ACTEMRA SQ

Products Affected

- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started in tocilizumab (IV/SC) for a Covered Use.
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	N/A
Prescriber Restrictions	RA/GCA/PJIA - Prescribed by or in consultation with a rheumatologist.
Coverage Duration	GCA-6 mo initial, 3 yr cont.PJIA-4 mo initial, 3 yr cont.All other dx-3 mo initial, 3 yr cont.
Other Criteria	RA initial - approve if the patient has tried TWO of the following: Enbrel, Humira, Orencia (IV/SC) , or Xeljanz/XR (Note: if the patient has not tried TWO of these drugs listed, previous trial(s) with the following drugs can count towards meeting the try TWO requirement: Cimzia, infliximab, golimumab SC/IV) OR if, according to the prescribing physician, the patient has heart failure or a previously treated lymphoproliferative disorder. PJIA, approve if the patient has tried etanercept, Orencia or adalimumb. (Note: the patient does not have to have a trial with etanercept, Orencia or adalimumb if they have had a trial with infliximab in the past.) Cont tx - pt must have had a response as determined by the prescriber.

ACTHAR

Products Affected

- ACTHAR H.P.

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for diagnostic procedure.
Required Medical Information	Diagnosis, prescriber or consulting physician specialty, previous medications tried and response
Age Restrictions	Infantile spasms- less than 2yo. Acute MS exac-adult
Prescriber Restrictions	Infantile spasms, prescr/consult w/neurolo/epileptologist.MS exacerbation, prescr/consult w/neuro/phys specializes MS.RA, JIA/JRA, AS, PsA, SLE, Systemic Dermatomyositis, prescr/consult w/rheum.Severe Erythema Multiforme, prescr/consult w/derm.Serum Sickness,prescr/consult w/ allergist.Severe acute/chronic allergic/inflamm processes of eye and its adnexa, prescr/consult w/ ophthalmologist.Symptomatic Sarcoidosis, prescr/consult w/pulm/cardio.Nephrotic Syndrome, prescr/consult w/nephrologist.
Coverage Duration	All diagnoses-1 month
Other Criteria	For acute MS exacerbation, approve if the patient cannot use high-dose IV corticosteroids because IV access is not possible or if the patient has tried high-dose corticosteroids administered IV for an acute MS exacerbation and has experienced a severe adverse effect or treatment failure AND is NOT being used as pulse therapy on a monthly basis. For all other FDA approved diagnoses (other than Infantile spasms or MS exacerbation), approve if the patient has tried a systemic corticosteroid (oral or IV) for the current condition and patient has experienced a severe adverse effect or treatment failure with the corticosteroid (e.g., a psychotic reaction).

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PAH and CTEPH- must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Right heart cathererization is not required in pts who are currently receiving Adempas or another agent indicated for WHO group 1.

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already taking Afinitor for a Covered Use. Advanced, unresectable or metastatic neuroendocrine tumors. Perivascular Epitheloid Cell Tumors (PEComa), Recurrent Angiomyolipoma, Lymphangioleiomyomatosis, relapsed or refractory classical Hodgkin lymphoma, Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL), Osteosarcoma, Thymomas and Thymic carcinomas, Differentiated (i.e. papillary, follicular, and Hurthle cell) Thyroid Carcinoma, Endometrial Carcinoma, Gastrointestinal Stromal Tumors (GIST) and Recurrent or progressive Meningioma.
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer-HER2 status, hormone receptor (HR) status.
Age Restrictions	Relapsed or refractory classical Hodgkin lymphoma-18 years and older
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Under CMS Review

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic NSCLC - is anaplastic lymphoma kinase (ALK)-positive as detected by an approved test.

ALPHA 1 PROTEINASE INHIBITORS

Products Affected

- ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG
- GLASSIA
- PROLASTIN-C INTRAVENOUS RECON SOLN
- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	PiMZ or PiMS phenotypes of AAT, IgA antibody deficient with antibodies against IgA
Required Medical Information	N/A
Age Restrictions	18 years and older (initial and continuation therapy)
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	12 months
Other Criteria	For AAT deficiency with panacinar emphysema, approve when all of the following criteria are met: 1) alpha1-antitrypsin (AAT) concentration less than 80mg/dl or less than 11 micromolar and 2) confirmation of PiZZ, PiZ(null) or Pi(null, null) phenotype (homozygous) AAT deficiency and 3) obstructive lung disease as defined by a forced expiratory volume in one second (FEV1) of 35 to 65% of predicted or a rapid decline in lung function defined as a change in FEV1 of greater than 120ml per year.

ALUNBRIG

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on brigatinib for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	ALK status, treatment history and results
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic NSCLC, patient new to therapy must be ALK-positive AND experienced progression or intolerance while on Xalkori, Zykadia or Alecensa.

AMPYRA

Products Affected

- AMPYRA
- dalfampridine

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	MS. If prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

ANABOLIC STEROIDS

Products Affected

- ANADROL-50
- oxandrolone

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Patients w/Turner's Syndrome or Ullrich-Turner Syndrome (oxandrolone only), management of protein catabolism w/burns or burn injury (oxandrolone only), AIDS wasting and cachexia.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A

ARANESP

Products Affected

- ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (IN POLYSORBATE) INJECTION SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications not otherwise excluded from Part D worded as anemia associated with chronic renal failure (CRF), including patients on dialysis and not on dialysis, and worded as anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. Anemia due to myelodysplastic syndrome (MDS).
Exclusion Criteria	N/A
Required Medical Information	Anemia w/CRF on and not on dialysis.A hemoglobin (Hb) of less than 10.0 g/dL for adults and less than or equal to 11 g/dL for children required for start,Hb has to be less than or equal 11.5 g/dL adults or less than or equal to 12 g/dL in children if previously receiving epoetin alfa (EA) or Aranesp or less than or equal to 11.5 g/dL in adults currently receiving Mircera. Anemia due to myelosuppressive chemotx,Hb is 10.0 g/dL or less to start or less than or equal to 12.0 g/dL if previously on EA or Aranesp AND currently receiving myelosuppressive chemo. MDS, approve tx if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start. If the pt has previously been receiving Aranesp or EA, approve only if Hb is 12.0 g/dL or less. All conds, deny if Hb exceeds 12.0 g/dL.
Age Restrictions	MDS anemia = 18 years of age and older.
Prescriber Restrictions	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist.
Coverage Duration	Anemia w/myelosuppressive = 4 mos, Other=6 mos.
Other Criteria	For all covered uses, the patient is required to try Procrit first line.

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent biologic therapy
Required Medical Information	N/A
Age Restrictions	Initial tx CAPS-Greater than or equal to 12 years of age.
Prescriber Restrictions	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist.
Coverage Duration	3 mos initial, 3 years continue.
Other Criteria	CAPS renewal - approve if the patient has had a response as determined by the prescriber.

ARIKAYCE

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous medication history
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by a pulmonologist, infectious disease physician or a physician who specializes in the treatment of MAC lung infections
Coverage Duration	1 year
Other Criteria	MAC Lung disease-approve if the patient has NOT achieved negative sputum cultures for Mycobacterium avium complex after greater than or equal to 6 consecutive months of a background multidrug regimen AND Arikayce will be used in conjunction to a background multidrug regimen. Note-a multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol and a rifamycin (rifampin or rifabutin).

AUBAGIO

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Aubagio with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Information	MS, patient must have a relapsing form of MS (RRMS, SPMS with relapses, or PRMS). MS, previous MS therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	For patients already taking Aubagio, approve.

AURYXIA

Products Affected

- AURYXIA

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

AVONEX

Products Affected

- AVONEX (WITH ALBUMIN)
- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of other disease-modifying agent used for multiple sclerosis (ie, interferon beta-1a, interferon beta-1b, glatiramer, natalizumab, fingolimod, teriflunomide, dimethyl fumarate DR)
Required Medical Information	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

BENLYSTA SC

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with other biologics or with cyclophosphamide intravenous (IV)
Required Medical Information	Diagnosis, medications that will be used in combination, autoantibody status
Age Restrictions	18 years and older (initial and continuation)
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist or dermatologist (initial and continuation)
Coverage Duration	Initial-4 months, cont-3 years
Other Criteria	Initial-The patient has autoantibody-positive SLE (i.e., positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA]) AND Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician. Continuation-Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician AND The patient has responded to Benlysta as determined by the prescriber.

BETASERON/EXTAVIA

Products Affected

- BETASERON SUBCUTANEOUS KIT
- EXTAVIA SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis
Required Medical Information	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For patients requesting Extavia, approve if the patient has tried two of the following: interferon beta-1a intramuscular (Avonex), interferon beta-1a subcutaneous (Rebif), interferon beta-1b (Betaseron), pegylated interferon beta-1a (Plegridy) or glatiramer acetate (Copaxone).

BOSULIF

Products Affected

- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients with Phildelphia chromosome positive Acute Lymphoblastic Leukemia. Plus patients already started on Bosulif for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis. For CML/ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For ALL, prior therapies tried
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, patient must have Ph-positive CML For ALL, patient must have Ph-positive ALL and has tried ONE other tyrosine kinase inhibitors that are used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).

BRAFTOVI

Products Affected

- BRAFTOVI ORAL CAPSULE 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Braftovi for a covered use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, BRAF V600 status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation.

C1 ESTERASE INHIBITORS

Products Affected

- RUCONEST

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on the prescribed drug for a covered use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
Coverage Duration	Authorization will be for 3 Years.
Other Criteria	N/A

CABOMETYX

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients with Non-Small Cell Lung Cancer with RET Gene Rearrangements. Plus patients already taking Cabometyx for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, histology, RET gene rearrangement status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Advance Renal Cell Carcinoma (Predominant Clear Cell or Non-Clear Cell Histology)-Approve.

CALQUENCE

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus Chronic Lymphocytic Leukemia (CLL). Plus Small Lymphocytic Lymphoma (SLL).
Exclusion Criteria	N/A
Required Medical Information	Previous medications/therapies tried
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	CLL and SLL-approve if the patient has tried one prior therapy.

CAPRELSA

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma. Plus Non-Small Cell Lung Cancer with RET Gene Rearrangements
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 YEARS
Other Criteria	MTC - approve. DTC - approve if refractory to radioactive iodine therapy.disease AND has nonradioiodine-responsive tumors at sites other than central nervous system.

CHENODAL

Products Affected

- CHENODAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For the treatment of gallstones, approve if the patient has tried or is currently using an ursodiol product.

CHOLBAM

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination Therapy with Chenodal
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with hepatologist, metabolic specialist, GI or geneticist
Coverage Duration	3 mos initial, 12 mos cont
Other Criteria	Bile acid synthesis d/o due to SEDs initial - Diagnosis based on an abnormal urinary bile acid as confirmed by Fast Atom Bombardment ionization - Mass Spectrometry (FAB-MS) analysis. Cont - responded to initial Cholbam tx with an improvement in LFTs AND does not have complete biliary obstruction. Bile-Acid Synthesis Disorders Due to Peroxisomal Disorders (PDs), Including Zellweger Spectrum Disorders initial - PD with an abnormal urinary bile acid analysis by FAB-MS AND has liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption (e.g., rickets). Cont - responded to initial Cholbam therapy as per the prescribing physician (e.g., improvements in liver enzymes, improvement in steatorrhea) AND does not have complete biliary obstruction.

CIALIS

Products Affected

- CIALIS ORAL TABLET 2.5 MG, 5 MG
- tadalafil oral tablet 2.5 mg, 5 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Indication for which tadalafil is being prescribed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 mos.
Other Criteria	Benign prostatic hyperplasia (BPH), after confirmation that tadalafil is being prescribed as once daily dosing, to treat the signs and symptoms of BPH and not for the treatment of erectile dysfunction (ED).

CIMZIA

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D plus patients already started on certolizumab pegol for Covered use.
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried
Age Restrictions	Adults for CD.
Prescriber Restrictions	RA/AS, prescribed by or in consultation with a rheumatologist. Crohn's disease, prescribed by or in consultation with a gastroenterologist.PsA prescribed by or in consultation with a rheumatologist or dermatologist
Coverage Duration	3 months initial, 3 years cont.
Other Criteria	AS, approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx. PsA, approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx, Stelara, Otezla, Orencia or Xeljanz/XR. RA, approve if the patient has tried two of the following: Enbrel, Humira, Orencia, or Xeljanz/XR. CD, approve if patient has previously tried Humira. Plaque Psoriasis-approve if the patient has tried TWO of the following: Enbrel, Humira, Stelara SC, Otezla, or Cosentyx. Cont tx - approve if the patient has had a response to therapy, as according to the prescribing physician

COMETRIQ

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus Non-Small Cell Lung Cancer with RET Gene Rearrangements, Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma and patients already started on Cometriq for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MTC - approve. Non-Small Cell Lung Cancer with RET Gene Rearrangements - approve. Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma-approve if the patient's carcinoma is refractory to radioactive iodine therapy.

COPAXONE

Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML
- glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml
- glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple scelorosis sclerosis
Required Medical Information	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

COPIKTRA

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Copiktra for a covered use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	CLL/Follicular Lymphoma/SLL-approve if the patient has tried two prior therapies

CORLANOR

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Previous use of a Beta-blocker, LVEF, sinus rhythm, and resting HR
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	HF in pts not currently receiving Corlanor - must all of the following 1. have LVEF of less than or equal 35 percent, 2. have sinus rhythm and a resting HR of greater than or equal to 70 BPM, AND 3. tried or is currently receiving a Beta-blocker for HF (e.g., metoprolol succinate sustained-release, carvedilol, bisoprolol, carvedilol ER) unless the patient has a contraindication to the use of beta blocker therapy (e.g., bronchospastic disease such as COPD and asthma, severe hypotension or bradycardia). HF in pts currently receiving Corlanor - had a LVEF of less than or equal to 35 percent prior to initiation of Corlanor therapy AND has tried or is currently receiving a Beta-blocker for HF unless the patient has a contraindication to the use of beta blocker therapy.

COSENTYX

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already taking Cosentyx for a Covered Use.
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis and previous medications use
Age Restrictions	PP/AS/PSA initial - 18 years of age and older
Prescriber Restrictions	PP initial - prescribed by or in consultation with a dermatologist or rheumatologist. AS initial- by or in consultation with rheumatologist, PsA initial- by or in consultation with rheumatologist or dermatologist.
Coverage Duration	PP/AS/PsA -initial tx 3 mos, cont tx 3 years
Other Criteria	PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to "step back" and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PP/AS/PsA cont - patient must have responded, as determined by the prescriber.

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Melanoma initial - must have BRAF V600 mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Melanoma (unresectable, advanced or metastatic) - being prescribed in combination with Zelboraf.

CRINONE GEL

Products Affected

- CRINONE VAGINAL GEL 8 %

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, secondary amenorrhea, support of an established pregnancy.
Exclusion Criteria	Use in patients to supplement or replace progesterone in the management of infertility.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Secondary amenorrhea, 12 months.Support of an established pregnancy, 9 months.
Other Criteria	N/A

DALIRESP

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD),medications tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	COPD, approve in patients who meet all of the following conditions: Patients has severe COPD or very severe COPD, AND Patient has a history of exacerbations, AND Patient has tried a medication from two of the three following drug categories: long-acting beta2-agonist (LABA) [eg, salmeterol, indacaterol], long-acting muscarinic antagonist (LAMA) [eg, tiotropium], inhaled corticosteroid (eg, fluticasone).

DARAPRIM

Products Affected

- DARAPRIM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus chronic maintenance and prophylaxis of Toxoplasma Gondii encephalitis.
Exclusion Criteria	N/A
Required Medical Information	Patient's immune status
Age Restrictions	N/A
Prescriber Restrictions	Toxoplasma gondii Encephalitis, Chronic Maintenance and Prophylaxis (Primary)-prescribed by or in consultation with an infectious diseases specialist. Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.
Coverage Duration	12 months
Other Criteria	Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis (Primary), approve if the patient is immunosuppressed.

DESOXYN

Products Affected

- methamphetamine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Weight loss.
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

DIABETIC SUPPLIES

Products Affected

- alcohol pads
- GAUZE PADS 2 X 2
- INSULIN PEN NEEDLE 29 GAUGE X 1/2"
- INSULIN SYRINGE (DISP) U-100 0.3 ML, 1 ML, 1/2 ML
- NEEDLES, INSULIN DISP.,SAFETY

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation that medical supply is directly associated with delivering insulin to the body
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 mos.
Other Criteria	N/A

DOPTELET

Products Affected

- DOPTELET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, platelet count, date of procedure
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	5 days
Other Criteria	Approve if the patient has a current platelet count less than 50 x 109/L AND the patient is scheduled to undergo a procedure within 10 to 13 days after starting Doptelet therapy.

DUPIXENT

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prescriber specialty, other medications tried and length of trials
Age Restrictions	Under CMS Review
Prescriber Restrictions	Prescribed by or in consultation with a an allergist, immunologist or dermatologist
Coverage Duration	Initial-16 weeks, Continuation-1 year
Other Criteria	Under CMS Review

ENBREL

Products Affected

- ENBREL
- ENBREL SURECLICK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D plus patient already on etanercept for a Covered Use. Graft versus host disease (GVHD). Behcet's disease. Uveitis
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	RA/Ankylosing spondylitis/JIA/JRA,prescribed by or in consult w/ rheumatologist. Psoriatic arthritis, prescribed by or in consultation w/ rheumatologist or dermatologist.Plaque psoriasis (PP), prescribed by or in consult w/ dermatologist.GVHD,prescribed by or in consult w/ oncologist,hematologist,or physician affiliated w/ transplant center. Behcet's disease,prescribed by or in consult w/ rheumatologist,dermatologist,ophthalmologist,gastroenterologist,or neurologist.
Coverage Duration	FDA approved indications - 3 months initial, 3 years cont, others 12 months.
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA, approve if the pt has aggressive disease, as determined by the prescriber, or the pt has tried one other agent for this condition (eg, MTX, sulfasalazine, leflunomide, NSAID, biologic DMARD or the pt will be started on Enbrel concurrently with MTX, sulfasalazine, or leflunomide or the pt has an absolute contraindication to MTX (eg, pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias), sulfasalazine, or leflunomide.Plaque psoriasis (PP) initial approve if the patient meets one of the following conditions: 1) patient has tried at least one traditional systemic agent for at least 3 months for plaque psoriasis, unless intolerant (eg, MTX, cyclosporine, Soriatane,

PA Criteria	Criteria Details
	oral methoxsalen plus PUVA, (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) the patient has a contraindication to one oral agent for psoriasis such as MTX. GVHD. Tried or currently is receiving with etanercept 1 conventional GVHD tx (high-dose systemic corticosteroid, CSA, tacrolimus, MM, thalidomide, antithymocyte globulin, etc.). Behcet's. Has tried at least 1 conventional tx (eg, systemic corticosteroid, immunosuppressant, interferon alfa, MM, etc) or adalimumab or infliximab. Uveitis-tried one of the following: periocular, intraocular, or systemic coricosteroid, immunosuppressives, Humira or an infliximab product.RA/AS/JIA/PP/PsA Cont - must have a response to tx according to the prescriber. Clinical criteria incorporated into the Enbrel 25 mg quantity limit edit, approve additional quantity (to allow for 50 mg twice weekly dosing) if one of the following is met: 1) Patient has plaque psoriasis, OR 2) Patient has RA/JIA/PsA/AS and is started and stabilized on 50 mg twice weekly dosing, OR 3) Patient has RA and the dose is being increased to 50 mg twice weekly and patient has taken MTX in combination with Enbrel 50 mg once weekly for at least 2 months, unless MTX is contraindicated or intolerant, OR 4) Patient has JIA/PsA/AS and the dose is being increased to 50 mg twice weekly after taking 50 mg once weekly for at least 2 months.

EPCLUSA

Products Affected

- EPCLUSA
- sofosbuvir-velpatasvir

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients started on Epclusa for a Covered Use.
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

EPIDIOLEX

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Epidiolex for a covered use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies
Age Restrictions	Patients 2 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	N/A

EPOETIN/PROCRIT

Products Affected

- EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML
- PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus anemia in patients with HIV who are receiving zidovudine. Anemic patients (Hb of 13.0 g/dL or less) at high risk for perioperative transfusions (secondary to significant, anticipated blood loss and are scheduled to undergo elective, noncardiac, nonvascular surgery to reduce the need for allogeneic blood transfusions).Plus anemia due to myelodysplastic syndrome (MDS).
Exclusion Criteria	N/A
Required Medical Information	CRF anemia in patients on and not on dialysis.Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start.Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if previously on epoetin alfa or Aranesp or less than or equal to 11.5 g/dL if currently receiving Mircera.Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start.Hb less than or equal to 12.0 g/dL if previously on epoetin alfa or Aranesp.MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start.Previously receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. Anemia in HIV with zidovudine, Hb is 10.0 g/dL or less or endogenous erythropoetin levels are 500 mU/mL or less at tx start.Previously on EA approve if Hb is 12.0 g/dL or less. Surgical pts to reduce RBC transfusions - pt is unwilling or unable to donate autologous blood prior to surgery
Age Restrictions	MDS anemia/HepC anemia = 18 years of age and older
Prescriber Restrictions	MDS anemia, prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	Anemia w/myelosuppressive = 4 mos.Transfus=1 mo.Other=6mo. HIV + zidovudine = 4 mo

PA Criteria	Criteria Details
Other Criteria	For all covered uses, if the request is for Epogen, then the patient is required to try Procrit first line.

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patient already started on Erivedge for a covered use.
Exclusion Criteria	BCC (La or Met) - must not have had disease progression while on Odomzo.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	Locally advanced basal cell carcinoma (LABCC), approve if 1. the patient's BCC has recurred following surgery or radiation, OR 2. the patient is not a candidate for surgery and radiation therapy.

ERLEADA

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	N/A

ESBRIET

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with nintedanib
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	Authorization will be for 3 years.
Other Criteria	IPF baseline - must have FVC greater than or equal to 50 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.

FARYDAK

Products Affected

- FARYDAK ORAL CAPSULE 10 MG, 15 MG, 20 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 month.
Other Criteria	N/A

FIRAZYR

Products Affected

- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

FORTEO

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Fortical], abaloparatide), except calcium and Vitamin D.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 2 years of therapy over a patient's lifetime
Other Criteria	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had an osteoporotic fracture or fragility fracture. Increase bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogondal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast),

PA Criteria	Criteria Details
	OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.

GABAPENTIN/LYRICA

Products Affected

- gabapentin oral capsule
- gabapentin oral solution 250 mg/5 ml
- gabapentin oral tablet 600 mg, 800 mg
- LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG
- LYRICA ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. Plus, patients already started on Lyrica for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A

GALAFOLD

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, nephrologist, or a physician who specializes in the treatment of Fabry disease
Coverage Duration	3 years
Other Criteria	Approve if the patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data.

GATTEX

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

GILENYA

Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Gilenya with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	For use in MS, patient has a relapsing form of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For NSCLC - EGFR exon deletions or mutations, or if NSCLC is squamous cell type
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	NSCLC EGFR pos - For the treatment of metastatic non small cell lung cancer (NSCLC) must be used in tumors with non-resistant EGFR mutation positive NSCLC as detected by an approved test. NSCLC metastatic squamous cell must have disease progression with first line treatment with platinum based chemotherapy.

GLUCAGON-LIKE PEPTIDE-1 AGONISTS

Products Affected

- BYDUREON
- BYDUREON BCISE
- BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML, 5 MCG/DOSE (250 MCG/ML) 1.2 ML
- TRULICITY

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

GONADOTROPIN-RELEASING HORMONE AGONISTS - INJECTABLE LONG ACTING

Products Affected

- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For abnormal uterine bleeding/endomet/uterine leiomyomata approve 6 months/all other dx 12 mo
Other Criteria	N/A

GROWTH HORMONES

Products Affected

- HUMATROPE
- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	GHD in children/adolescents initial must meet ONE of the following - 1. had hypophysectomy, 2. has congenital hypopituitarism AND had growth hormone response to one preferred GH test of less than 10 ng/mL (preferred tests are levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon), 3. has panhypopituitarism AND had growth hormone response to one preferred GH test of less than 10 ng/mL, has 3 or more pituitary hormone deficiencies (ACTH, TSH, LH/FSH, or prolactin), or pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, or ectopic posterior "bright spot" on MRI or CT, 4. pt had brain radiation, had growth hormone response to one preferred GH test of less than 10 ng/mL, AND meets one of these a. pretreatment growth rate (GR) is less than 7 cm/yr in children younger than 3 or b. GR is less than 4 cm/yr in 3 y/o or older, c. or if 18 y/o or younger with growth velocity that is less than 10th percentile for age/gender on last 6 months of data, OR 5. had growth hormone response to one preferred GH test of less than 10 ng/mL, ht less than the 10th percentile for age/gender, AND meets one of these a. pretreatment growth rate (GR) is less than 7 cm/yr in children younger than 3 or b. GR is less than 4 cm/yr in 3 y/o or older, c. or if 18 y/o or younger with growth velocity that is less than 10th percentile for age/gender on last 6 months of data. Continuation of tx-approve if the patient has experienced improvement, according to the prescribing physician.
Age Restrictions	ISS-5y/o or older,SGA 2y/o or older,SBS/HIVwasting/cachexia 18y/o or older
Prescriber Restrictions	GHD (Initial tx children or adolescents w/o hypophysectomy), GHD adults or transitional adolescents, Noonan (initial), Prader Willi (initial for child/adult and cont tx in adults), SHOX (initial), SGA (initial) - prescribed by or in consultation with an endocrinologist. CKD (initial) endocrinologist or nephrologist.

PA Criteria	Criteria Details
Coverage Duration	ISS - 6 mos intial, 12 months cont tx, SBS 4 weeks, others 12 mos
Other Criteria	GHD initial in adults and adolescents 1. endocrine must certify not being prescribed for anti-aging or to enhance athletic performance, 2. has either childhood onset or adult onset resulting from GHD alone, multiple hormone deficiency from pituitary dx, hypothalmic dz, pituitary surgery, cranial radiation tx, tumor treatment, TBI or subarachnoid hemorrhage, AND 3. meets one of the following - A. childhood onset has known mutations, embryonic lesions, congenital defects or irreversible structural hypothalmic pituitary lesion/damage, B. 3 or more pituitary hormone def (ACTH, TSH, LH/FSH, or prolactin, IGF1 less than 84 mcg/L (Esoterix RIA), AND other causes of low serum IGF-1 have been excluded, C. Neg response to ONE preferred GH stim test (insulin peak response less than or equal to 5 mcg/L, Glucagon peak less than or equal to 3 mcg/L, if insulin and glucagon contraindicated then Arginine alone test with peak of less than or equal to 0.4 mcg/L, GHRH plus arginine peak of less than or equal to 11 mcg/L if BMI is less than 25, peak less than 8 mcg/L if BMI is more than 25 but less than 30, or peak less than 4 mcg/L if BMI if more than 30) AND if a transitional adolescent must be off tx for at least one month before retesting. Cont tx - endocrine must certify not being prescribed for anti-aging or to enhance athletic performance. ISS initial - baseline ht less than the 1.2 percentile or a standard deviation score (SDS) less than -2.25 for age and gender, open epiphyses, does not have CDGP and height velocity is either growth rate (GR) is a. less than 4 cm/yr for pts older than 5 or b. growth velocity is less than 10th percentile for age/gender. Cont tx - prescriber confirms response to therapy. CKD initial - CKD defined by abnormal CrCl. Noonan initial - baseline height less than 5th percentile. PW cont tx in adults or adolescents who don't meet child requir - physician certifies not being used for anti-aging or to enhance athletic performance. SHOX initial - SHOX def by chromo analysis, open epiphyses, height less than 3rd percentile for age/gender. SGA initial -baseline ht less than 5th percentile for age/gender and born SGA (birth weight/length that is more than 2 SD below mean for gestational age/gender and didn't have sufficient catch up growth by 2-4 y/o). Cont tx - prescriber confirms response to therapy.Cont Tx for CKD, Noonan, PW in child/adolescents, SHOX, and TS - prescriber confirms response to therapy. SBS initial pt receiving specialized nutritional support. Cont tx - 2nd course if pt responded to tx with a decrease in the requirement for specialized nutritional support.

HAEGARDA

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
Coverage Duration	Authorization will be for 3 Years.
Other Criteria	N/A

HARVONI

Products Affected

- HARVONI
- ledipasvir-sofosbuvir

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients with recurrent HCV post-liver transplant. Plus patients started on Harvoni for a covered use.
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Information	N/A
Age Restrictions	12 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

HETLIOZ

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation the patient is totally blind with no perception of light.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of sleep disorders
Coverage Duration	6 mos initial, 12 mos cont
Other Criteria	Initial - dx of Non-24 is confirmed by either assessment of one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset, assessment of core body temperature), or if assessment of physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed for at least 1 week plus evaluation of sleep logs recorded for at least 1 month.Approve if pt has received at least 6 months of continuous therapy (i.e., 6 consecutive months of daily treatment) with Hetlioz under the guidance of a physician who specializes in the treatment of sleep disorders AND has achieved adequate results with Hetlioz therapy according to the prescribing physician (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep).

HIGH RISK MEDICATION- ANTIEMETICS

Products Affected

- promethazine oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Previous medication use
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	End of the Contract Year
Other Criteria	PA does NOT apply to patients less than 65 yrs of age.These medications will be approved if ALL of the following are met: a. Patient has an FDA-approved diagnosis or CMS-approved compendia accepted indication for the requested high risk medication.For the treatment of emesis, approve if the patient has had a trial of of one of the following non high risk medication alternative (brand or generic): prochlorperazine, ondansetron or granisetron b.Prescriber has completed a risk assessment of the high risk medication for the patient and has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND c.Prescriber has documented that s/he discussed risks and potential side effects of the medication with the patient.

HIGH RISK MEDICATION- ESTROGENS

Products Affected

- estradiol oral
- estradiol transdermal patch semiweekly
- estradiol transdermal patch weekly
- estradiol-norethindrone acet
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- PREMARIN ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Previous medication use
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	End of the Contract Year
Other Criteria	PA does NOT apply to patients less than 65 yrs of age.These medications will be approved if ALL of the following are met: a. Patient has an FDA-approved diagnosis or CMS-approved compendia accepted indication for the requested high risk medication.For the treatment of Vulvar Vaginal Atrophy, approve if the patient has had a trial of one of the following : Estradiol Vaginal Cream, or Estring. For the prophylaxis of Postmenopausal Osteoporosis, approve if the patient has had a trial of one of the following (brand or generic): alendronate, ibandronate, risidronate, Raloxifene, or Prolia. For the treatment of vasomotor symptoms of menopause, approve if the patient has had a trial of one of the following : Citalopram, Fluoxetine, Paroxetine, Venlafaxine or Gabapentin b.Prescriber has completed a risk assessment of the high risk medication for the patient and has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND c.Prescriber has documented that s/he discussed risks and potential side effects of the medication with the patient.

HIGH RISK MEDICATION PRIOR AUTHORIZATION

Products Affected

- benztropine oral
- dicyclomine oral capsule
- dicyclomine oral solution
- dicyclomine oral tablet
- digitek oral tablet 250 mcg
- digox oral tablet 250 mcg
- digoxin oral solution 50 mcg/ml
- digoxin oral tablet 250 mcg
- ergoloid
- meclizine oral tablet 12.5 mg, 25 mg
- megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml
- megestrol oral tablet
- phenobarbital
- scopolamine base
- thioridazine

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	End of the Contract Year
Other Criteria	PA does NOT apply to patients less than 65 yrs of age. High Risk Medications will be approved if ALL of the following is met: a.Patient has an FDA-approved diagnosis or CMS-approved compendia accepted indication for the requested high risk medication AND b.Prescriber has completed a risk assessment of the high risk medication for the patient and has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND c.Prescriber has documented that s/he discussed risks and potential side effects of the medication with the patient.

HIGH RISK MEDICATION- SEDATIVE HYPNOTICS

Products Affected

- zaleplon oral capsule 10 mg, 5 mg
- zolpidem oral tablet

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Previous medication use
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	End of the Contract Year
Other Criteria	PA does NOT apply to patients less than 65 yrs of age.These medications will be approved if ALL of the following are met: a. Patient has an FDA-approved diagnosis or CMS-approved compendia accepted indication for the requested high risk medication.For the treatment of Insomnia, approve if the patient has had a trial of one of the following (brand or generic): Rozerem or Trazodone b.Prescriber has completed a risk assessment of the high risk medication for the patient and has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND c.Prescriber has documented that s/he discussed risks and potential side effects of the medication with the patient.

HIGH RISK MEDICATION- URINARY ANTI INFECTIVES

Products Affected

- nitrofurantoin
- nitrofurantoin macrocrystal
- nitrofurantoin monohyd/m-cryst

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Previous medication use
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	End of the Contract Year
Other Criteria	PA does NOT apply to patients less than 65 yrs of age.These medications will be approved if ALL of the following are met: a. Patient has an FDA-approved diagnosis or CMS-approved compendia accepted indication for the requested high risk medication.For the treatment of urinary track infections and acute cystitis the patient must have tried and failed one formulary non high risk medication alternative (brand or generic): ciprofloxacin, levofloxacin, ampicillin, amoxiciliin/clavulanate, amoxicillin, cephalexin or SMZ/TMP b.Prescriber has completed a risk assessment of the high risk medication for the patient and has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND c.Prescriber has documented that s/he discussed risks and potential side effects of the medication with the patient.

HIGH RISK MEDICATION-ANTIPLATELETS

Products Affected

- dipyridamole oral

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Previous medication use
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	End of the Contract Year
Other Criteria	PA does NOT apply to patients less than 65 yrs of age.These medications will be approved if ALL of the following are met: a. Patient has an FDA-approved diagnosis or CMS-approved compendia accepted indication for the requested high risk medication.For the treatment of thromboembolic complications, approve if the patient has had a trial of one of the following (brand or generic) : clopidogrel, Brilinta or Effient b.Prescriber has completed a risk assessment of the high risk medication for the patient and has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND c.Prescriber has documented that s/he discussed risks and potential side effects of the medication with the patient.

HIGH RISK MEDICATIONS - BENZODIAZEPINES

Products Affected

- alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg
- clobazam
- clonazepam
- clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg
- diazepam intensol
- diazepam oral solution 5 mg/5 ml (1 mg/ml)
- diazepam oral tablet
- lorazepam oral concentrate
- lorazepam oral tablet 0.5 mg, 1 mg, 2 mg
- ONFI ORAL SUSPENSION
- ONFI ORAL TABLET 10 MG, 20 MG
- oxazepam
- temazepam

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Procedure-related sedation = 1mo. All other conditions = End of the Contract Year
Other Criteria	PA does NOT apply to patients less than 65 yrs of age.These medications will be approved if ALL of the following are met: a. Patient has an FDA-approved diagnosis or CMS-approved compendia accepted indication for the requested high risk medication. For Insomnia, approve lorazepam, oxazepam, or temazepam if the patient has had a trial with two of the following: ramelteon, trazodone, or zaleplon AND b.Prescriber has completed a risk assessment of the high risk medication for the patient and has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND c.Prescriber has documented that s/he discussed risks and potential side effects of the medication with the patient AND d. if patient is taking conconmitantly a benzodiazepine with an opioid, the prescriber indicated that the benefits of the requested combination therapy outweigh the risks for the patient.

HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES

Products Affected

- hydroxyzine hcl oral tablet

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	End of the Contract Year
Other Criteria	PA does NOT apply to patients less than 65 yrs of age. Hydroxyzine hydrochloride will be approved if ALL of the following are met: a. Patient has an FDA-approved diagnosis. For the management of anxiety, approve hydroxyzine hydrochloride if the patient has tried at least two of the following formulary medications: buspirone, escitalopram, paroxetine, sertraline, venlafaxine, alprazolam, clonazepam, clorazepate, diazepam, lorazepam, oxazepam AND b.Prescriber has completed a risk assessment of the high risk medication for the patient and has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND c.Prescriber has documented that s/he discussed risks and potential side effects of the medication with the patient.

HIGH RISK MEDICATIONS - SKELETAL MUSCLE RELAXANTS

Products Affected

- cyclobenzaprine oral tablet

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other
Prescriber Restrictions	N/A
Coverage Duration	End of the Contract Year
Other Criteria	PA does NOT apply to patients less than 65 yrs of age. High Risk Medications will be approved if ALL of the following are met: a. Patient has an FDA-approved diagnosis or CMS-approved compendia accepted indication for the requested high risk medication. Musculoskeletal conditions/disorders, approve if the patient has had a trial with Chlorzoxazone, AND b.Prescriber has completed a risk assessment of the high risk medication for the patient and has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND c.Prescriber has documented that s/he discussed risks and potential side effects of the medication with the patient AND d. if patient is taking conconmitantly a muscle relaxant with an opioid, the prescriber indicated that the benefits of the requested combination therapy outweigh the risks for the patient.

HIGH RISK MEDICATIONS - TERTIARY TRICYCLIC ANTIDEPRESSANTS

Products Affected

- amitriptyline
- clomipramine
- desipramine
- doxepin oral
- imipramine hcl
- nortriptyline
- trimipramine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	End of the Contract Year
Other Criteria	PA does NOT apply to patients less than 65 yrs of age. High Risk Medications will be approved if ALL of the following are met: a. Patient has an FDA-approved diagnosis or CMS-approved compendia accepted indication for the requested high risk medication. For the treatment of depression, approve if the patient has tried at least two of the following agents (brand or generic): citalopram, escitalopram, fluoxetine, paroxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, bupropion, mirtazapine, nortriptyline, desipramine, or trazodone. For the treatment of pain, may approve amitriptyline (single-entity only, not amitriptyline combination products) or imipramine (brand or generic) if the patient has tried at least two of the following agents: duloxetine, pregabalin, gabapentin, venlafaxine, venlafaxine Er, desipramine, or notriptyline. For the treatment of obsessive compulsive disorder (OCD), may approve clomipramine (brand or generic) if the patient has tried at least two of the following medications: fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram, or venlafaxine AND b.Prescriber has completed a risk

PA Criteria	Criteria Details
	assessment of the high risk medication for the patient AND c.Prescriber has indicated that the benefits of the requested high risk medication outweigh the risks for the patient AND d.Prescriber has documented that s/he discussed risks and potential side effects of the medication with the patient.

HUMIRA

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 40 MG/0.8 ML (6 PACK)
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML
- HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML
- HUMIRA(CF) PEN
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on adalimumab for a Covered Use. Hidradenitis Suppurativa.
Exclusion Criteria	Concurrent use with another biologic DMARD or targeted synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried
Age Restrictions	Crohn's disease (CD), 6 or older. Ulcerative colitis (UC), adults.
Prescriber Restrictions	RA/JIA/JRA/Ankylosing spondylitis, prescribed by or in consultation with rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. UC/ CD, prescribed by or in consultation with a gastroenterologist. HS - dermatologist.UV-ophthalmologist
Coverage Duration	Initial 3 mo, cont tx 3 years.
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to "step back" and try a conventional synthetic DMARD). JIA/JRA initial. Tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD (eg, etanercept,

PA Criteria	Criteria Details
	abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to "step back" and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial. Tried corticosteroids (CSs) or if CSs are contraindicated or if pt currently on CSs or patient has tried one other agent for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR pt had ilecolonic resection OR enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC initial. Pt has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab, golimumab SC, or a corticosteroid such as prednisone or methylprednisolone) for 2 months or was intolerant to one of these agents, or the pt has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. FDA approve indications cont tx - must respond to tx as determined by prescriber. HS - tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). Clinical criteria incorporated into the Humira 40 mg quantity limit edit allow for approval of additional quantities to accommodate induction dosing. The allowable quantity is dependent upon the induction dosing regimen for the applicable FDA-labeled indications as outlined in product labeling.

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus liposarcoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast cancer - approve advanced (metastatic) hormone receptor positive (HR+) [i.e., estrogen receptor positive- (ER+) and/or progesterone receptor positive (PR+)] disease, and HER2-negative breast cancer for patients who have not had disease progression while on Ibrance, Kisqali or Verzenio when the pt meets ONE of the following 1. Pt is postmenopausal and Ibrance will be used as first line therapy in combination with anastrozole, exemestane, or letrozole 2, pt is premonopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonists, or has had surgical bilateral oophorectomy, or ovarian irradiation AND it will be used as first line endocrine therapy in combination with anastrozole, exemestane, or letrozole, 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving GnRH agonist AND Ibrance with be used as first line endocrine therapy in combination with anastrozole, exemestane, tamoxifen or letrozole, 4. Pt is postmenopausal and has relapsed or progressed during endocrine therapy with at least one of the following: anastrozole, exemestane, letrozole, tamoxifen Fareston, exemestane plus Afinitor, Faslodex, Afinitor plus Faslodex or tamoxifen, megestrol acetate, fluoxymesterone or ethinyl estradiol AND will be used in combination with Faslodex, 5. Pt is premenopausal or perimenopausal

PA Criteria	Criteria Details
	and is receiving ovarian suppression/ablation with GnRH agonist, or has had surgical bilateral oophorectomy, or ovarian irradiation, relapsed or progressed on prior endocrine therapy with at least one of the following: anastrozole, exemestane, letrozole, tamoxifen, Fareston, exemestane plus Afinitor, Faslodex, Afinitor plus Faslodex or tamoxifen, megestrol acetate, fluoxymesterone, or ethinyl estradiol AND will be used in combination with Faslodex.

ICLUSIG

Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Iclusig for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
Age Restrictions	CML/ALL - Adults
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	CML Ph+, T315I-positive or has tried TWO other TKIs indicated for use in Philadelphia chromosome positive CML (e.g., Gleevec, Sprycel, Tasigna). ALL Ph+, T315I-posistive or has tried TWO other TKIs indicated for use in Ph+ ALL (e.g. Gleevec, Sprycel.)

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already started on Idhifa for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	IDH2-mutation status
Age Restrictions	Adults
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	AML - approve if relapsed or refractory-AND the patient is IDH2-mutation status positive as detected by an approved test

IMATINIB

Products Affected

- imatinib oral tablet 100 mg, 400 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus chordoma, advanced or unresectable fibromatosis (desmoid tumors), cKit positive advanced/recurrent or metastatic melanoma, and pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor. Plus patients already started on imatinib for a covered use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For ALL/CML, new patient must have Ph-positive CML for approval of Imatinib.

IMBRUVICA

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus relapsed or refractory Central Nervous System Lymphoma (Primary). Plus relapsed or refractory Hairy Cell Leukemia. Plus Diffuse Large B-Cell Lymphoma (e.g., follicular lymphoma, gastric MALT lymphoma, nongastric MALT lymphoma, primary DLBCL of the central nervous system). Plus patients already taking Imbruvica for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	GVHD-1 year, all others-3 years
Other Criteria	Marginal Zone Lymphoma - Approve if the patient has tried Rituxan (rituximab for intravenous infusion) or according to the prescribing physician, Rituxan is contraindicated for use in this patient. GVHD-Approve if the patient has tried one conventional systemic treatment for graft versus host disease (e.g., corticosteroids [methylprednisolone, prednisone], cyclosporine, tacrolimus, mycophenolate mofetil, imatinib). Diffuse large B-cell lymphoma-approve if the patient is using Imbruvica as second-line or subsequent therapy according to the prescribing physician.

INLYTA

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma. Plus, patients already started on Inlyta for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years
Other Criteria	Advanced renal cell carcinoma, approve.Differentiated thyroid cancer, approve if patient is refractory to radioactive iodine therapy.

IRESSA

Products Affected

- IRESSA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic NSCLC - The patient has epidermal growth factor receptor (EGFR) exon 19 deletions OR has exon 21 (L858R) substitution mutations as detected by an FDA-approved test.

IVIG

Products Affected

- BIVIGAM
- CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- GAMMAGARD LIQUID
- GAMMAGARD S-D (IGA < 1 MCG/ML)
- GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- GAMMAPLEX
- GAMMAPLEX (WITH SORBITOL)
- GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- OCTAGAM
- PANZYGA
- PRIVIGEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Part B versus D determination per CMS guidance to establish if drug used for PID in pt's home.

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already started on Jakafi for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For polycythemia vera patients must have tried hydroxyurea.

JUXTAPID

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Combination use with Kynamro, Praluent, or Repatha.
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, an endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	12 months
Other Criteria	Patient must meet ALL of the following criteria: 1) Patient has had genetic confirmation of two mutant alleles at the LDL receptor, apolipoprotein B APOB, PCSK9, or LDLRAP1 gene locus OR the patient has an untreated LDL-C level greater than 500 mg/dL (prior to treatment with antihyperlipidemic agents) OR the patient has a treated LDL-C level greater than or equal to 300 mg/dL (after treatment with antihyperlipidemic agents but prior to agents such as Repatha or Kynamro) OR the patient has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) Patient has tried Repatha and had an inadequate response according to the prescribing physician OR the patient is known to have two LDL-receptor negative alleles, AND 3) Patient has tried one high-intensity statin therapy (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than 20 mg daily [as a single-entity or as a combination product]) for greater than or equal to 8 continuous weeks and the LDL-C level remains greater than or equal to 70 mg/dL OR the patient has been determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or patient experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation.

JYNARQUE

Products Affected

- JYNARQUE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient is currently receiving Samsca (tolvaptan tablets) . Patients with Stage 5 CKD
Required Medical Information	Diagnosis, renal function
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist
Coverage Duration	1 year (initial and continuation)
Other Criteria	Approve if the patient has rapidly-progressing autosomal dominant polycystic kidney disease (ADPKD) (e.g., reduced or declining renal function, high or increasing total kidney volume [height adjusted]),according to the prescriber.

KALYDECO

Products Affected

- KALYDECO ORAL GRANULES IN PACKET
- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with Orkambi or Symdeko
Required Medical Information	N/A
Age Restrictions	two years of age and older
Prescriber Restrictions	Prescribed by or inconsultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - must have one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, S945L, S977F, F1052V, K1060T, A1067T, G1069R, R1070Q, R1070W, F1074L, D1152H, D1270N, G551D, G178R, S549N, S549R, G551S, G1244E, S1251N, S1255P, G1349D, 2789+5G A, 3272-26A G, 3849+10kbC T, 711+3A G, E831X OR R117H AND must NOT be Homozygous for the F508del Mutation in the CFTR Gene or have unknown CFTR gene mutations.

KISQALI

Products Affected

- KISQALI
- KISQALI FEMARA CO-PACK

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast cancer - approve advanced or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)]disease, and HER2-negative breast cancer in patients who have not had disease progression while on Kisqali, Ibrance or Verzenio when the pt meets ONE of the following 1. Pt is postmenopausal and Kisqali will be used as first line endocrine therapy in combination with anastrozole, exemestane, or letrozole 2. pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonist, or has had surgical bilateral oophorectomy, or ovarian irradiation AND Kisqali will be used as first line endocrine therapy in combination with anastrozole, exemestane, or letrozole 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving GnRH agonist AND Kisqali with be used as first line endocrine therapy in combination with anastrozole, exemestane, tamoxifen or letrozole. If the request is for Kisqali Femara, patients do not need to use in combination with anastrozole, exemestane, letrozole or tamoxifen.

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients with Endogenous Cushing's Syndrome, awaiting surgery
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior surgeries
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome
Coverage Duration	Authorization will be for 3 years
Other Criteria	Approve if, according to the prescribing physician, the patient is not a candidate for surgery or surgery has not been curative AND if Korlym is being used to control hyperglycemia secondary to hypercortisolism in patients who have type 2 diabetes mellitus or glucose intolerance.

KYNAMRO

Products Affected

- KYNAMRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Combination use with Juxtapid, Praluent, or Repatha.
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, an endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	12 months
Other Criteria	Patient must meet ALL of the following criteria: 1) Patient has had genetic confirmation of two mutant alleles at the LDL receptor, apolipoprotein B APOB, PCSK9, or LDLRAP1 gene locus OR the patient has an untreated LDL-C level greater than 500 mg/dL (prior to treatment with antihyperlipidemic agents) OR the patient has a treated LDL-C level greater than or equal to 300 mg/dL (after treatment with antihyperlipidemic agents but prior to agents such as Repatha or Juxtapid) OR the patient has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) Patient has tried Repatha and had an inadequate response according to the prescribing physician OR the patient is known to have two LDL-receptor negative alleles, AND 3) Patient has tried one high-intensity statin therapy (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than 20 mg daily [as a single-entity or as a combination product]) for greater than or equal to 8 continuous weeks and the LDL-C level remains greater than or equal to 70 mg/dL OR the patient has been determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or patient experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation.

LENVIMA

Products Affected

- LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients with Medullary Thyroid Carcinoma (MTC).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 Years
Other Criteria	DTC - must be refractory to radioactive iodine treatment for approval. RCC - approve if the pt meets ONE of the following criteria: 1) pt has RCC with predominant clear-cell histology AND the pt has tried one antiangiogenic therapy (eg, Inlyta, Votrient, Sutent, Cabometyx) AND Lenvima will be used in combination with everolimus (Afinitor), OR 2) pt has RCC with non-clear cell histology AND Lenvima will be used in combination with everolimus (Afinitor). MTC-approve if the patient has tried Caprelsa or Cometriq.

LETAIRIS/TRACLEER

Products Affected

- LETAIRIS
- TRACLEER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Chronic thromboembolic pulmonary hypertension (CTEPH) (Tracleer).
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1 patients not currently on Letairis or Tracleer or another agent indicated for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1 patients currently on Letairis or Tracleer or another agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	For treatment of pulmonary arterial hypertension, Letairis or Tracleer must be prescribed by or in consultation with a cardiologist or a pulmonologist.CTEPH-prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	Authorization will be for 3 years.
Other Criteria	CTEPH - pt must have tried Adempas, has a contraindication to Adempas, or is currently receiving Tracleer for CTEPH. PAH-pt must have tried Opsumit or Letairis prior to approval of Tracleer.

LIDODERM

Products Affected

- lidocaine topical adhesive patch,medicated

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus diabetic neuropathic pain.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	N/A

LONG ACTING OPIOIDS

Products Affected

- fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr
- methadone oral solution 10 mg/5 ml, 5 mg/5 ml
- methadone oral tablet 10 mg, 5 mg
- morphine oral capsule, er multiphase 24 hr 120 mg, 30 mg, 45 mg, 60 mg, 75 mg, 90 mg
- morphine oral capsule,extend.release pellets
- morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg
- tramadol oral tablet extended release 24 hr
- tramadol oral tablet, er multiphase 24 hr
- XTAMPZA ER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Medicated Assisted Treatment (MAT) therapy
Required Medical Information	Nature and intensity of pain, past and current treatments of pain, underlying or co-occurring disorders and conditions.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pain specialist or oncologist
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Long acting opioids will be approved if ALL of the following is met: a. Patient has an FDA-approved diagnosis or CMS-approved compendia accepted indication AND b. Documentation that shows the patient's diagnosis, evaluation and medical assessment for the requested medication which clearly indicates ALL of the following: diagnosis, evaluation and medical assessment for the requested medication including the nature and intensity of pain, past and current treatments of pain (e.g., receiving opioids previously in treatment of acute pain), underlying or concomitant disorders and conditions, effect of the pain on physical and psychological functioning, review of history, physical examination and laboratory findings AND c. Attestation from the provider that a pain management agreement is signed by the patient and the provider in the past six months AND d. Attestation from the provider that he/she has completed a risk assessment for aberrant behavior associated with opioid misuse AND e.

PA Criteria	Criteria Details
	Attestation that Prescriber has checked the state controlled substance database in the past 90 days AND f. Attestation from the provider that a treatment plan that has been signed by the patient and the provider that includes goals and monitoring AND g. Attestation from the provider that the patient experienced previous treatment with short-acting opioids at the lowest dose possible as calculated using morphine milligram equivalent (MME).

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

LORBRENA

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Lorbrena for a covered use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, ALK status, previous therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	NSCLC - Approve if the patient has ALK-positive metastatic NSCLC and meets one of the following: a) patient has disease progression on Xalkori (crizotinib capsules) and at least one other ALK inhibitor (e.g., Zykadia [ceritinib capsules], Alecensa [alectinib capsules], Alunbrig [brigatinib tablets]), or b) patient has disease progression on Alecensa (alectinib capsules) as the first ALK inhibitor therapy, or c) patient has disease progression on Zykadia (ceritinib capsules) as the first ALK inhibitor therapy.

LYNPARZA

Products Affected

- LYNPARZA ORAL CAPSULE
- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Lynparza.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Ovarian cancer approve if the patient has a germline BRCA mutation confirmed by an approved test AND as per product labeling, has progressed on three or more prior lines of chemotherapy. Breast Cancer-Approve if the patient meets the following criteria (A, B, C, and D)-A. The patient has metastatic, germline BRCA mutation-positive breast cancer AND B. The patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND C. The patient meets ONE of the following criteria (i or ii)- i. The patient meets BOTH of the following criteria (a and b)-a) The patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive ER+ and/or progesterone receptor positive PR+] disease AND b) The patient meets ONE of the following criteria (1 or 2)-1-The patient has been treated with prior endocrine therapy OR-2 The patient is considered inappropriate for endocrine therapy OR ii. Patient has triple negative disease (i.e., ER-negative, PR-negative, and HER2-negative) AND D. The patient has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting.

LYRICA CR

Products Affected

- LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 330 MG, 82.5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A

MAVYRET

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients started on Mavyret for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

MEKINIST

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Mekinist for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Mekinist is being used. For melanoma, thyroid cancer and NSCLC must have documentation of BRAF V600 mutations
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma must be used in patients with BRAF V600 mutation, and patient has unresectable, advanced (including Stage III or Stage IV disease), or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery. For NSCLC requires BRAF V600E Mutation and use in combination with Tafinlar. Thyroid cancer, anaplastic-patient has locally advanced or metastatic anaplastic disease AND Mekinist will be taken in combination with Tafinlar, unless intolerant AND the patient has BRAF V600-positive disease.

MEKTOVI

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Mektovi for a covered use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, BRAF V600 status, concomitant medications
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation AND Mektovi will be used in combination with Braftovi.

MULPLETA

Products Affected

- MULPLETA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, platelet count, date of procedure
Age Restrictions	18 years and older
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	Approve if the patient has a current platelet count less than 50 x 109/L AND the patient is scheduled to undergo a procedure within 8 to 14 days after starting Mulpleta therapy.

NAMENDA

Products Affected

- memantine
- NAMZARIC

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients with mild to moderate vascular dementia who are receiving memantine.
Exclusion Criteria	N/A
Required Medical Information	Indication for which memantine is being prescribed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	3 years
Other Criteria	Chronic hypoparathyroidism, initial therapy - approve if before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician. Chronic hypoparathyroidism, continuing therapy - approve if during Natpara therapy, the patient's 25-hydroxyvitamin D stores are sufficient per the prescribing physician, AND the patient is responding to Natpara therapy, as determined by the prescriber.

NERLYNX

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Stage of cancer, HER2 status, previous or current medications tried
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve for 12 months
Other Criteria	Breast cancer - approve if the patient meets all of the following criteria: 1. Patient has early stage disease, AND 2. Patient has HER2-positive breast cancer, AND 3. Patient has completed one year of adjuvant therapy with trastuzumab OR could not tolerate one year of therapy.

NEULASTA

Products Affected

- NEULASTA SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients undergoing PBPC collection and therapy
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist. PBPC - prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation. Radiation syndrome-prescribed by or in consultation with physician with expertise in treating acute radiation syndrome.
Coverage Duration	Cancer pts receiving chemo-6 mo. PBPC/Radiation Syndrome-1 mo
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.

NEUPOGEN

Products Affected

- NEUPOGEN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D worded more broadly as cancer patients receiving myelosuppressive chemotherapy, patients with acute myeloid leukemia (AML) receiving chemotherapy, cancer patients receiving bone marrow transplantation (BMT), patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, and patients with severe chronic neutropenia [SCN] (e.g., congenital neutropenia, cyclic neutropenia, idiopathic neutropenia). Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	AML, HIV/AIDS, MDS - adults. Other uses - no age requirements.
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chemo/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT-3 mo.All other=12mo.
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years,

PA Criteria	Criteria Details
	prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver or renal dysfunction, poor performance status, HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, Neulasta, Neupogen Granix, or Zarxio) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).

NEXAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus , patients already started on Nexavar for a covered use, osteosarcoma, angiosarcoma, advanced or unresectable desmoids tumors, gastrointestinal stromal tumors (GIST), medullary thyroid carcinoma, Acute Myeloid Leukemia, Chordoma with recurrent disease, solitary fibrous tumor and hemangiopericytoma
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Osteosarcoma, approve if the patient has tried standard chemotherapy and have relapsed/refractory or metastatic disease. GIST, approve if the patient has tried TWO of the following: imatinib mesylate (Gleevec), sunitinib (Sutent), or regorafenib (Stivarga). Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma (DTC), approve if the patient is refractory to radioactive iodine treatment. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). AML - Approve

NINLARO

Products Affected

- NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus , patients already started on Ninlaro.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MM - be used in combination with Revlimid and dexamethasone AND pt had received at least ONE previous therapy for multiple myeloma (e.g., Thalomid, Revlimid, Pomalyst, Alkeran, dexamethasone, prednisone).

NIVESTYM

Products Affected

- NIVESTYM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D worded more broadly as cancer patients receiving myelosuppressive chemotherapy, patients with acute myeloid leukemia (AML) receiving chemotherapy, cancer patients receiving bone marrow transplantation (BMT), patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, and patients with severe chronic neutropenia [SCN] (e.g., congenital neutropenia, cyclic neutropenia, idiopathic neutropenia). Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	AML, HIV/AIDS, MDS - adults
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	Under CMS Review
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years,

PA Criteria	Criteria Details
	prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, or HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, Neulasta, Neupogen) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).

NORTHERA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Medication history
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a neurologist
Coverage Duration	12 months
Other Criteria	NOH, approve if the patient meets ALL of the following criteria: a) Patient has been diagnosed with symptomatic NOH due to primary autonomic failure (Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND b) Patient has tried midodrine

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with Xolair
Required Medical Information	N/A
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an allergist, immunologist, or pulmonologist
Coverage Duration	Authorization will be for 6 months initial, 12 months continuation.
Other Criteria	Asthma Initial - must have peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks (prior to treatment with an IL-5 antagonist monoclonal antibody) AND Patient has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid AND one of the following A. inhaled LABA, B. inhaled long-acting muscarinic antagonist, C. Leukotriene receptor antagonist, or D. Theophylline. Patient's asthma continues to be uncontrolled as defined by ONE of the following - patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, patient has a FEV1 less than 80 percent predicted, Patient has an FEV1/FVC less than 0.80, or Patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation - The patient has responded to Nucala therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND Patient continues to receive therapy with an inhaled corticosteroid.EGPA initial-patient has/had a blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6

PA Criteria	Criteria Details
	weeks or within 6 weeks prior to treatment with any anti-interleukin (IL)-5 therapy (e.g., Nucala, Cinqair, Fasenra). Continuation-The patient has responded to Nucala therapy as determined by the prescribing physician (e.g., reduced rate of relapse, corticosteroid dose reduction, reduced eosinophil levels).

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	N/A

NUPLAZID

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG, 17 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	N/A

NUVIGIL/PROVIGIL

Products Affected

- modafinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.Excessive daytime sleepiness (EDS) due to myotonic dystrophy - modafinil only. Adjunctive/augmentation for treatment of depression in adults - modafinil only.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients must be greater than or equal to 17 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Excessive sleepiness due to SWSD if the patient is working at least 5 overnight shifts per month. Adjunctive/augmentation treatment for depression in adults if the patient is concurrently receiving other medication therapy for depression.

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus metastatic BCC.
Exclusion Criteria	N/A
Required Medical Information	BCC - Must not have had disease progression while on Erivedge (vismodegib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Locally advanced BCC approve if the BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery AND the patient is not a candidate for radiation therapy, according to the prescribing physician. Metastatic BCC - approve.

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with pirfenidone.
Required Medical Information	N/A
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	IPF baseline - must have FVC greater than or equal to 50 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	PAH WHO group, right heart catheterization results, WHO functional status, previous drugs tried
Age Restrictions	N/A
Prescriber Restrictions	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1 patients not currently on Opsumit or another agent indicated for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1 patients currently on Opsumit or another agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization.

ORENCIA

Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients who have already been started on abatacept (IV or SC) for a covered use.
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	N/A
Prescriber Restrictions	RA and JIA/JRA prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist.
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). Juvenile idiopathic arthritis (JIA) [or Juvenile Rheumatoid Arthritis (JRA)], approve. Cont tx - responded to therapy as per the prescriber.

ORILISSA

Products Affected

- ORILISSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Previous medication use
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an obstetrician-gynecologist or a health care practitioner who specializes in the treatment of womens health.
Coverage Duration	Initial- 6 months. Cont- up to a total duration of therapy of 24 months
Other Criteria	Initial tx Endometriosis- Approve if ALL of the following are met: a) The patient has tried a prescription strength non-steroidal anti-inflammatory medication (NSAID), or has a contraindication to NSAID use AND b) The patient has tried one of the following: a contraceptive (e.g., combination oral contraceptives, levonorgestrel-releasing intrauterine systems [e.g., Mirena, Liletta]) or a progesterone product (e.g., norethindrone tablets, depo-medroxyprogesterone injection), unless contraindicated (NOTE: An exception to the requirement for trials of both of the above therapies can be made if the patient had previously used a gonadotropin-releasing hormone [GnRH] agonist (e.g., Lupron Depot)). AND c) The patient has continued to experience moderate to severe pain associated with endometriosis after treatment with 1) a NSAID and a contraceptive or a progesterone product unless contraindicated or 2) a gonadotropin-releasing hormone [GnRH] agonist . Cont tx - pt must have had a response as determined by the prescriber.

ORKAMBI

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with Kalydeco
Required Medical Information	N/A
Age Restrictions	2 years of age and older
Prescriber Restrictions	prescribed by or inconsultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)

OTEZLA

Products Affected

- OTEZLA
- OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients currently taking Otezla for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous drugs tried
Age Restrictions	N/A
Prescriber Restrictions	PsA - Prescribed by or in consultation with a dermatologist or rheumatologist. PP - prescribed by or in consultation with a dermatologist.
Coverage Duration	4 months initial, 3 years cont
Other Criteria	PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PsA initial-approve if the patient has tried at least one conventional synthetic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant (note: pts who have already tried a biologic DMARD are not required to step back and try a conventional DMARD first). PsA/PP cont - pt has received 4 months of therapy and had a response, as determined by the prescribing physician.

PALYNZIQ

Products Affected

- PALYNZIQ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, phenylalanine concentrations
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases
Coverage Duration	1 year (initial and continuation)
Other Criteria	Initial therapy - approve if the patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on at least one existing treatment modality (e.g., restriction of dietary phenylalanine and protein intake, prior treatment with Kuvan). Maintenance therapy - approve if the patient's blood phenylalanine concentration is less than or equal to 600 micromol/L OR the patient has achieved at least a 20% reduction in blood phenylalanine concentration from pre-treatment baseline.

PHEOCHROMOCYTOMA

Products Affected

- DEMSER
- phenoxybenzamine

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior medication trials
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the management of pheochromocytoma (initial therapy for phenoxybenzamine, initial and continuation therapy for Demser)
Coverage Duration	Authorization will be for 1 year
Other Criteria	If brand Dibenzyline is being requested, approve if the patient has tried and cannot take generic phenoxybenzamine due to a formulation difference in the inactive ingredients between the brand and the bioequivalent generic product which, per the prescribing physician, would result in a significant allergy or a serious adverse reaction. If the requested drug is Demser for intial therapy, approve if the patient has tried a selective alpha blocker (e.g., doxazosin, terazosin or prazosin) AND the patient has tried phenoxybenzamine (brand or generic). If the requested drug is Demser for continuation therapy, approve if the patient is currently receiving Demser or has received Demser in the past.

PHOSPHODIESTERASE-5 INHIBITORS FOR PAH

Products Affected

- ADCIRCA
- sildenafil (pulmonary arterial hypertension) oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients not currently taking an agent indication for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1patients currently receiving an agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Clinical criteria incorporated into the quantity limit edits for sildenafil 20 mg tablets and suspension (Revatio, generics) require confirmation that the indication is PAH (ie, FDA labeled use) prior to reviewing for quantity exception.

PLEGRIDY

Products Affected

- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	For use in MS, patient has a relapsing form of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus Myelofibrosis and Systemic Light Chain Amyloidosis
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years
Other Criteria	N/A

PRALUENT

Products Affected

- PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML, 75 MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Juxtapid or Kynamro.
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Hyperlipidemia in patients with HeFH-approve if meets all of the following 1. Pt has been diagnosed with HeFH AND 2. tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) AND 3. LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. Hyperlipidemia Pt with Clinical ASCVD -approve if meets all of the following: has one of the following conditions prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND tried ONE high intensity statin (as defined above) AND LDL-C remains greater than or equal to 70 mg/dL unless the pt is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c.

PROLIA

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Fortical], abaloparatide), except calcium and Vitamin D.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Treatment of postmenopausal osteoporosis/Treatment of osteoporosis in men (to increase bone mass) [a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression], approve if the patient meets one of the following: 1. has had inadequate response after 12 months of therapy with an oral bisphosphonate, had osteoporotic fracture or fragility fracture while receiving an oral bisphosphonate, or intolerability to an oral bisphosphonate, OR 2. the patient cannot take an oral bisphosphonate because they cannot swallow or have difficulty swallowing, they cannot remain in an upright position, or they have a pre-existing GI medical condition, OR 3. pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR 4. the patient has severe renal impairment (eg, creatinine clearance less than 35 mL/min) or chronic kidney disease, or if the patient has an osteoporotic fracture or fragility fracture . Treatment of bone loss in patient at high risk for fracture receiving ADT for nonmetastatic prostate cancer, approve if the patient has prostate cancer that is not metastatic to the bone and the patient is receiving ADT (eg, leuprolide, triptorelin, goserelin) or the patient has undergone a bilateral orchiectomy. Treatment of bone loss (to increase bone mass) in patients at high risk for fracture receiving adjuvant AI therapy for breast cancer,

PA Criteria	Criteria Details
	approve if the patient has breast cancer that is not metastatic to the bone and in receiving concurrent AI therapy (eg, anastrozole, letrozole, exemestane). Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Use in the management of thrombocytopenia in myelodysplastic syndrome (MDS).
Required Medical Information	Cause of thrombocytopenia. Thrombocytopenia due to HCV-related cirrhosis, platelet counts. Severe aplastic anemia, platelet counts and prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Thrombocytopenia due to chronic ITP or Aplastic Anemia, approve if prescribed by, or after consultation with, a hematologist. Thrombocytopenia due to HCV-related cirrhosis, approve if prescribed by, or after consultation with, a gastroenterologist, hematologist, hepatologist, or a physician who specializes in infectious disease.
Coverage Duration	Chronic ITP - 3 years, others 12 months.
Other Criteria	Thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia purpura, approve if the patient has tried corticosteroids or IVIG or has undergone a splenectomy. Treatment of thrombocytopenia due to HCV-related cirrhosis, approve to allow for initiation of antiviral therapy if the patient has low platelet counts (eg, less than 75,000 mm3) and the patient has chronic HCV infection and is a candidate for hepatitis C therapy. Aplastic anemia - has low platelet counts at baseline/pretreatment (e.g., less than 30,000 mm3) AND tried one immunosuppressant therapy (e.g., cyclosporine, mycophenolate moefetil, sirolimus)

REBIF

Products Affected

- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML, 8.8MCG/0.2ML-22 MCG/0.5ML (6)
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients who experienced an attack and are at risk for multiple sclerosis.
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis (ie, interferon beta-1a, interferon beta-1b, glatiramer, natalizumab, fingolimod, terflunomide, dimethyl fumarate).
Required Medical Information	Diagnosis of MS includes the following patient types: patients with actual diagnosis of MS, patients who have experienced an MS attack, and patients who are at risk for developing MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

REPATHA

Products Affected

- REPATHA
- REPATHA PUSHTRONEX
- REPATHA SURECLICK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	ASCVD/HeFH/Primary Hyperlipidemia - 18 yo and older, HoFH 13 yo and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	ASCVD/HeFH/HoFH - 3 years. Primary hyperlipidemia- 1 year.
Other Criteria	Hyperlipidemia with HeFH - approve if: 1) diagnosis of HeFH AND 2) tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) and LDL remains 70 mg/dL or higher unless pt is statin intolerant defined by experiencing statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the symptoms resolved upon discontinuation. Hyperlipidemia with ASCVD -approve if: 1) has one of the following conditions: prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND 2) tried ONE high intensity statin (defined above) and LDL remains 70 mg/dL or higher unless pt is statin intolerant (defined above). HoFH - approve if: 1) has one of the following: a) genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, OR b) untreated LDL greater than 500 mg/dL (prior to treatment), OR c) treated LDL greater than or equal to 300 mg/dL (after treatment but prior to agents such as Repatha, Kynamro or Juxtapid), OR d) has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) tried ONE high intensity statin

PA Criteria	Criteria Details
	(defined above) for 8 weeks or longer and LDL remains 70 mg/dL or higher unless statin intolerant (defined above). Primary hyperlipidemia (not associated with ASCVD, HeFH, or HoFH)-approve if all of the following are met: 1) coronary artery calcium or calcification (CAC) score 300 Agatston units or higher, AND 2) tried one high-intensity statin therapy (defined above) and ezetimibe for 8 weeks or longer and LDL remains 100 mg/dL or higher unless statin intolerant (defined above).

REVLIMID

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Revlimid for a Covered Use. Systemic Amyloidosis Light Chain, Diffuse Large B Cell Lymphoma (Non-Hodgkin's Lymphoma), Follicular Lymphoma (Non-Hodgkin's Lymphoma), Myelofibrosis.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and previous therapies or drug regimens tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	MCL-approve if the patient meets one of the following 1) Pt has tried two prior therapies or therapeutic regimens OR 2) Pt has tried one prior therapy or therapeutic regimen and cannot take Velcade according to the prescribing physician. MDS-approve if the patient meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Epogen, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). Diffuse, Large B Cell Lymphoma (Non-Hodgkin's Lymphoma)-approve if the pt has tried one other medication treatment regimen. Myelofibrosis-approve if the pt has tried one other therapy.

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Rubraca for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Rubraca is being used. BRCA-mutation (germline or somatic) status. Other medications tried for the diagnosis provided
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3years
Other Criteria	Initial Therapy-treatment. Approve for 3 years if the patient meets the following criteria (i and ii): i.The patient has a BRCA-mutation (germline or somatic) as confirmed by an approved test, AND ii.The patient has progressed on two or more prior lines of chemotherapy. Recurrence, Maintenance Therapy of Ovarian, Fallopian tube or Primary peritoneal cancer-i. The patient is in a complete response or a partial response to platinum-based chemotherapy.

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on midostaurin for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	For AML, FLT3 status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	AML-approve if the patient is FLT3-mutation positive as detected by an approved test.

SAMSCA

Products Affected

- SAMSCA ORAL TABLET 15 MG, 30 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 30 days
Other Criteria	Hyponatremia - Pt must meet ONE of the following: 1. serum sodium less than 125 mEq/L at baseline, OR 2. marked hyponatremia, defined as less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion), OR 3. patient has already been started on Samsca and has received less than 30 days of therapy.

SIMPONI

Products Affected

- SIMPONI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on golimumab (IV or SC) for a covered use.
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	RA/Ankylosing spondylistis, prescribed by or in consultation with a rheumatologist. Psoriatic arthritis, prescribed by or in consultation with a rheumatologist or dermatologist. UC-prescribed by or in consultation with a gastroenterologist
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	AS approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx. PsA-approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx, Stelara, Otezla, Orencia, Xeljanz/XR. RA, approve if the patient has tried two of the following: Enbrel, Humira, Orencia, or Xeljanz/XR. Ulcerative colitis - approve if the patient has had a trial with Humira. Cont tx - must have a response to therapy as according to prescriber

SOLARAZE

Products Affected

- diclofenac sodium topical gel 3 %

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

SPRYCEL

Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus GIST and patients already started on Sprycel for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Sprycel is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, new patient must have Ph-positive CML for approval of Sprycel. For ALL, new patient must have Ph-positive ALL for approval of Sprycel. GIST - has D842V mutation AND previously tried Sutent and Gleevec.

STELARA

Products Affected

- STELARA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus approve Stelara SC in patients already started on Stelara (IV/SC) for a Covered Use.
Exclusion Criteria	Ustekinumab should not be given in combination with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	Adults-PsA and CD. PP-12 years and older.
Prescriber Restrictions	Plaque psoriasis.Prescribed by or in consultation with a dermatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist. CD-prescribed by or in consultation with a gastroenterologist.
Coverage Duration	PP/PsA Init-3mo,CD load-approve 1 dose IV,CD post IV load-approve SC 3 mo,cont tx-approve SC 3 yr
Other Criteria	PP initial - approve Stelara SC. CD, induction therapy - approve single dose of IV formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD (eg, azathioprine, 6-MP, MTX, certolizumab, vedolizumab, adalimumb, infliximab). CD, initial therapy (only after receiving single IV loading dose) - approve 3 months of the SC formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD. PP/PsA/CD cont - approve Stelara SC if according to the prescribing physician, the patient has responded to therapy.

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Stivarga for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Stivarga is being used. Prior therapies tried. For metastatic CRC, KRAS/NRAS mutation status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For GIST, patient must have previously been treated with imatinib (Gleevec) and sunitinib (Sutent). For HCC, patient must have previously been treated with Nexavar (sorafenib).

SUTENT

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Sutent for a Covered Use. Advanced, unresectable neuroendocrine tumors, chordoma, angiosarcoma, solitary fibrous tumor/hemangiopericytoma, alveolar soft part sarcoma (ASPS), differentiated (ie, papillary, follicular, and Hurthle) thyroid carcinoma, medullary thyroid carcinoma, meningioma, thymic carcinoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Gastrointestinal stromal tumors (GIST), approve if Sutent will be used as a single agent and the patient has previously tried imatinib (Gleevec) OR Sutent will be used in combination with Afinitor AND the patient has tried TWO of the following: imatinib, Sutent, or Stivarga. Chordoma, approve if the patient has recurrent disease. Differentiated thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). Meningioma, approve if the patient has recurrent or progressive disease. Thymic carcinoma - has tried chemotherapy or radiation therapy.

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Patients with unknown CFTR gene mutations
Required Medical Information	Diagnosis, specific CFTR gene mutations
Age Restrictions	Twelve years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - must have at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, 711+3A G, S945L, S977F, F1052V, E831X, K1060T, A1067T, R1070W, F1074L, D1152H, D1270N, 2789+5G A, 3272-26A G, or 3849 + 10kbC T OR the patient has two copies of the F508del mutation

SYMLIN

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D worded as patient has type 1 or 2 diabetes mellitus.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

SYPRINE

Products Affected

- trientine

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Trientine for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, medication history, pregnancy status, disease manifestations
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For Wilson's Disease, approve if the patient meets ONE of the following: 1) Patient has tried a penicillamine product and per the prescribing physician the patient is intolerant to penicillamine therapy, OR 2) Per the prescribing physician, the patient has clinical features indicating the potential for intolerance to penicillamine therapy (ie, history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency), OR 3) Per the prescribing physician, the patient has a contraindication to penicillamine therapy, OR 4) The patient has neurologic manifestations of Wilson's disease, OR 5) The patient is pregnant.

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients with Differentiated Thyroid Cancer. Plus patients already started on Tafinlar for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Tafinlar is being used. BRAF V600 mutations
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma with BRAF V600 mutation AND patient has unresectable, advanced (including Stage III or Stage IV disease) or metastatic melanoma. Note - This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery. For NSCLC, must have BRAF V600E mutation. Thyroid Cancer, anaplastic-must have BRAF V600-positive disease AND Tafinlar will be taken in combination with Mekinist, unless intolerant AND the patient has locally advanced or metastatic anaplastic disease. Thyroid Cancer, differentiated (i.e., papillary, follicular, or Hurthle cell) AND the patient has disease that is refractory to radioactive iodine therapy AND the patient has BRAF-positive disease.

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	NSCLC - prior therapies and EGFR T790M mutation or EGFR exon 19 deletion or exon 21 (L858R) substitution
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	NSCLC - Must have metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC as detected by an approved test AND has progressed on or after one of Tarceva, Iressa, or Gilotrif therapy OR Advanced or metastatic Non-Small Cell Lung Cancer (NSCLC) who have EGFR exon 19 deletion or exon 21 (L858R) substitution as detected by an approved test.

TAKHZYRO

Products Affected

- TAKHZYRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, lab values
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders (initial and continuation).
Coverage Duration	3 years
Other Criteria	Under CMS Review

TALZENNA

Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Talzenna for a covered use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, BRCA mutation status, HER2 status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Locally-advanced or metastatic breast cancer-approve if the patient has germline BRCA mutation-positive AND human epidermal growth factor receptor 2 (HER2) negative disease

TARCEVA

Products Affected

- TARCEVA ORAL TABLET 100 MG, 150 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus Renal Cell Carcinoma and Bone Cancer-Chordoma. Plus patients already started on Tarceva for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Advanced, recurrent, or metastatic non small cell lung cancer (NSCLC), EGFR mutation or gene amplification status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Metastatic NSCLC, approve if the patient meets both of the following: 1. patient is EGFR mutation positive, AND 2. patient has EGFR exon 19 deletions OR exon 21 (L858R) substitution mutations as detected by an FDA-approved test. Advanced RCC, approve if the patient has non-clear cell histology.

TASIGNA

Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Tasigna for a Covered Use. Plus Philadelphia positive Acute Lymphoblastic Leukemia (ALL) and Gastrointestinal Stromal Tumor (GIST).
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Tasigna is being used. For indication of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For indication of gastrointestinal stromal tumor (GIST) and ALL, prior therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, new patient must have Ph-positive CML for approval of Tasigna. For GIST, patient must have tried TWO of the following - sunitinib (Sutent), imatinib (Gleevec), or regorafenib (Stivarga). For ALL, Approve if the patient has tried one other tyrosine kinase inhibitor that is used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).

TAVALISSE

Products Affected

- TAVALISSE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies or surgeries
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with a hematologist
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Approve if the patient has tried one other therapy or the patient has undergone splenectomy.

TAZORAC

Products Affected

- tazarotene
- TAZORAC TOPICAL CREAM 0.05 %
- TAZORAC TOPICAL GEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Cosmetic uses
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PP/acne vulgaris - 3 years, other - 12 months
Other Criteria	Acne vulgaris after a trial with at least 1 other topical retinoid product (eg, tretinoin cream/gel/solution/microgel, adapalene).

TECFIDERA

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS.
Required Medical Information	MS, patient must have a relapsing form of MS (RRMS, SPMS with relapses, or PRMS). MS, previous MS therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	N/A

THALOMID

Products Affected

- THALOMID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Thalomid for a Covered Use, Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Discoid lupus erythematosus or cutaneous lupus erythematosus, approve if the patient has tried two other therapies (eg, corticosteroids [oral, topical, intralesional], hydroxychloroquine, tacrolimus [Protopic], methotrexate, dapsone, acitretin [Soriatane]). Myelofibrosis, approve if the patient has tried one other therapy (eg, ruxolitinib [Jakafi], danazol, epoetin alfa [Epogen/Procrit], prednisone, lenalidomide [Revlimid], hydroxyurea). Prurigo nodularis, approve if the patient has tried two other therapies (eg, azathioprine, capsaicin, psoralen plus ultraviolet A [PUVA] therapy, ultraviolet B [UVB] therapy). Recurrent aphthous ulcers or aphthous stomatitis, approve if the patient has tried two other therapies (eg, topical or intralesional corticosteroids, systemic corticosteroids, topical anesthetics/analgesics [eg, benzocaine lozenges], antimicrobial mouthwashes [eg, tetracycline], acyclovir, colchicine).

TIBSOVO

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Tibsovo for a covered use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, IDH1 Status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	AML- approve if the patient has relapsed or refractory disease AND the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive.

TOPICAL AGENTS FOR ATOPIC DERMATITIS

Products Affected

- tacrolimus topical

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.

TOPICAL RETINOID PRODUCTS

Products Affected

- adapalene topical cream
- adapalene topical gel
- avita topical cream
- tretinoin topical

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for cosmetic use.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	N/A

TOPICAL TESTOSTERONE PRODUCTS

Products Affected

- ANDRODERM
- ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)
- ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM)
- testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)
- testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of primary hypogonadism (congenital or acquired) in males. Diagnosis of secondary (hypogonadotropic) hypogonadism (congenital or acquired) in males. Hypogonadism (primary or secondary) in males, serum testosterone level. [Man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. hypogonadism has been confirmed by a low for age serum testosterone (total or free) level defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-

PA Criteria	Criteria Details
	treatment serum testosterone level that was low. For patients requesting Androderm, approve if the patient has previously tried Androgel 1.62% or testosterone 1% gel.[Note: male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]

TRANSMUCOSAL FENTANYL DRUGS

Products Affected

- fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate). Clinical criteria incorporated into the quantity limit edits for all transmucosal fentanyl drugs require confirmation that the indication is breakthrough cancer pain (ie, FDA labeled use) prior to reviewing for quantity exception.

TREMFYA

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Tremfya for a covered use.
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Previous medication use
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist
Coverage Duration	Initial therapy - 3 months, Continuation therapy - 3 years
Other Criteria	Plaque Psoriasis initial therapy-approve if the patient has tried TWO of the following: Enbrel, Humira, Stelara SC, Otezla, or Cosentyx. Cont tx - approve if the patient has had a response to therapy, as according to the prescribing physician.

TYKERB

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Tykerb for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Tykerb is being used. Metastatic breast cancer, HER2 status or hormone receptor (HR) status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	HER2-positive advanced or metastatic breast cancer, approve if Tykerb will be used in combination with Xeloda or Herceptin and the patient has received prior therapy with Herceptin. HER2-positive HR positive metastatic breast cancer, approve if the patient is a man receiving a LHRH agonist, a premenopausal or perimenopausal woman receiving ovarian suppression/ablation with a LHRH agonist, or a postmenopausal woman and Tykerb will be used in combination with an aromatase inhibitor, that is letrozole (Femara), anastrozole, or exemestane. In this criteria, man/woman is defined as an individual with the biological traits of a man/woman, regardless of the individual's gender identity or expression.

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, calcitonin nasal spray [Fortical], Forteo), except calcium and Vitamin D. Previous use of Tymlos and/or Forteo for a combined total no greater than 2 years duration during a patient's lifetime.
Required Medical Information	Previous medications tried, renal function
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 2 years of therapy over a patient's lifetime
Other Criteria	Treatment of PMO, approve if the patient meets ONE of the following criteria: patient has tried one oral bisphosphonate or cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or patient cannot remain in an upright position post oral bisphosphonate administration or patient has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR patient has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR patient has severe renal impairment or CKD, OR patient has had an osteoporotic fracture or fragility fracture

UPTRAVI

Products Affected

- UPTRAVI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients currently taking Uptravi.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of right heart catheterization (select populations), medication history.
Age Restrictions	N/A
Prescriber Restrictions	PAH must be prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	3 years
Other Criteria	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Right heart catheterization is NOT required in pts who are currently receiving Uptravi or another agent indicated for PAH (WHO group 1). Patient must meet a) OR b): a) tried TWO or is currently taking TWO oral therapies for PAH (either alone or in combination) each for 30 days, unless patient has experienced treatment failure, intolerance, or oral therapy is contraindicated: PDE5 inhibitor (eg, sildenafil, Revatio), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit], or Adempas, OR b) receiving or has received in the past one prostacyclin therapy for PAH (eg, Orenitram, Ventavis, or epoprostenol injection).

VENCLEXTA

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus Small Lymphocytic Lymphoma (SLL). Plus Mantle Cell Lymphoma. Plus patients currently taking Venclexta for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	CLL with or without 17p deletion - approve if the patient has tried one prior therapy. SLL-approve if the patient has tried one prior therapy. Mantle Cell Lymphoma-approve if the patient has tried one prior therapy.

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	HR status, HER2 status, previous medications/therapies tried, concomitant therapy, menopausal status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast cancer - approve advanced or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)]disease, and HER2-negative breast cancer in patients who have not had disease progression while on Kisqali, Ibrance or Verzenio when the pt meets ONE of the following 1. Pt is postmenopausal and Verzenio will be used as first line endocrine therapy in combination with anastrozole, exemestane, or letrozole 2. pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonist, or has had surgical bilateral oophorectomy, or ovarian irradiation AND Verzenio will be used as first line endocrine therapy in combination with anastrozole, exemestane, or letrozole 3. Patient is postmenopausal and meets the following conditions: The patient has relapsed or progressed during prior endocrine therapy with at least one of the following: anastrozole, exemestane, letrozole, tamoxifen, Fareston, exemestane plus Afinitor, Faslodex, Afinitor plus Faslodex or tamoxifen, megestrol acetate, fluoxymesterone, ethinyl estradiol AND Verzenio will be used in combination with Faslodex. 4. patient is premenopausal or perimenopausal and meets the following conditions: The patient is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist, or has had surgical bilateral oophorectomy or ovarian irradiation AND patient has relapsed or progressed during prior endocrine therapy

PA Criteria	Criteria Details
	with at least one of the following: anastrozole, exemestane, letrozole, tamoxifen, Fareston, exemestane plus Afinitor, Faslodex, Afinitor plus Faslodex or tamoxifen, megestrol acetate, fluoxymesterone, ethinyl estradiol AND Verzenio will be used in combination with Faslodex 5. patient is postmenopausal, premenopausal, perimenopausal or a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) and meets the following conditions: Verzenio will be used as monotherapy AND patient's breast cancer has relapsed or progressed during prior endocrine therapy with at least one of the following: anastrozole, exemestane, letrozole, tamoxifen, Fareston, exemestane plus Afinitor, Faslodex, Afinitor plus Faslodex or tamoxifen, megestrol acetate, fluoxymesterone, ethinyl estradiol AND patient has tried chemotherapy for metastatic breast cancer. 6. pt is a man who is receiving GnRH agonist AND Verzenio with be used as first line endocrine therapy in combination with anastrozole, exemestane, tamoxifen or letrozole.

VIZIMPRO

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.Plus patients already started on Vizimpro for a covered use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, EGFR status, exon deletions or substitutions
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic-NSCLC-Epidermal Growth Factor Receptor (EGFR) mutation positive AND has epidermal growth factor receptor (EGFR) exon 19 deletion as detected by an approved test OR exon 21 (L858R) substitution mutations as detected by an approved test.

VOLTAREN GEL

Products Affected

- diclofenac sodium topical gel 1 %

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A

VOSEVI

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients started on Vosevi for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already taking Votrient for a Covered Use. Differentiated (ie, papillary, follicular, Hurthle cell) thyroid carcinoma. Uterine sarcoma, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer, Gastrointestinal Stromal Tumor (GIST).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Soft tissue sarcoma other than GIST [angiosarcoma, Pleomorphic rhabdomyosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma that is unresectable or progressive, soft tissue sarcoma of the extremity/superficial trunk or head/neck, including synvovial sarcoma, or other non-lipogenic (non-adipocytic) soft tissue sarcoma], approve. Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Uterine sarcoma, approve if the patient has recurrent, advanced or metastatic disease. Advanced RCC - approve. Ovarian Cancer (ie, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer) - approve if the patient has persistent or recurrent disease OR the patient has complete clinical remission after receiving primary treatment with chemotherapy and/or surgery. GIST - approve if the patient has tried TWO of the following: Gleevec, Sutent, or Stivarga. Medullary Thyroid Carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq).

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus soft tissue sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK translocation, Plus peripheral T-Cell Lymphoma - Anaplastic Large Cell Lymphoma (ALCL), Plus NSCLC with high level MET amplification or MET Exon 14 skipping mutation. Plus patients already started on crizotinib for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	For the FDA-approved indication of NSCLC for patients new to therapy, ALK status and ROS1 rearrangement required. For soft tissue sarcoma IMT, ALK translocation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years
Other Criteria	NSCLC, patient new to therapy must be ALK-positive, have high level MET amplification, have MET Exon 14 skipping mutation, or have ROS1 rearrangement for approval. For IMT, patient new to therapy must have ALK translocation for approval.

XELJANZ

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Xeljanz/XR for a Covered Use.
Exclusion Criteria	Concurrent use with a biologic for an inflammatory condition (eg, tocilizumab, anakinra, abatacept, rituximab) or a TNF inhibitor (eg, certolizumab pegol, etanercept, adalimumab, infliximab, golimumab). Concurrent use with potent immunosuppressants that are not methotrexate (MTX) [eg, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil].
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	N/A
Prescriber Restrictions	RA, prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or a dermatologist.
Coverage Duration	Authorization will be for 3months initial, 3 years cont.
Other Criteria	RA/PsA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). Continuation Therapy - Patient must have responded, as determined by the prescriber

XENAZINE

Products Affected

- tetrabenazine oral tablet 12.5 mg, 25 mg
- XENAZINE ORAL TABLET 12.5 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Hyperkinetic dystonia. Hemiballism.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, must be prescribed by or after consultation with a neurologist. For TD, must be prescribed by or after consultation with a neurologist or psychiatrist.
Coverage Duration	Authorization will be for 12 months
Other Criteria	N/A

XERMELO

Products Affected

- XERMELO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapy, concomitant therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Initial therapy - approve if the patient meets ALL of the following criteria: 1) patient has been on long-acting somatostatin analog (SSA) therapy (eg, Somatuline Depot [lanreotide for injection]) for at least 3 consecutive months, AND 2) while on long-acting SSA therapy (prior to starting Xermelo), the patient continues to have at least four bowel movements per day, AND 3) Xermelo will be used concomitantly with a long-acting SSA therapy. Continuation therapy - approve if the patient is continuing to take Xermelo concomitantly with a long-acting SSA therapy for carcinoid syndrome diarrhea.

XOLAIR

Products Affected

- XOLAIR SUBCUTANEOUS RECON SOLN
- XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.5 ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Seasonal or perennial allergic rhinitis (SAR or PAR).
Exclusion Criteria	Concurrent use with an Interleukin (IL) Antagonist Monoclonal Antibody
Required Medical Information	Moderate to severe persistent asthma and SAR/PAR, baseline IgE level of at least 30 IU/mL. For asthma, patient has a positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay (eg, immunoCAP, ELISA) or the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds). For SAR/PAR, patient has positive skin testing (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach) and/or positive in vitro testing (ie, a blood test for allergen-specific IgE antibodies) for one or more relevant allergens (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach). CIU - must have urticaria for more than 6 weeks, with symptoms present more than 3 days/wk despite daily non-sedating H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) AND must have tried therapy with a leukotriene modifier (e.g., montelukast) with a daily non-sedating H1 antihistamine
Age Restrictions	Moderate to severe persistent asthma-6 years and older. All other diagnoses-12 years and older
Prescriber Restrictions	Moderate to severe persistent asthma/SAR/PAR if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist.
Coverage Duration	Initial tx 4 months, continued tx 12 months.
Other Criteria	Moderate to severe persistent asthma approve if pt meets criteria 1 and 2: 1)pt has received at least 3 months of combination therapy with an inhaled

PA Criteria	Criteria Details
	corticosteroid and at least one the following: long-acting beta-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist, or theophylline, and 2)inadequate control demonstrated by hospitalization for asthma or requirement for systemic corticosteroids to control asthma exacerbation(s). For continued Tx for asthma - must meet specialist criteria and patient has responded to therapy as determined by the prescribing physician. SAR/PAR - approve if pt meets all of the following criteria: 1) pt has tried concurrent therapy with at least one drug from 2 of the following classes: an oral non-sedating or low-sedating antihistamine, a nasal antihistamine, a nasal corticosteroid, or montelukast, AND 2) pt has had immunotherapy, is receiving immunotherapy, or will be receiving immunotherapy or has contraindications to immunotherapy. For continued tx SAR/PAR - must meet specialist criteria and pt must have responded to therapy as determined by the prescribing physician. For CIU cont tx - must meet specialist criteria and have responded to therapy as determined by the prescribing physician.

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Xtandi for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Xtandi is being used.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years
Other Criteria	N/A

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Medication history
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a sleep specialist physician or a Neurologist
Coverage Duration	12 months.
Other Criteria	For Excessive daytime sleepiness (EDS) in patients with narcolepsy - approve if the patient has tried one CNS stimulant (e.g., methylphenidate, dexmethylphenidate, dextroamphetamine), modafinil, or Nuvigil.

YONSA

Products Affected

- YONSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Yonsa for a covered use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concomitant medications
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic castration-resistant prostate cancer (mCRPC) - approve if the patient will be using Yonsa in combination with methylprednisolone.

ZARXIO

Products Affected

- ZARXIO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D worded more broadly as cancer patients receiving myelosuppressive chemotherapy, patients with acute myeloid leukemia (AML) receiving chemotherapy, cancer patients receiving bone marrow transplantation (BMT), patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, and patients with severe chronic neutropenia [SCN] (e.g., congenital neutropenia, cyclic neutropenia, idiopathic neutropenia). Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	AML, HIV/AIDS, MDS - adults
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chemo/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT-3 mo.All other=12mo.
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years,

PA Criteria	Criteria Details
	prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, or HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, Neulasta, Neupogen) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).

ZEJULA

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Zejula for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Recurrent ovarian, fallopian tube, or primary peritoneal cancer - approve if the patient has had a complete or partial response after platinum-based chemotherapy regimen AND Zejula is requested for maintenance treatment.

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients with Hairy Cell Leukemia, Non-Small Cell Lung Cancer (NSCLC) with BRAF V600E Mutation, Differentiated thyroid carcinoma (i.e., papillary, follicular, or Hurthle cell) with BRAF-positive disease and patients already started on vemurafenib for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	BRAFV600 mutation status required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma, patient new to therapy must have BRAFV600 mutation for approval AND have unresctable, advanced or metastatic melanoma. HCL - must have relapsed or refractory disease AND tried at least two therapies for hairy cell leukemia.Thyroid Cancer-patient has disease that is refractory to radioactive iodine therapy.

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus Marginal Zone Lymphoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	CLL-approve if the patient has tried one prior therapy. Marginal Zone Lymphoma/Follicular B-Cell Non-Hodgkin Lymphoma/SLL - approve if the patient has tried two prior therapies.

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus Soft Tissue Sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK Translocation. Plus patients with NSCLC with ROS1 Rearrangement-First-line therapy.
Exclusion Criteria	N/A
Required Medical Information	Must have metastatic NSCLC that is anaplastic lymphoma kinase (ALK)-positive as detected by an approved test or ROS1 Reaarangement. IMT - ALK Translocation status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

ZYTIGA

Products Affected

- abiraterone
- ZYTIGA ORAL TABLET 250 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus Prostate Cancer-Regional Risk Group or Locally Advanced. Plus Prostate Cancer - Metastatic (Castration-Resistant or Castration-Sensitive), Post-External Beam Radiation Therapy (EBRT). Plus, patients already started on Zytiga for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Prostate Cancer-Metastatic, Castration-Resistant (mCRPC) and Metastatic, Castration-Sensitive (mCSPC), high risk-Approve if Zytiga is being used in combination with prednisone. Prostate Cancer - Regional Risk Group or Locally Advanced. Approve if the patient meets all of the following criteria (A, B, and C): A) Zytiga is used in combination with prednisone AND B) Patient has regional lymph node metastases and no distant metastases AND C) Patient meets one of the following criteria (i or ii): i. Zytiga with prednisone is used in combination with gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide acetate for injection], Lupron Depot [leuprolide acetate for depot suspension], Trelstar [triptorelin pamoate for injectable suspension], Zoladex [goserelin acetate implant], Vantas [histrelin acetate subcutaneous implant]) OR ii. Patient has had an orchiectomy. Prostate Cancer - Metastatic (Castration-Resistant or Castration-Sensitive), Post-External Beam Radiation Therapy (EBRT)-Approve if the patient meets all of the following criteria (A, B, C, D, and E): A) Zytiga is used in combination with prednisone AND B) Patient

PA Criteria	Criteria Details
	meets one of the following criteria (i, ii, or iii): i. Zytiga with prednisone is used in combination with gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron [leuprolide acetate for injection], Lupron Depot [leuprolide acetate for depot suspension], Trelstar [triptorelin pamoate for injectable suspension], Zoladex [goserelin acetate implant], Vantas [histrelin acetate subcutaneous implant]) OR ii. Zytiga with prednisone is used in combination with GnRH antagonist (e.g., Firmagon [degarelix for injection]) OR iii. Patient has had an orchiectomy. C) Patient meets one of the following criteria (i or ii): i. There is an increase in prostate specific antigen (PSA) after EBRT OR ii Patient has had a positive digital rectal exam (DRE) after EBRT AND D) Patient is not a candidate for local therapy AND E) Patient has had a positive bone scan.

PART B VERSUS PART D

Products Affected

- ABELCET
- acetylcysteine
- acyclovir sodium intravenous solution
- albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml
- AMBISOME
- AMINOSYN 7 % WITH ELECTROLYTES
- AMINOSYN II 10 %
- AMINOSYN II 15 %
- AMINOSYN II 8.5 %
- AMINOSYN II 8.5 %-ELECTROLYTES
- AMINOSYN-HBC 7%
- AMINOSYN-PF 10 %
- AMINOSYN-PF 7 % (SULFITE-FREE)
- AMINOSYN-RF 5.2 %
- amphotericin b
- aprepitant
- azathioprine
- BETHKIS
- budesonide inhalation
- caspofungin
- CLINIMIX 5%/D15W SULFITE FREE
- CLINIMIX 5%/D25W SULFITE-FREE
- CLINIMIX 4.25%/D10W SULF FREE
- CLINIMIX 4.25%/D5W SULFIT FREE
- CLINIMIX 4.25%-D25W SULF-FREE
- CLINIMIX 5%-D20W(SULFITE-FREE)
- CLINIMIX E 4.25%/D10W SUL FREE
- CLINIMIX E 5%/D15W SULFIT FREE
- cromolyn inhalation
- cyclophosphamide oral capsule
- cyclosporine modified
- cyclosporine oral capsule
- dronabinol
- ENGERIX-B (PF) INTRAMUSCULAR SYRINGE
- ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE
- FIRMAGON KIT W DILUENT SYRINGE
- gengraf oral capsule 100 mg, 25 mg
- gengraf oral solution
- granisetron hcl oral
- HEPATAMINE 8%
- intralipid intravenous emulsion 20 %
- INTRALIPID INTRAVENOUS EMULSION 30 %
- ipratropium bromide inhalation
- ipratropium-albuterol
- levalbuterol hcl
- methotrexate sodium (pf) injection solution
- methotrexate sodium injection
- mycophenolate mofetil
- mycophenolate sodium
- NEBUPENT
- NEPHRAMINE 5.4 %
- ondansetron
- ondansetron hcl oral
- PERFOROMIST
- plenamine
- premasol 10 %
- PREMASOL 6 %
- PULMOZYME
- RAPAMUNE ORAL SOLUTION
- RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML
- RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE
- sirolimus
- SYNRIBO
- tacrolimus oral
- tobramycin in 0.225 % nacl
- travasol 10 %
- TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION
- TROPHAMINE 10 %
- TROPHAMINE 6%
- XGEVA
- ZORTRESS

Details

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

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