, and 2) Patient has a rapid-acting beta2-agonist available for rescue therapy. For initial therapy only: 1) Patient has a diagnosis of moderate to severe persistent asthma, 2) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 3) Patient has baseline IgE level greater than or equal to 30 IU/mL, 4) Asthma is inadequately controlled despite use of inhaled corticosteroid at the optimal dose (unless patient has an intolerance or contraindication to inhaled corticosteroid therapy), and 5) Patient is optimizing the use of a long-acting inhaled beta2-agonist, leukotriene modifier, or sustained-release theophylline (unless patient has an intolerance or contraindication to such therapies). For continuation therapy only: Patient's asthma control has improved on Xolair treatment since initiation of therapy. For chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks, and 3) Patient has remained symptomatic despite second generation H1 antihistamine therapy with maximized dosing used continuously for at least two weeks (unless patient has an intolerance or contraindication to antihistamine therapy). For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.
<b><i>Age Restrictions</i></b>	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.
<b><i>Prescriber Restrictions</i></b>	For CIU: allergist, dermatologist, or immunologist
<b><i>Coverage Duration</i></b>	Allergic asthma: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year.
<b><i>Other Criteria</i></b>	Xolair will be administered in a controlled healthcare setting with access to emergency medications (e.g., anaphylaxis kit).

<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>	For non-castration-resistant disease, Xtandi will be used in combination with androgen deprivation therapy to: 1) enhance the effectiveness of radiation therapy, 2) supplement androgen deprivation therapy if the patient experienced inadequate testosterone suppression, OR 3) prevent androgen flare in androgen deprivation therapy naive patients who are at risk of developing symptoms.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	

<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>	Taking alcohol or sedative hypnotic agents while taking Xyrem.
<b>Required Medical Information</b>	1) The drug is being prescribed for the treatment excessive daytime sleepiness in a patient with narcolepsy without cataplexy and 2) The patient experienced an inadequate treatment response or intolerance to a CNS stimulant drug and a CNS promoting wakefulness drug OR 3) the patient has a contraindication to a CNS stimulant drug or a CNS wakefulness promoting drug (NOTE: Examples of a CNS stimulant drug are amphetamine, dextroamphetamine, or methylphenidate. Examples of a CNS wakefulness promoting drug are modafinil or armodafinil. Coverage of modafinil or armodafinil or amphetamines or methylphenidates may require prior authorization). OR 4) The drug is being prescribed for the treatment of cataplexy in a patient with narcolepsy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	If the request is for the continuation of Xyrem, the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

<b><i>Prior Authorization Group</i></b>	YERVOY
<b><i>Drug Names</i></b>	YERVOY
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, CNS metastases from primary tumor (melanoma).
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For unresectable or metastatic melanoma, Yervoy will be used as a single agent or in combination with nivolumab (Opdivo). For the adjuvant treatment of melanoma, member must meet all of the following: 1) Yervoy will be used as adjuvant therapy following complete resection, including total lymphadenectomy, AND 2) the disease has pathologic involvement of regional lymph nodes of more than 1 millimeter. For CNS metastases from primary tumor (melanoma), member must meet all of the following: 1) Yervoy was active against the primary tumor (melanoma), 2) the disease is recurrent, and 3) Yervoy will be used as a single agent.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	
<b><i>Prior Authorization Group</i></b>	ZAVESCA
<b><i>Drug Names</i></b>	ZAVESCA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	Diagnosis of Type 1 Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. Enzyme replacement therapy is not a therapeutic option (e.g., due to constraints such as allergy, hypersensitivity, or poor venous access).
<b><i>Age Restrictions</i></b>	18 years of age and older.
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

<i>Prior Authorization Group</i>	ZEJULA
<i>Drug Names</i>	ZEJULA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	Treatment is being started or was started no later than 8 weeks after the most recent platinum-based chemotherapy.

<i>Prior Authorization Group</i>	ZELBORAF
<i>Drug Names</i>	ZELBORAF
<i>Covered Uses</i>	All FDA-approved uses not otherwise excluded from Part D, melanoma with BRAF V600K mutation, CNS metastases from primary tumor (melanoma), NSCLC with BRAF V600E mutation, and hairy cell leukemia.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	For unresectable or metastatic melanoma: The tumor is positive for either BRAF V600E or V600K mutation AND clinical deterioration is anticipated in less than or equal to 12 weeks. For CNS metastases: Zelboraf has activity against the primary tumor (melanoma) AND Zelboraf will be used as a single agent. For NSCLC: The tumor is positive for the BRAF V600E mutation. For refractory hairy cell leukemia: Zelboraf will be used as a single agent.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	

<b><i>Prior Authorization Group</i></b>	ZEPATIER
<b><i>Drug Names</i></b>	ZEPATIER
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D.
<b><i>Exclusion Criteria</i></b>	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C). Liver transplant recipient or awaiting liver transplantation
<b><i>Required Medical Information</i></b>	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants (eg, NS5A polymorphisms) where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current prescribing information and AASLD-IDSA treatment guidelines.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Criteria will be applied consistent with current AASLD-IDSA guidance.
<b><i>Other Criteria</i></b>	For HCV and HIV coinfection, patient meets the criteria for approval for the requested regimen.
<b><i>Prior Authorization Group</i></b>	ZOLINZA
<b><i>Drug Names</i></b>	ZOLINZA
<b><i>Covered Uses</i></b>	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, multiple myeloma.
<b><i>Exclusion Criteria</i></b>	
<b><i>Required Medical Information</i></b>	For multiple myeloma: Zolinza will be used as salvage therapy in combination with bortezomib (Velcade).
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	



<b>Prior Authorization Group</b>	ZYDELIG
<b>Drug Names</b>	ZYDELIG
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, relapsed or refractory chronic lymphocytic leukemia (CLL) as a single agent, relapsed or refractory small lymphocytic lymphoma as a single agent or in combination with rituximab, refractory or progressive follicular lymphoma, primary cutaneous B-cell lymphoma [primary cutaneous marginal zone lymphoma and follicle center lymphoma], and marginal zone lymphomas [gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].
<b>Exclusion Criteria</b>	History of serious allergic reactions including anaphylaxis or toxic epidermal necrolysis.
<b>Required Medical Information</b>	For relapsed or refractory CLL, Zydelig is used as a single agent or in combination with rituximab. For relapsed or refractory SLL, Zydelig is used as a single agent or in combination with rituximab and the patient has received at least two prior systemic therapies. For relapsed, refractory, or progressive follicular B-cell non-Hodgkin lymphoma, Zydelig is used as a single agent and the patient has received at least two prior systemic therapies. For gastric mucosa associated lymphoid tissue (MALT) lymphoma, the disease is recurrent or progressive. For non-gastric MALT and Splenic marginal zone lymphomas, the disease is refractory or progressive.

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

Plan Year

<b>Prior Authorization Group</b>	ZYKADIA
<b>Drug Names</b>	ZYKADIA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor.

**Exclusion Criteria**  
**Required Medical Information**

For NSCLC, patient meets all of the following: 1) Tumor is ALK-positive, and 2) Disease is recurrent or metastatic. For ALK-positive inflammatory myofibroblastic tumor: Zykadia is prescribed as a single agent.

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

Plan Year

<b><i>Prior Authorization Group</i></b>	ZYPREXA RELPREVV
<b><i>Drug Names</i></b>	ZYPREXA RELPREVV
<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>	Tolerability with oral olanzapine has been established.
<b><i>Age Restrictions</i></b>	
<b><i>Prescriber Restrictions</i></b>	
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	

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