ACTEMRA IV (S)

**MEDICATION(S)**
ACTEMRA 200 MG/10 ML VIAL, ACTEMRA 400 MG/20 ML VIAL, ACTEMRA 80 MG/4 ML VIAL

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Trial and failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), or attestation demonstrating a trial may be inappropriate, OR for continuation of prior Actemra therapy. Systemic Juvenile Idiopathic arthritis (SJIA) (Initial): Diagnosis of active SJIA. Trial and failure, contraindication, or intolerance to one NSAID or systemic glucocorticoid. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: Trial and failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), or attestation demonstrating a trial may be inappropriate, OR for continuation of prior Actemra therapy. RA, SJIA, PJIA (Initial, reauth): Patient is not receiving Actemra in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Cytokine Release Syndrome (CRS) Risk due to CAR T-cell Therapy: Patient will receive or is receiving chimeric antigen receptor (CAR) T-cell immunotherapy [i.e., Kymriah (tisagenlecleucel), Yescarta (axicabtagene ciloleucel)].

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
RA, SJIA, PJIA (Initial): Prescribed by or in consultation with a rheumatologist. CRS Risk due to CAR T-cell Therapy: Prescribed by or in consultation with an oncologist or hematologist.

**COVERAGE DURATION**
RA, SJIA, PJIA (Initial, reauth): 12 months. CRS risk due to CAR T-cell therapy: 2 months

**OTHER CRITERIA**
RA, SJIA, PJIA (Reauth): Documentation of positive clinical response to Actemra therapy.
MEDICATION(S)
ACTIMMUNE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of one of the following: 1) Chronic granulomatous disease (CGD), or 2) severe malignant osteopetrosis (SMO).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
ADAGEN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Excluded if patient has severe thrombocytopenia

REQUIRED MEDICAL INFORMATION
Adenosine deaminase (ADA) deficiency: Diagnosis of ADA deficiency in a patient with severe combined immunodeficiency disease (SCID) AND patient is not a suitable candidate for, or who has failed, bone marrow transplantation, hematopoietic stem cell transplant, or gene therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
ADCIRCA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
PAH (Reauth): Documentation of positive clinical response to therapy.
MEDICATION(S)
DEXTROAMPHETAMINE-AMPHER ER

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to members 19 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
ADEMPAS

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Chronic thromboembolic pulmonary hypertension (CTEPH) (Initial): One of the following: A) Both of the following: 1) Diagnosis of inoperable or persistent/recurrent CTEPH and 2) CTEPH is symptomatic OR B) Patient is currently on any therapy for the diagnosis of CTEPH.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PAH, CTEPH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.

COVERAGE DURATION
PAH, CTEPH: Initial: 6 months. Reauth: 12 months.

OTHER CRITERIA
PAH, CTEPH (Reauth): Documentation of positive clinical response to therapy.
AFINITOR (S)

MEDICATION(S)
AFINITOR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention but patient is not a candidate for curative surgical resection. Renal cell carcinoma: Diagnosis of advanced or metastatic renal cell carcinoma AND trial and failure, contraindication, or intolerance to SUTENT (sunitinib) or NEXAVAR (sorafenib). Neuroendocrine tumors of pancreatic origin (pNET): Diagnosis of progressive pNET that are unresectable, locally advanced, or metastatic. Renal angiomyolipoma: Diagnosis of renal angiomyolipoma and TSC AND Patient does not require immediate surgery. Breast Cancer: Patient is a postmenopausal woman AND Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer AND trial and failure, contraindication, or intolerance to FEMARA (letrozole) or ARIMIDEX (anastrozole) AND Afinitor will be used in combination with AROMASIN (exemestane). Neuroendocrine tumors of gastrointestinal (GI) or lung origin: Diagnosis of progressive, well-differentiated, non-functional NET of GI or lung origin AND patient has unresectable, locally advanced or metastatic disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
All Indications: Prescribed by or in consultation with an oncologist

COVERAGE DURATION
All Indications: 12 months

OTHER CRITERIA
All Indications: Approve for continuation of prior therapy.
MEDICATION(S)
AFINITOR DISPERZ

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Subependymal Giant Cell Astrocytoma (SEGA): Diagnosis of SEGA associated with tuberous sclerosis complex (TSC) that requires therapeutic intervention but patient is not a candidate for curative surgical resection. TSC-associated partial-onset seizures: Diagnosis of TSC-associated partial-onset seizures. Used as adjunctive therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
SEGA: Prescribed by or in consultation with an oncologist. TSC-associated partial-onset seizures: Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
ALDURAZYME (S)

MEDICATION(S)
ALDURAZYME

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Mucopolysaccharidosis I: confirmed diagnosis of Hurler and Hurler-Scheie forms of Mucopolysaccharidosis I (MPS I), OR confirmed diagnosis of Scheie form of Mucopolysaccharidosis I (MPS I) who have moderate to severe symptoms.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
ALECENSA (S)

**MEDICATION(S)**
ALECENSA

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Non-small cell lung cancer (NSCLC): A) Diagnosis of metastatic NSCLC AND B) Patient has anaplastic lymphoma kinase (ALK)-positive disease as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist.

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
MEDICATION(S)
ALIQOPA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Relapsed Follicular Lymphoma: Diagnosis of relapsed follicular lymphoma AND patient has received at least two prior systemic therapies.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
ARALAST NP, GLASSIA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Alpha-1 proteinase inhibitor (alpha-1 antitrypsin) deficiency: All of the following: A) Patient has an alpha-1 proteinase inhibitor (alpha-1 antitrypsin) deficiency AND B) Diagnosis of emphysema AND C) One of the following: 1) Patient has a high risk phenotype: PiZZ, PiZ(), or Pi()() OR 2) Patient has serum alpha-1 antitrypsin concentrations of less than 11 M/L (80 mg/dL), AND D) One of the following: FEV1 level is between 30% and 65% of predicted OR the patient has experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment, AND E) Trial and failure, or intolerance to Prolastin-C.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
PROLASTIN C, ZEMAIRA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Alpha-1 proteinase inhibitor (alpha-1 antitrypsin) deficiency: All of the following: A) Patient has an alpha-1 proteinase inhibitor (alpha-1 antitrypsin) deficiency AND B) Diagnosis of emphysema AND C) One of the following: 1) Patient has a high risk phenotype: PiZZ, PiZ(), or Pi()() OR 2) Patient has serum alpha-1 antitrypsin concentrations of less than 11 M/L (80 mg/dL) AND D) One of the following: FEV1 level is between 30% and 65% of predicted OR the patient has experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
ALUNBRIG (S)

MEDICATION(S)
ALUNBRIG

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC. Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. Trial and failure or intolerance to Xalkori (crizotinib).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
AMPYRA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple Sclerosis (MS) (initial): Diagnosis of MS. Physician confirmation that patient has difficulty walking (eg, timed 25 foot walk test). One of the following: expanded disability status scale (EDSS) score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
MS (Initial): Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
MS (Initial): 6 months. (Reauth): 12 months.

OTHER CRITERIA
MS (Reauth): Physician confirmation that the patient's walking improved with Ampyra therapy. One of the following: EDSS score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).
**MEDICATION(S)**
ANADROL-50

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Anemia (initial): Diagnosis of anemia caused by deficient red cell production AND trial and failure or intolerance to standard therapies for anemia (i.e., erythropoiesis-stimulating agents, immunosuppressants) AND Treatment will not replace other supportive measures (e.g., transfusion, correction of iron, folic acid, vitamin B12 or pyridoxine deficiency, antibacterial therapy, corticosteroids).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Initial and reauth: 12 months

**OTHER CRITERIA**
Anemia (reauth): patient has experienced an objective improvement in anemia (e.g., increased hemoglobin, increased reticulocyte count, reduction/elimination for need of blood transfusions)
MEDICATION(S)
APOKYN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
PD (Initial): Patient is using Apokyn with any 5-HT3 antagonist (eg, ondansetron, granisetron, dolasetron, palonosetron, alosetron)

REQUIRED MEDICAL INFORMATION
Parkinson's disease (PD) (Initial): Diagnosis of advanced PD. Patient is experiencing acute intermittent hypomobility (defined as episodes characterized by muscle stiffness, slow movements, or difficulty starting movements). Patient is receiving Apokyn in combination with other medications for the treatment of PD (e.g., carbidopa/levodopa, pramipexole, ropinirole, benztropine, etc.).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PD (Initial, reauth): 12 months

OTHER CRITERIA
PD (Reauth): Patient is benefiting from therapy (eg, patient had an improvement in motor function).
ARANESP (S)

**MEDICATION(S)**
ARANESP 10 MCG/0.4 ML SYRINGE, ARANESP 100 MCG/0.5 ML SYRINGE, ARANESP 100 MCG/ML VIAL, ARANESP 150 MCG/0.3 ML SYRINGE, ARANESP 200 MCG/0.4 ML SYRINGE, ARANESP 200 MCG/ML VIAL, ARANESP 25 MCG/0.42 ML SYRING, ARANESP 25 MCG/ML VIAL, ARANESP 300 MCG/0.6 ML SYRINGE, ARANESP 300 MCG/ML VIAL, ARANESP 40 MCG/0.4 ML SYRINGE, ARANESP 40 MCG/ML VIAL, ARANESP 500 MCG/1 ML SYRINGE, ARANESP 60 MCG/0.3 ML SYRINGE, ARANESP 60 MCG/ML VIAL

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial): Other causes of anemia have been ruled out. Anemia by lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request. Cancer is a non-myeloid malignancy. Patient is concurrently on chemo, or will receive concomitant chemo for a minimum of 2 months, or anemia is caused by cancer chemo. Will not be approved if patient is not receiving cancer chemotherapy. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of MDS. Serum erythropoietin level is 500 mU/mL or less, or dx of transfusion-dependent MDS. CKD (init, reauth), Chemo (init), MDS (init): Verify iron evaluation for adequate iron stores.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
CKD (Init): 6 mo. CKD (reauth): 12 mo. Chemo(init, reauth): 3 mo. MDS: (init) 3 mo,(reauth) 12 mo.
OTHER CRITERIA
Subject to ESRD review. CKD (Reauth): Dx of CKD. Most recent or average (avg) Hct over 3 mo is 33% or less OR most recent or avg Hgb over 3 months is 11 g/dL or less. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Chemo (Reauth): Anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Patient is concurrently on chemo, or will receive concomitant chemo for a minimum of 2 months, or anemia is caused by cancer chemo. Will not be approved if patient is not receiving cancer chemotherapy. MDS (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Off-label uses (except MDS): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%.
MEDICATION(S)
ARCALYST

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Cryopyrin-Associated Periodic Syndromes (CAPS) (Initial): Diagnosis of CAPS, including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS). The medication will not be used in combination with another biologic.

AGE RESTRICTION
CAPS (Initial): 12 years of age or older

PRESCRIBER RESTRICTION
CAPS (Initial): Prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist or other medical specialist.

COVERAGE DURATION
CAPS (initial, reauth): 12 months

OTHER CRITERIA
CAPS (Reauth): Patient has experienced disease stability or improvement in clinical symptoms while on therapy as evidence by one of the following: A) improvement in rash, fever, joint pain, headache, conjunctivitis, B) decreased number of disease flare days, C) normalization of inflammatory markers (CRP, ESR, SAA), D) corticosteroid dose reduction, OR E) improvement in MD global score or active joint count.
MEDICATION(S)
AUBAGIO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
AURYXIA (S)

**MEDICATION(S)**
AURYXIA

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
Exclude if used for iron deficiency anemia in chronic kidney disease (CKD) not on dialysis.

**REQUIRED MEDICAL INFORMATION**
Hyperphosphatemia in chronic kidney disease: Diagnosis of hyperphosphatemia. Patient has chronic kidney disease (CKD). Patient is on dialysis.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
N/A
MEDICATION(S)
AUSTEDO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chorea associated with Huntington's disease (initial): Diagnosis of Chorea associated with Huntington's disease. Tardive dyskinesia (initial): Diagnosis of moderate to severe tardive dyskinesia. One of the following: 1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication or 2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Huntington's disease chorea (initial): Prescribed by a neurologist. Tardive dyskinesia (initial): Prescribed by or in consultation with a neurologist or psychiatrist.

COVERAGE DURATION
initial: 3 months, Reauth: 12 months

OTHER CRITERIA
All indications (Reauth): Documentation of positive clinical response to Austedo therapy.
BAVENCIO (S)

MEDICATION(S)
BAVENCIO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Merkel Cell Carcinoma (MCC): Diagnosis of metastatic Merkel cell carcinoma. Urothelial Carcinoma (UC): Diagnosis of locally advanced or metastatic urothelial carcinoma. One of the following: 1) Patient has disease progression during or following platinum-containing chemotherapy, OR 2) Patient has disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy

AGE RESTRICTION
MCC: Patient is 12 years of age or older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy
**BELEODAQ (S)**

**MEDICATION(S)**
BELEODAQ

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Peripheral T-cell lymphoma (PTCL): Diagnosis of PTCL. Trial and failure, contraindication, or intolerance to at least one prior therapy (e.g., conventional chemotherapy).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with a hematologist/oncologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
MEDICATION(S)
BENLYSTA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Systemic lupus erythematosus (SLE) (init): Diagnosis of active SLE. Autoantibody positive (ie, anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL). Currently receiving at least one standard of care treatment for active SLE (eg, antimalarials [eg, Plaquenil (hydroxychloroquine)], corticosteroids [eg, prednisone], or immunosuppressants [eg, methotrexate, Imuran (azathioprine), CellCept (mycophenolate mofetil)]).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
SLE (init): Prescribed by or in consultation with a rheumatologist

COVERAGE DURATION
SLE (init, reauth): 6 months

OTHER CRITERIA
SLE (reauth): Documentation of positive clinical response to Benlysta therapy
MEDICATION(S)
ALPRAZOLAM 0.25 MG TABLET, ALPRAZOLAM 0.5 MG TABLET, ALPRAZOLAM 1 MG TABLET, ALPRAZOLAM 2 MG TABLET, ALPRAZOLAM ER, ALPRAZOLAM XR, CHLORDIAZEPoxide HCL, ESTAZOLAM, LORAZEPAM 0.5 MG TABLET, LORAZEPAM 1 MG TABLET, LORAZEPAM 2 MG TABLET, LORAZEPAM 2 MG/ML ORAL CONCENT, LORAZEPAM INTENSOL, TEMAZEPAM

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
For alprazolam only: concomitant use with ketoconazole or itraconazole.

REQUIRED MEDICAL INFORMATION
Verify the medication is being used for an FDA-approved diagnosis or compendia-supported indication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
BERINERT (S)

MEDICATION(S)
BERINERT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HAE: Prescribed by or in consultation with an immunologist, allergist, or rheumatologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
**MEDICATION(S)**
BORTEZOMIB

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Multiple myeloma (MM): Diagnosis of MM. Mantle cell lymphoma (MCL): Diagnosis of MCL AND patient has received at least one prior therapy for MCL.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
MM, MCL: Prescribed by or in consultation with an oncologist/hematologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
**MEDICATION(S)**
BOSULIF

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Chronic myelogenous/myeloid leukemia (CML): Diagnosis of Philadelphia chromosome-positive (Ph+) CML.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist or hematologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
**MEDICATION(S)**
BOTOX

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Migraine (Initial): Prescribed by a neurologist or pain specialist. CBP (Initial): Prescribed by a neurologist, neurosurgeon, orthopedist, or pain specialist. UI, OAB (initial): Prescribed by a neurologist, neurosurgeon, or urologist.
COVERAGE DURATION
Achalasia: 6mo
CBP: 1 tx (series of injxs)
UI: 3mo (1 dose, 200 units)
Other: 3mo

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

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renal cell carcinoma (RCC): Diagnosis of RCC. RCC is advanced.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
CALQUENCE (S)

MEDICATION(S)
CALQUENCE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma (MCL) AND patient has received at least one prior therapy for MCL

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
CAPRELSA (S)

MEDICATION(S)
CAPRELSA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Thyroid Cancer: Diagnosis of medullary thyroid cancer (MTC)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with oncologist or endocrinologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
CARISOPRODOL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
CAYSTON

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Cystic fibrosis (CF) (Initial, Reauth): Diagnosis of CF AND Patient has evidence of Pseudomonas aeruginosa in the lungs

AGE RESTRICTION
CF (Initial): 7 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
CF (Initial, reauth): 12 months

OTHER CRITERIA
CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations)
MEDICATION(S)
CERDELGA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Gaucher disease (initial, reauth): 12 months

OTHER CRITERIA
Gaucher disease (Reauth): Patients condition has not progressed, as defined by ALL of the following: A) Hemoglobin level decreased greater than 1.5 g/dL from baseline, AND B) Platelet count decreased greater than 25% from baseline, AND C) Spleen volume increased greater than 25% from baseline, AND D) Liver volume increased greater than 20% from baseline.
MEDICATION(S)
CEREZYME 400 UNITS VIAL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Gaucher disease: 12 months

OTHER CRITERIA
N/A
MEDICATION(S)
CHOLBAM

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
All uses (initial, reauth): 12 months

OTHER CRITERIA
All uses (reauth): documentation of positive clinical response to Cholbam therapy
CHORIONIC GONADOTROPIN (S)

MEDICATION(S)
CHORIONIC GONAD 10,000 UNIT VL, NOVAREL, PREGNYL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
Excluded if used to promote fertility. MHH (Reauth): Documentation of positive clinical response to therapy.
MEDICATION(S)
CICLOPIROX 8% SOLUTION

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
All of the following: 1) Patient does not have dermatophytomas or lunula (matrix) involvement, 2) one of the following: a) Diagnosis of onychomycosis of the toenails, OR b) Diagnosis of onychomycosis of the fingernails, 3) Diagnosis of onychomycosis has been confirmed by one of the following: a) positive potassium hydroxide (KOH) preparation, OR b) culture, OR c) histology, 4) If toenail onychomycosis, patient has mild to moderate disease involving at least 1 great toenail, AND 5) Trial and inadequate response, intolerance or hypersensitivity to oral terbinafine.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
48 weeks.

OTHER CRITERIA
N/A
MEDICATION(S)
CIMZIA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis (RA, initial): Diagnosis (dx) of moderately to severely active RA. TF/C/I to Enbrel and Humira, or attestation demonstrating a trial may be inappropriate, OR for continuation of prior Cimzia therapy. Crohn's Disease (CD, initial): Dx of moderately to severely active CD. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine (Purinethol), Azathioprine (Imuran), Corticosteroid (eg, prednisone, methylprednisolone), Methotrexate (Rheumatrex, Trexall). TF/C/I to Humira OR for continuation of prior Cimzia therapy. Psoriatic Arthritis (PsA, initial): Dx of active PsA. TF/C/I to Cosentyx and either Humira or Enbrel OR for continuation of prior Cimzia therapy. Ankylosing Spondylitis (AS, initial): Dx of active AS. TF/C/I to Enbrel and Humira, or attestation demonstrating a trial may be inappropriate, OR for continuation of prior Cimzia therapy. Plaque Psoriasis (initial): Dx of moderate to severe plaque psoriasis. TF/C/I to Cosentyx AND either Humira or Enbrel OR for continuation of prior Cimzia therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
**MEDICATION(S)**
CINRYZE

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Prophylaxis of hereditary angioedema (HAE) attacks: Diagnosis of HAE. For prophylaxis against HAE attacks. For continuation of prior therapy or Trial and failure, contraindication, or intolerance of one of the following: 17-alpha alkylated androgen (eg, danazol, oxandrolone) or antifibrinolytics (eg, aminocaproic acid, tranexamic acid).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
HAE (prophylaxis, treatment): Prescribed by or in consultation with an immunologist, allergist, or rheumatologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
N/A
MEDICATION(S)
COMETRIQ

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medullary thyroid cancer (MTC): Diagnosis of Metastatic MTC.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
MTC: Prescribed by or in consultation with an oncologist/hematologist or endocrinologist.

COVERAGE DURATION
All uses: 12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
CORLANOR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic heart failure (CHF) (initial): Diagnosis of CHF with NYHA Class II, III, or IV symptoms. Left ventricular ejection fraction less than or equal to 35%. Patient is in sinus rhythm with a resting heart rate of greater than or equal to 70 BPM and has been hospitalized for worsening HF in the previous 12 months. Trial and failure, intolerance, or contraindication to maximally tolerated doses of at least one beta-blocker with proven mortality benefit (i.e., carvedilol, bisoprolol, sustained-release metoprolol) AND trial and failure, intolerance, or contraindication to maximally tolerated doses of an ACE inhibitor or ARB.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CHF (initial): Prescribed by or in consultation with a cardiologist

COVERAGE DURATION
CHF (initial, reauth): 12 months

OTHER CRITERIA
CHF (reauth): patient does not have contraindications/exclusions to therapy.
MEDICATION(S)
COSENTYX (2 SYRINGES), COSENTYX PEN, COSENTYX PEN (2 PENS), COSENTYX SYRINGE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Trial and failure, contraindication, or intolerance to Enbrel (etanercept) OR Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: Trial and failure, contraindication, or intolerance to Enbrel (etanercept) or Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: Trial and failure, contraindication, or intolerance to Enbrel (etanercept) or Humira (adalimumab), OR for continuation of prior Cosentyx therapy. All indications (Initial, reauth): Patient is not receiving Cosentyx in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

AGE RESTRICTION
N/A

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

COVERAGE DURATION
All indications (Initial, reauth): 12 months

OTHER CRITERIA
All indications (Reauth): Documentation of positive clinical response to Cosentyx therapy.
MEDICATION(S)
COTELLIC

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Melanoma: Diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation as detected by an FDA-approved test (e.g., cobas 4800 BRAF V600 Mutation Test) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with vemurafenib.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
CRINONE (S)

MEDICATION(S)
CRINONE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
All indications: Excluded if for fertility uses.

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
CYRAMZA (S)

MEDICATION(S)
CYRAMZA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Gastric cancer: All of the following: 1) diagnosis of one of the following: a) gastric adenocarcinoma, OR b) gastro-esophageal junction (GEJ) adenocarcinoma, AND 2) disease is one of the following: a) locally advanced, OR b) metastatic, AND 3) disease has progressed on or after one of the following first-line therapies: a) fluoropyrimidine-containing chemotherapy (eg, fluorouracil, capecitabine), OR b) platinum-containing chemotherapy (eg, cisplatin, carboplatin, oxaliplatin). Non-small cell lung cancer: All of the following: 1) diagnosis of metastatic non-small cell lung cancer, AND 2) used in combination with docetaxel, AND 3) disease has progressed on or after platinum-based chemotherapy (eg, cisplatin, carboplatin, oxaliplatin). Metastatic colorectal cancer (mCRC): 1) Diagnosis of metastatic CRC AND 2) Patient had disease progression on or after prior therapy with bevacizumab, oxaliplatin, and a fluoropyrimidine.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
CYSTARAN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Cystinosis: Diagnosis of cystinosis, confirmed by elevated leukocyte cystine levels (LCL), genetic analysis of the CTNS gene or corneal cystine crystal accumulation AND Patient is concomitantly receiving treatment with oral cysteamine

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
DACOGEN (S)

MEDICATION(S)
DECITABINE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Myelodysplastic syndrome (MDS): Diagnosis of myelodysplastic syndrome.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
DAKLINZA (S)

MEDICATION(S)
DAKLINZA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria will be applied consistent with current AASLD/IDSA guideline. For genotype 1, ONE of the following: 1) Patient has had a trial and failure, contraindication or intolerance to both of the following: a) Harvoni or Epclusa AND b) Mavyret OR 2) For continuation of prior Daklinza therapy. For genotype 1 liver transplant recipient, ONE of the following: 1) Patient has had a trial and failure, contraindication or intolerance to Harvoni OR Mavyret OR 2) For continuation of prior Daklinza therapy. For genotype 2 or 3 (except liver transplant recipients), ONE of the following: 1) Patient has had a trial and failure, contraindication or intolerance to one of the following: Epclusa or Mavyret OR 2) For continuation of prior Daklinza therapy. For genotype 2 or 3 liver transplant recipients without cirrhosis, ONE of the following: 1) Patient has had a trial and failure, contraindication or intolerance to Mavyret OR 2) For continuation of prior Daklinza therapy. For genotype 2 or 3 liver transplant recipients with decompensated cirrhosis, ONE of the following: 1) Patient has had a trial and failure, contraindication or intolerance to Epclusa OR 2) For continuation of prior Daklinza therapy. All: One of the following: 1) Patient has not failed a prior HCV NS5A-containing regimen (eg, Daklinza) OR 2) patient has failed prior therapy with an NS5A-containing regimen AND submission of medical records (eg, chart notes) documenting that the patient does not have NS5A inhibitor resistance-associated variants detected using commercially available assays. All: One of the following: 1) requested daily dosage is less than 90 mg OR 2) both of the following: requested daily dosage is equal to 90 mg and patient is concomitantly receiving a moderate CYP3A inducer (eg, bosentan, dexamethasone, efavirenz, etravirine, modafinil).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
COVERAGE DURATION
12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline

OTHER CRITERIA
N/A
MEDICATION(S)
DALIRESP

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic Obstructive Pulmonary Disease (COPD): (Initial) Diagnosis of moderate to very severe COPD. Patient has chronic bronchitis. Trial and failure, intolerance, or contraindication to two prior therapies for COPD.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
COPD (init, reauth): 12 months

OTHER CRITERIA
COPD (reauth): Documentation of positive clinical response to Daliresp therapy.
MEDICATION(S)
DARAPRIM

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Toxoplasmosis: 1) Patient is using Daraprim for the treatment of toxoplasmic encephalitis, secondary prophylaxis of toxoplasmic encephalitis, or treatment of congenital toxoplasmosis OR 2) Patient is using Daraprim for the primary prophylaxis of toxoplasmic encephalitis, patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX), and one of the following: patient has been re-challenged with TMP-SMX using a desensitization protocol and is still unable to tolerate, or evidence of life-threatening reaction to TMP-SMX in the past (eg, toxic epidermal necrolysis, Stevens-Johnson syndrome). Malaria: Patient is using Daraprim for the treatment of acute malaria or chemoprophylaxis of malaria. Patient does not have megaloblastic anemia due to folate deficiency. The provider acknowledges that Daraprim is not recommended by the Centers for Disease Control and Prevention (CDC) for the treatment and/or prophylaxis of malaria.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an infectious disease specialist

COVERAGE DURATION
12 months

OTHER CRITERIA
Toxoplasmosis only: Approve for continuation of prior therapy.
MEDICATION(S)
DARZALEX

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Relapsed/Refractory Multiple Myeloma (MM): Diagnosis of MM. One of the following: A) Patient has received at least three prior treatment regimens which included both a proteasome inhibitor (eg, bortezomib [Velcade], carfilzomib [Kyprolis]) and an immunomodulatory agent (eg, lenalidomide [Revlimid], thalidomide [Thalomid]) or patient is double-refractory to a proteasome inhibitor and an immunomodulatory agent. OR B) Patient has received at least one prior therapy. Darzalex will be used in combination with either 1) lenalidomide and dexamethasone or 2) bortezomib and dexamethasone. OR C) Both of the following: used in combination with either pomalidomide and dexamethasone, AND patient has received at least two prior therapies including lenalidomide and a proteasome inhibitor (e.g., bortezomib [Velcade], carfilzomib [Kyprolis]). Newly Diagnosed Multiple Myeloma: Newly diagnosed multiple myeloma, patient is ineligible for autologous stem cell transplant and used in combination with all of the following: bortezomib, melphalan, and prednisone.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist/hematologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy
DEFERASIROX (S)

MEDICATION(S)
EXJADE, JADENU, JADENU SPRINKLE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

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

PRESCRIBER RESTRICTION
N/A

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

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

MEDICATION(S)
DEXMETHYLPHENIDATE HCL, DEXMETHYLPHENIDATE HCL ER

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to members 19 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
DEXTROAMPHETAMINE (S)

MEDICATION(S)
DEXTROAMPHETAMINE 10 MG TAB, DEXTROAMPHETAMINE 5 MG TAB,
DEXTROAMPHETAMINE SULFATE ER

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to members 19 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
DUPIXENT 300 MG/2 ML SAFE SYRG

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Atopic dermatitis (initial): Diagnosis of moderate to severe atopic dermatitis. Trial and failure, contraindication, or intolerance to one medium to high potency topical corticosteroid. One of the following: A) Trial and failure or intolerance to Elidel (pimecrolimus) topical cream, unless the patient is not a candidate for Elidel therapy (e.g., immunocompromised, severe atopic dermatitis), B) Trial and failure or intolerance to tacrolimus topical ointment, unless the patient is not a candidate for tacrolimus ointment therapy (e.g., immunocompromised).

AGE RESTRICTION
Initial: Age 18 years of age or older

PRESCRIBER RESTRICTION
Initial: Prescribed by or in consultation with one of the following: dermatologist, allergist/immunologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Atopic dermatitis (reauth): Documentation of a positive clinical response to Dupixent therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity)
MEDICATION(S)
ELAPRASE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of Hunter Syndrome (Mucopolysaccharidosis II (MPS II))

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
EMFLAZA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial: Diagnosis of Duchenne muscular dystrophy (DMD) AND Patient has received genetic testing for a mutation of the dystrophin gene AND One of the following: A) Documentation of a confirmed mutation of the dystrophin gene or B) Muscle biopsy confirmed an absence of dystrophin protein AND Patient has had a trial and failure or intolerance to prednisone or prednisolone AND Dose will not exceed 0.9 milligrams per kilogram of body weight once daily

AGE RESTRICTION
Initial: 5 years of age or older

PRESCRIBER RESTRICTION
Initial: Prescribed by or in consultation with a neurologist who has experience treating children

COVERAGE DURATION
12 months

OTHER CRITERIA
Reauthorization: Patient has experienced a benefit from therapy (e.g., improvement or preservation of muscle strength) AND Dose will not exceed 0.9 milligrams per kilogram of body weight once daily
EMPLICITI (S)

MEDICATION(S)
EMPLICITI

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple myeloma: Diagnosis of multiple myeloma. Patient has received at least one prior therapy for multiple myeloma [eg, Revlimid (lenalidomide), Thalomid (thalidomide), Velcade (bortezomib)].

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
ENBREL (S)

MEDICATION(S)
ENBREL, ENBREL MINI, ENBREL SURECLICK

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Failure, contraindication, or intolerance to one disease-modifying antirheumatic drug (DMARD) [eg, methotrexate (Rheumatrex/Trexall), Arava (leflunomide), Azulfidine (sulfasalazine)]. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Trial and failure, contraindication, or intolerance to one of the following DMARDs: Arava (leflunomide) or methotrexate (Rheumatrex/Trexall). Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. Plaque psoriasis (Initial): Diagnosis of moderate to severe chronic plaque psoriasis. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Trial and failure, contraindication, or intolerance to two NSAIDs.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA (Initial), PJIA (Initial), AS (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. Plaque Psoriasis (Initial): Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION
All indications (Initial, reauth): 12 months

OTHER CRITERIA
All indications (Reauth): Documentation of positive clinical response to Enbrel therapy.
MEDICATION(S)
ENDARI

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Sickle cell disease (initial): Diagnosis of sickle cell disease. Used to reduce acute complications of sickle cell disease. One of the following: (a) Patient is using Endari with concurrent hydroxyurea therapy, OR (b) Patient has a contraindication or intolerance to hydroxyurea. Patient has had 2 or more painful sickle cell crises within the past 12 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Sickle cell disease (initial): Prescribed by or in consultation with a hematologist/oncologist

COVERAGE DURATION
Sickle cell disease (initial, reauth): 12 months

OTHER CRITERIA
Sickle cell disease (reauth): Documentation of positive clinical response to Endari therapy.
MEDICATION(S)
EPCLUSA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria will be applied consistent with current AASLD/IDSA guideline. Diagnosis of chronic hepatitis C virus. Patient is not receiving Epclusa in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir), Olysio (simeprevir)].

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A
MEDICATION(S)
PROCRIT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with HIV (Initial): Anemia by lab values (Hgb less than 12 g/dL or Hct less than 36%) collected within 30 days of request. Serum erythropoietin level less than or equal to 500 mU/mL. Receiving zidovudine therapy or dx of HIV. Anemia with chemo (Initial): Other causes of anemia have been ruled out. Anemia by lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request. Cancer is a non-myeloid malignancy. Patient is concurrently on chemo, or will receive concomitant chemo for a minimum of 2 mos, or anemia is caused by cancer chemo. Will not be approved if patient is not receiving cancer chemotherapy. Preoperative for reduction of allogeneic blood transfusion: Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery. Hgb is greater than 10 to less than or equal to 13 g/dL. Patient is at high risk for perioperative transfusions. Patient is unwilling or unable to donate autologous blood pre-operatively. Anemia in hepatitis C virus (HCV)-infected pts due to ribavirin in combination with interferon or peg-interferon (Initial): Dx of HCV infection. Anemia by labs (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. Patient is receiving ribavirin and one of the following: interferon alfa or peginterferon alfa. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of MDS. Serum erythropoietin level is 500 mU/mL or less, or dx of transfusion-dependent MDS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A
COVERAGE DURATION

OTHER CRITERIA
Subject to ESRD review. CKD (Reauth): Dx of CKD. Most recent or average (avg) Hct over 3 months is 33% or less OR most recent or avg Hgb over 3 months is 11 g/dL or less. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. HIV (Reauth): Most recent or avg Hct over 3 months is below 36% or most recent or avg Hgb over 3 months is below 12 g/dL. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Chemo (Reauth): Anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Patient is concurrently on chemo, or will receive concomitant chemo for a minimum of 2 months, or anemia is caused by cancer chemo. Will not be approved if patient is not receiving cancer chemotherapy. HCV (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. If patient has demonstrated response to therapy, authorization will be issued for the full course of ribavirin therapy. MDS (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Off-label uses (except MDS): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%. CKD (init, reauth), HIV (init), Chemo (init), Preop, MDS (init), HCV (init): Verify iron evaluation for adequate iron stores.
ERBITUX (S)

**MEDICATION(S)**
ERBITUX 100 MG/50 ML VIAL

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist

**COVERAGE DURATION**
12 months.

**OTHER CRITERIA**
Approve for continuation of prior therapy.
**MEDICATION(S)**
ERIVEDGE

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Basal cell carcinoma: One of the following: A) Diagnosis of metastatic basal cell carcinoma OR B) Both of the following: 1) Diagnosis of locally advanced basal cell carcinoma AND 2) One of the following: a) Disease recurred following surgery or b) Patient is not a candidate for surgery and radiation.

**AGE RESTRICTION**
18 years of age or older

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist or dermatologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
ERLEADA (S)

**MEDICATION(S)**
ERLEADA

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Non-metastatic castration-resistant prostate cancer (NM-CRPC): Diagnosis of non-metastatic, castration-resistant (chemical or surgical) prostate cancer. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog OR 2) Patient received a bilateral orchiectomy.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist or urologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy
ESBRIET (S)

MEDICATION(S)
ESBRIET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Idiopathic pulmonary fibrosis (IPF) (initial): Both of the following: 1) diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity), AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF, AND 2) not used in combination with Ofev (nintedanib).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
IPF (initial): Prescribed by a pulmonologist

COVERAGE DURATION
initial, reauth: 12 months

OTHER CRITERIA
IPF (reauth): Documentation of positive clinical response to Esbriet therapy
EXONDYS 51 (S)

MEDICATION(S)
EXONDYS 51

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial: Diagnosis of Duchenne muscular dystrophy (DMD). Documentation of a confirmed mutation of the dystrophin gene amenable to exon 51 skipping. Patient is ambulatory. Initial/Reauth: Exondys 51 dosing for DMD is in accordance with the United States Food and Drug Administration approved labeling: maximum dosing of 30 mg/kg infused once weekly.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
(initial, reauth): Prescribed by or in consultation with a neurologist who has experience treating children

COVERAGE DURATION
Initial: 6 months, Reauth: 12 months

OTHER CRITERIA
Reauth: One of the following: 1) All of the following: Patient has been on therapy for less than 12 months, patient is maintaining ambulatory status, and patient is tolerating therapy, OR 2) All of the following: Patient has been on therapy for 12 months or more, Patient is maintaining ambulatory status, patient has experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients), and patient is tolerating therapy.
MEDICATION(S)
FABRAZYME 35 MG VIAL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Fabry Disease: Diagnosis of Fabry disease.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Fabry Disease: 12 months

OTHER CRITERIA
N/A
MEDICATION(S)
FARYDAK

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple Myeloma (MM): Diagnosis of MM. Used in combination with both of the following: Velcade (bortezomib) and dexamethasone. Patient has received at least two prior treatment regimens which included both of the following: Velcade (bortezomib) and an immunomodulatory agent [eg, Revlimid (lenalidomide), Thalomid (thalidomide)].

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist/hematologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
FASENRA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Severe asthma (initial): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline blood eosinophil level greater than or equal to 150 cells per microliter. One of the following: 1) Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids within the past 12 months, OR 2) Any prior intubation for an asthma exacerbation, OR 3) Prior asthma-related hospitalization within the past 12 months. Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) High-dose inhaled corticosteroid (ICS) [e.g., greater than 500 mcg fluticasone propionate equivalent/day] and ii) additional asthma controller medication [e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline], OR b) One maximally-dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

AGE RESTRICTION
Initial: Patient is 12 years of age or older

PRESCRIBER RESTRICTION
Initial/Reauth: Prescribed by or in consultation with a pulmonologist or allergy/immunology specialist

COVERAGE DURATION
12 months

OTHER CRITERIA
Reauth: Documentation of a positive clinical response (e.g., reduction in exacerbations). Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) inhaled corticosteroid (ICS) and ii) additional asthma controller medication [e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline], OR b) One maximally-dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]
controller medication [e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline], OR b) A combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]
FENTANYL (S)

MEDICATION(S)
FENTANYL CIT OTFC 1,200 MCG, FENTANYL CIT OTFC 1,600 MCG, FENTANYL CITRATE OTFC 200 MCG, FENTANYL CITRATE OTFC 400 MCG, FENTANYL CITRATE OTFC 600 MCG, FENTANYL CITRATE OTFC 800 MCG

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
FERRIPROX

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Transfusional iron overload due to thalassemia syndromes (Initial): Patient has a diagnosis of transfusional iron overload due to thalassemia syndromes. Absolute neutrophil count (ANC) greater than 1.5 x 10^9/L. One of the following: A) Patient has failed prior chelation therapy (e.g., Exjade) [failure defined as serum ferritin greater than 2,500 mcg/L] OR B) Patient has a contraindication or intolerance to Desferal (deferroxamine) or Exjade (deferasirox).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
All uses (initial, reauth): 12 months

OTHER CRITERIA
All uses (reauth): Patient has experienced greater than or equal to 20% decline in serum ferritin levels from baseline. ANC greater than 0.5 x 10^9/L.
MEDICATION(S)
FIRAZYR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HAE: Prescribed by an immunologist, allergist, or rheumatologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
FIRMAGON

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of advanced or metastatic prostate cancer.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
FOLOTYN 40 MG/2 ML VIAL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
FORTEO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Postmenopausal Osteoporosis or osteopenia or men with primary or hypogonadal osteoporosis or osteopenia: One of the following: Set I) Both of the following: A) Diagnosis of osteoporosis defined as bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) either 1) patient has a history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) patient has a trial and failure, contraindication, or intolerance to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia (denosumab)), or Set II) Both of the following: A) Diagnosis of osteopenia defined by bone mineral density (BMD) T-score of between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site), AND B) One of the following: 1) patient has a history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) both of the following: i) Trial and failure, contraindication, or intolerance to at least one prior osteoporosis therapy (e.g., alendronate, risedronate, zoledronic acid, Prolia (denosumab) and ii) One of the following FRAX 10-year probabilities: a) Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) Hip fracture is 3% or more in the U.S., or the country-specific threshold in other countries or regions. Treatment duration of parathyroid hormones [e.g., Forteo (teriparatide), Tymlos (abaloparatide)] has not exceeded a total of 24 months during the patient's lifetime. Glucocorticoid-Induced Osteoporosis: See Other Criteria section.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
All indications: 24 months, max 2 years of therapy.
OTHER CRITERIA
Glucocorticoid-Induced Osteoporosis: Diagnosis of glucocorticoid-induced osteoporosis. History of prednisone or its equivalent at a dose of greater than or equal to 5mg/day for greater than or equal to 3 months. One of the following: A) BMD T score of -2.0 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) or B) Both of the following: 1) BMD T score between -1.0 and -2.0 (BMD T-score greater than -2.0 and less than or equal to -1.0) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and 2) either history of one of the following fx resulting from minimal trauma (vertebral compression fx, fx of the hip, or fx of the distal radius) or trial and failure, contraindication, or intolerance (TF/C/I) to one bisphosphonate [e.g., Fosamax (alendronate)] or C) Both of the following: 1) history of one of the following fractures resulting from minimal trauma (vertebral compression fx, fx of the hip, or fx of the distal radius) and 2) TF/C/I to one bisphosphonate [e.g., Fosamax (alendronate)]. Treatment duration of parathyroid hormones [e.g., Forteo (teriparatide), Tymlos (abaloparatide)] has not exceeded a total of 24 months during the patient’s lifetime.
MEDICATION(S)
GAMASTAN, GAMASTAN S-D

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months (Approve one dose only)

OTHER CRITERIA
Subject to Part B vs D review.
MEDICATION(S)
GATTEX

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Short Bowel Syndrome (SBS) (Initial) Diagnosis of SBS. Patient is dependent on parenteral nutrition/intravenous (PN/IV) support for at least 12 consecutive months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
SBS (Init): 6 months. SBS (Reauth): 12 months.

OTHER CRITERIA
SBS (Reauth): Documentation of positive clinical response to Gattex therapy.
MEDICATION(S)
GILENYA 0.5 MG CAPSULE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
GILOTRIF (S)

MEDICATION(S)
GILOTRIF

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Non-small cell lung cancer (NSCLC): A) Diagnosis of advanced or metastatic (stage IIIB or IV) NSCLC AND B) One of the following: 1) Both of the following: a) Tumors have non-resistant epidermal growth factor (EGFR) mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility AND b) GILOTRIF will be used as first-line treatment, OR 2) All of the following: a) disease progressed after platinum-based chemotherapy and b) squamous NSCLC

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
GLATIRAMER ACETATE (S)

**MEDICATION(S)**
COPAXONE 40 MG/ML SYRINGE, GLATIRAMER ACETATE, GLATOPA

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
N/A
GLEEVEC (S)

MEDICATION(S)
IMATINIB MESYLATE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For adults 18 years of age or older, One of the following: A) Diagnosis of Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia (CML) AND Patient is found to be Ph+ or BCR-ABL positive as detected by bone marrow cytogenetics, FISH or PCR OR B) Ph+ acute lymphoblastic leukemia (ALL) OR C) Gastrointestinal stromal tumor (GIST) AND one of the following: 1) Patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST, OR 2) Patient had resection of c-KIT (CD117) positive GIST and imatinib will be used as adjuvant therapy OR D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic OR E) Hypereosinophilic syndrome or chronic eosinophilic leukemia OR F) Myelodysplastic syndrome (MDS) or myeloproliferative disease associated with platelet-derived growth factor receptor gene rearrangements OR G) Aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown. For Pediatric patients younger than 18 years of age, One of the following: A) Diagnosis of Ph+ CML that is newly diagnosed in the chronic phase OR B) Diagnosis of newly diagnosed Ph+ALL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
All uses: Prescribed by or in consultation with an oncologist or hematologist

COVERAGE DURATION
All uses: 12 months

OTHER CRITERIA
All uses: Approve for continuation of prior therapy.
MEDICATION(S)
GOCOVRI

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Parkinson's disease (PD) (initial): Diagnosis of Parkinson's disease, patient is experiencing dyskinesia, patient is receiving levodopa-based therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial: Prescribed by or in consultation with a neurologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Parkinson's Disease (reauthorization): Documentation of positive clinical response to Gocovri therapy (e.g., decreased "off" periods or decreased "on" time with troublesome dyskinesia)
GROWTH HORMONE (S)

MEDICATION(S)
GENOTROPIN, NUTROPIN AQ NUSPIN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PGHD(initial): less than 4mo w/GD, or hx neonatal hypoglycemia assoc w/pituitary dz, or panhypopituitarism dx, or all of the following: PGHD dx [confrmd by ht (utilizing age and gender growth charts related to ht) documented (doc) by ht more than 2.0SD below midparental ht or more than 2.25SD below population (pop) mean (below 1.2 percentile for age and gender), or growth velocity more than 2SD below mean for age and gender, or delayed skeletal maturation more than 2SD below mean for age and gender (e.g., delayed more than 2yrs compared w/chronological age)].

PWS(reauth): evidence of positive response to tx (e.g., incr in total LBM, decr in fat mass) and expctd adult ht not attained and doc of expctd adult ht goal.

GFSGA(initial): SGA dx based on catchup growth failure in 1st 24mo of life using 0-36mo growth chart confirmed by birth wt or length below 3rd percentile for gestational age (more than 2SD below pop mean) and ht remains at or below 3rd percentile (more than 2SD below pop mean). TS, NS(initial): ped growth failure dx assoc w/TS w/doc female w/bone age less than 14yrs, or NS and ht below 5th percentile on growth charts for age and gender.

SHOX(initial): ped growth failure dx w/SHOX gene deficiency confirmed by genetic testing.

GFCRI(initial): ped growth failure dx assoc w/CRI. ISS(initial): ISS dx, diagnostic eval excluded other causes assoc w/short stature (e.g., GHD, chronic renal insufficiency), doc ht at or below -2.25SD score below corresponding mean ht for age and gender, doc growth velocity less than 25th percentile for bone age. PGHD, NS, SHOX, GFCRI, ISS (initial): doc male w/bone age less than 16yrs or female w/bone age less than 14yrs. PGHD, GFSGA, TS/NS, SHOX, GFCRI, ISS(reauth): expctd adult ht not attained and doc of expctd adult ht goal.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, TPAP, IGHDA, ISS: prescribed by endocrinologist.
GFCRI: prescribed by endocrinologist or nephrologist
COVERAGE DURATION
All indications (initial, reauth): 12 months

OTHER CRITERIA
Trial and failure or intolerance to Genotropin and Nutropin (no prerequisites needed for Genotropin and Nutropin). AGHD (initial): dx of AGHD with clin records supporting dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg, damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and pt has 1 GH stim test (insulin tolerance test [ITT], arginine/GHRH, glucagon, arginine) to confirm adult GHD w/peak GH values ([ITT at or below 5mcg/L], [GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2], [glucagon at or below 3mcg/L], [Arg at or below 0.4mcg/L]) or doc deficiency of 3 anterior pituitary hormones (prolactin, ACTH, TSH, FSH/LH) and IFG-1/somatomedinC below age and gender adj std nrml range as provided by physicians lab. AGHD, IGHDA (reauth): monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. Transition Phase Adolescent Pts (TPAP) (initial): attained expctd adult ht or closed epiphyses on bone radiograph, and doc high risk of GHD d/t GHD in childhood (from embryopathic/congenital defects, genetic mutations, irreversible structural hypothalamic-pituitary dz, panhypopituitarism, or deficiency of 3 anterior pituitary hormones: ACTH, TSH, prolactin, FSH/LH), w/IGF-1/somatomedinC below age and gender adj nrml range as provided by physicians lab, or pt does not have low IGF-1/somatomedinC and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT, GHRH+ARG, ARG, glucagon) after d/c of tx for at least 1mo w/peak GH value ([ITT at or below 5mcg/L], [GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2], [glucagon at or below 3mcg/L], [Arg at or below 0.4mcg/L], or at low risk of severe GHD (eg d/t isolated and/or idiopathic GHD) and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT, GHRH+ARG, ARG, glucagon) after d/c of tx for at least 1mo w/corresponding peak GH value ([ITT at or below 5mcg/L], [GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2], [glucagon at or below 3mcg/L], [Arg at or below 0.4mcg/L]). TPAP (reauth): evidence of positive response to therapy (eg, incr in total lean body mass, exercise capacity or IGF-1 and IGFBP-3). IGHDA (initial): doc GHD by failure to produce peak serum GH greater than 5 mcg/L after 2 provocative pharmacol stim tests (insulin, L-ARG, glucagon).
MEDICATION(S)
H.P. ACTHAR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
Infantile spasms: less than 2 years old

PRESCRIBER RESTRICTION

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

OTHER CRITERIA
HAEGARDA (S)

MEDICATION(S)
HAEGARDA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prophylaxis of hereditary angioedema (HAE) attacks: Diagnosis of HAE. For prophylaxis against HAE attacks. For continuation of prior therapy or trial and failure, contraindication, or intolerance to one of the following: 17-alpha alkylated androgen (e.g., danazol, oxandrolone) or antifibrinolytics (e.g., aminocaproic acid, tranexamic acid).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an immunologist, allergist, or rheumatologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
HALAVEN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
HARVONI

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria will be applied consistent with current AASLD/IDSA guideline. ALL (including patients with genotype 5 or 6 infection AND decompensated cirrhosis): A) Diagnosis of chronic hepatitis C (CHC) virus AND B) Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent [eg, Sovaldi (sofosbuvir), Olysio (simeprevir)].

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A
**MEDICATION(S)**
HERCEPTIN

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Breast cancer: Diagnosis of human epidermal growth factor receptor 2 (HER2)-overexpressing breast cancer. One of the following treatment regimens: a) As adjuvant treatment, b) metastatic disease and one of the following: 1) used in combination with a taxane (eg, docetaxel, paclitaxel), or 2) used as a single agent in a patient who has received one or more chemotherapy regimens for metastatic disease, or c) used in combination with Perjeta (pertuzumab). Gastric Cancer: Diagnosis of HER2-overexpressing gastric or gastroesophageal junction adenocarcinoma (locally advanced, recurrent, or metastatic). Used in combination with one of the following treatment regimens: a) Adrucil (5-fluorouracil), or b) Platinol (cisplatin) and Xeloda (capecitabine).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
All uses: Prescribed by or in consultation with an oncologist.

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
HETLIOZ (S)

MEDICATION(S)
HETLIOZ

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Non-24-Hour Sleep-Wake Disorder (Non-24) (initial): Both of the following: 1) Diagnosis of non-24-hour sleep-wake disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome), AND 2) patient is totally blind (has no light perception).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Non-24 (initial): Prescribed by or in consultation with a specialist in sleep disorders or neurologist

COVERAGE DURATION
Non-24 (initial): 6 mo. (reauth): 12 mo

OTHER CRITERIA
Non-24 (reauth): Documentation of positive clinical response to Hetlioz therapy.
HRM - ANTIHISTAMINES

MEDICATION(S)
CYPROHEPTADINE 4 MG TABLET, HYDROXYZINE 10 MG/5 ML SOLN, HYDROXYZINE 10 MG/5 ML SYRUP, HYDROXYZINE 100 MG/2 ML VIAL, HYDROXYZINE 25 MG/ML VIAL, HYDROXYZINE 50 MG/25 ML SYRUP, HYDROXYZINE 50 MG/ML VIAL, HYDROXYZINE 500 MG/10 ML VIAL, HYDROXYZINE HCL 10 MG TABLET, HYDROXYZINE HCL 25 MG TABLET, HYDROXYZINE HCL 50 MG TABLET, HYDROXYZINE PAM 100 MG CAP, HYDROXYZINE PAM 25 MG CAP, HYDROXYZINE PAM 50 MG CAP, MECLIZINE 12.5 MG TABLET, MECLIZINE 25 MG TABLET, PHENADOZ 12.5 MG SUPPOSITORY, PHENERGAN 12.5 MG SUPPOSITORY, PHENERGAN 25 MG SUPPOSITORY, PHENERGAN 50 MG SUPPOSITORY, PROMETHAZINE 12.5 MG SUPPOS, PROMETHAZINE 12.5 MG TABLET, PROMETHAZINE 25 MG SUPPOSITORY, PROMETHAZINE 25 MG TABLET, PROMETHAZINE 25 MG/ML AMPUL, PROMETHAZINE 25 MG/ML VIAL, PROMETHAZINE 50 MG SUPPOSITORY, PROMETHAZINE 50 MG TABLET, PROMETHAZINE 50 MG/ML AMPUL, PROMETHAZINE 50 MG/ML VIAL, PROMETHAZINE 6.25 MG/5 ML SOLN, PROMETHAZINE 6.25 MG/5 ML SYRP, PROMETHEGAN 25 MG SUPPOSITORY, PROMETHEGAN 50 MG SUPPOSITORY

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months
OTHER CRITERIA
N/A
MEDICATION(S)
GUANFACINE HCL, METHYLDOPA, METHYLDOPA-HYDROCHLOROTHIAZIDE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) unless alternative(s) is/are inappropriate or would not be applicable for the indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Requires trial of at least one Non-HRM alternative: Low dose thiazide or a second generation calcium channel blocker OR ACE inhibitor, ARB, beta-blocker or combination product based on specific chronic conditions
MEDICATION(S)
BENZTROPINE MES 0.5 MG TAB, BENZTROPINE MES 1 MG TABLET, BENZTROPINE MES 2 MG TABLET, TRIHEXYPHENIDYL 2 MG TABLET, TRIHEXYPHENIDYL 5 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
THIORIDAZINE HCL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) unless alternative(s) is/are inappropriate or would not be applicable for the indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Applies to New Starts only. Requires trial of at least one Non-HRM alternative: haloperidol, atypical antipsychotic
**MEDICATION(S)**
DICYCLOMINE 10 MG CAPSULE, DICYCLOMINE 10 MG/5 ML SOLN, DICYCLOMINE 20 MG TABLET, DICYCLOMINE 20 MG/2 ML VIAL, DIPHENOXYLATE-ATROP 2.5-0.025, SCOPOLAMINE, TRANSDERM-SCOP

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
PA applies to patients 65 years or older

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
N/A
MEDICATION(S)
DIGITEK 250 MCG TABLET, DIGOX 250 MCG TABLET, DIGOXIN 0.05 MG/ML SOLUTION,
DIGOXIN 0.25 MG TABLET, DIGOXIN 0.25 MG/ML SYRINGE, DIGOXIN 250 MCG TABLET,
DIGOXIN 500 MCG/2 ML AMPULE, DISOPYRAMIDE PHOSPHATE, LANOXIN 187.5 MCG TABLET,
NORPACE CR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
ERGOLOID MESYLATES 1 MG TAB

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) unless alternative(s) is/are inappropriate or would not be applicable for the indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Requires trial of at least one Non-HRM alternative: donepezil, galantamine, rivastigmine, memantine
MEDICATION(S)
MEGESTROL 20 MG TABLET, MEGESTROL 40 MG TABLET, MEGESTROL 625 MG/5 ML SUSP, MEGESTROL ACET 40 MG/ML SUSP, MEGESTROL ACET 400 MG/10 ML

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Applies to New Starts only.
MEDICATION(S)
MENEST 0.3 MG TABLET, MENEST 0.625 MG TABLET, MENEST 1.25 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of therapy.
**MEDICATION(S)**
AMABELZ, CLIMARA PRO, DIVIGEL, ELESTRIN, ESTRADIOL 0.025 MG PATCH, ESTRADIOL 0.0375 MG PATCH, ESTRADIOL 0.0375 MG/DAY PATCH, ESTRADIOL 0.05 MG PATCH, ESTRADIOL 0.06 MG/DAY PATCH, ESTRADIOL 0.075 MG PATCH, ESTRADIOL 0.075 MG/DAY PATCH, ESTRADIOL 0.1 MG PATCH, ESTRADIOL 0.5 MG TABLET, ESTRADIOL 1 MG TABLET, ESTRADIOL 2 MG TABLET, ESTRADIOL TDS 0.025 MG/DAY, ESTRADIOL TDS 0.0375 MG/DAY, ESTRADIOL TDS 0.05 MG/DAY, ESTRADIOL TDS 0.06 MG/DAY, ESTRADIOL TDS 0.075 MG/DAY, ESTRADIOL TDS 0.1 MG/DAY, ESTRADIOL-NORETHINDRONE ACETAT, ESTROPIPATE, FYAVOLV, JINTELI, MIMVEY, MIMVEY LO, NORETHIN-ETH ESTRAD 1 MG-5 MCG, NORETHIND-ETH ESTRAD 0.5-2.5, PREMARIN 0.3 MG TABLET, PREMARIN 0.45 MG TABLET, PREMARIN 0.625 MG TABLET, PREMARIN 0.9 MG TABLET, PREMARIN 1.25 MG TABLET, PREMPHASE, PREMPRO

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication. Breast cancer (formulary estradiol tablet and Premarin): Dx of breast cancer. Disease is metastatic. Used for palliative treatment. Prostatic carcinoma (formulary estradiol tablet and Premarin): Dx of advanced androgen-dependent carcinoma of the prostate. Used for palliative treatment.

**AGE RESTRICTION**
PA applies to patients 65 years or older

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months
OTHER CRITERIA
Breast cancer and prostatic carcinoma (formulary estradiol tablet and Premarin): Approve for continuation of therapy.
MEDICATION(S)
BUTALBITAL-ACETAMINOPHEN, BUTALBITAL-ASA-CAFFEINE CAP, INDOMETHACIN 25 MG CAPSULE, INDOMETHACIN 50 MG CAPSULE, KETOROLAC 10 MG TABLET, KETOROLAC 15 MG/ML VIAL, KETOROLAC 30 MG/ML CARPUJECT, KETOROLAC 30 MG/ML VIAL, KETOROLAC 60 MG/2 ML CARPUJECT, TENCON, VANATOL LQ, VANATOL S

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) unless alternative(s) is/are inappropriate or would not be applicable for the indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Requires trial of at least one Non-HRM alternative: Mild pain: codeine. Moderate to severe pain: short-term NSAIDs, tramadol, tramadol/APAP, morphine sulfate, hydrocodone/APAP, oxycodone, oxycodone/APAP, fentanyl.
MEDICATION(S)
PAROXETINE CR, PAROXETINE ER, PAROXETINE HCL, PAXIL 10 MG/5 ML SUSPENSION

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Applies to New Starts only.
MEDICATION(S)
PHENOBARBITAL 100 MG TABLET, PHENOBARBITAL 15 MG TABLET, PHENOBARBITAL 16.2 MG TABLET, PHENOBARBITAL 20 MG/5 ML ELIX, PHENOBARBITAL 20 MG/5 ML SOLN, PHENOBARBITAL 30 MG TABLET, PHENOBARBITAL 32.4 MG TABLET, PHENOBARBITAL 60 MG TABLET, PHENOBARBITAL 64.8 MG TABLET, PHENOBARBITAL 97.2 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of therapy.
MEDICATION(S)
ZALEPLON, ZOLPIDEM TARTRATE 10 MG TABLET, ZOLPIDEM TARTRATE 5 MG TABLET, ZOLPIDEM TARTRATE ER

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) when used longer than 90 days and wishes to proceed with the originally prescribed medication AND intended duration of therapy will be verified.

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
CHLORZOXAZONE 500 MG TABLET, CYCLOBENZAPRINE 10 MG TABLET, CYCLOBENZAPRINE 5 MG TABLET, METHOCARBAMOL 500 MG TABLET, METHOCARBAMOL 750 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
GLYBURIDE 1.25 MG TABLET, GLYBURIDE 2.5 MG TABLET, GLYBURIDE 5 MG TABLET, GLYBURIDE MICRONIZED, GLYBURIDE-METFORMIN HCL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) unless alternative(s) is/are inappropriate or would not be applicable for the indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Requires trial of at least one Non-HRM alternative: glimepiride, glipizide
MEDICATION(S)
AMITRIPTYLINE HCL 10 MG TAB, AMITRIPTYLINE HCL 100 MG TAB, AMITRIPTYLINE HCL 150 MG TAB, AMITRIPTYLINE HCL 25 MG TAB, AMITRIPTYLINE HCL 50 MG TAB, AMITRIPTYLINE HCL 75 MG TAB, AMOXAPINE, CHLORDIAZEPoxide-AMITRIPTYLINE, CLOMIPRAMINE 25 MG CAPSULE, CLOMIPRAMINE 50 MG CAPSULE, CLOMIPRAMINE 75 MG CAPSULE, DESIPRAMINE 10 MG TABLET, DESIPRAMINE 100 MG TABLET, DESIPRAMINE 150 MG TABLET, DESIPRAMINE 25 MG TABLET, DESIPRAMINE 50 MG TABLET, DESIPRAMINE 75 MG TABLET, DOXEPIN 10 MG CAPSULE, DOXEPIN 10 MG/ML ORAL CONC, DOXEPIN 100 MG CAPSULE, DOXEPIN 150 MG CAPSULE, DOXEPIN 25 MG CAPSULE, DOXEPIN 50 MG CAPSULE, DOXEPIN 75 MG CAPSULE, IMIPRAMINE HCL 10 MG TABLET, IMIPRAMINE HCL 25 MG TABLET, IMIPRAMINE HCL 50 MG TABLET, NORTRIPTYLINE 10 MG/5 ML SOL, NORTRIPTYLINE 10 MG/5 ML SOLN, NORTRIPTYLINE 20 MG/10 ML SOLN, NORTRIPTYLINE HCL 10 MG CAP, NORTRIPTYLINE HCL 25 MG CAP, NORTRIPTYLINE HCL 50 MG CAP, NORTRIPTYLINE HCL 75 MG CAP, PERPHENAZINE-AMITRIPTYLINE, PROTRIPTYLINE HCL, TRIMIPRAMINE MALEATE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to patients 65 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
PAGE 122
Applies to New Starts only.
**MEDICATION(S)**
HUMIRA, HUMIRA PEDIATRIC CROHN’S, HUMIRA PEN, HUMIRA PEN CROHN-UC-HS STARTER, HUMIRA PEN PSORIASIS-UVEITIS

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Trial and failure, contraindication, or intolerance (TF/C/I) to one disease modifying antirheumatic drug (DMARD) [eg, methotrexate (Rheumatrex/Trexall), Arava (leflunomide), Azulfidine (sulfasalazine)]. Juvenile Idiopathic Arthritis (JIA) (Initial): Diagnosis of moderately to severely active polyarticular JIA. TF/C/I to one of the following DMARDs: Arava (leflunomide) or methotrexate (Rheumatrex/Trexall). Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. Plaque psoriasis (Initial): Diagnosis of moderate to severe chronic plaque psoriasis. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. TF/C/I to two NSAIDs. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, Imuran (azathioprine), corticosteroid (eg, prednisone, methylprednisolone), methotrexate (Rheumatrex/Trexall), or failure (ie, lost response) or intolerance to infliximab. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, Imuran (azathioprine), corticosteroid (eg, prednisone, methylprednisolone), aminosalicylate [eg, mesalamine (Asacol, Pentasa, Rowasa), Dipentum (olsalazine), Azulfidine (sulfasalazine)]. Hidradenitis suppurativa (Initial): Diagnosis of moderate to severe hidradenitis suppurativa (ie, Hurley Stage II or III). Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis. All indications (initial, reauth): Patient is not receiving Humira in combination with a biologic DMARD [eg, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)].

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
RA, AS, JIA (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque Psoriasis, HS (Initial): Prescribed by
or in consultation with a dermatologist. CD, UC (Initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.

**COVERAGE DURATION**
UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial, reauth): 12 mo.

**OTHER CRITERIA**
RA, JIA, PsA, Plaque psoriasis, AS, CD, Hidradenitis suppurativa (HS), Uveitis (Reauth): Documentation of positive clinical response to Humira therapy. UC (Reauth): For patients who initiated Humira therapy within the past 12 weeks: Documentation of clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on Humira therapy for longer than 12 weeks: Documentation of positive clinical response to Humira therapy.
HYDROXYPROGESTERONE (S)

MEDICATION(S)
HYDROXYPROGEST 1,250 MG/5 ML, HYDROXYPROGESTERONE 1.25 G/5ML

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
All uses (initial): Pregnant patients.

REQUIRED MEDICAL INFORMATION
Amenorrhea: Diagnosis of primary or secondary amenorrhea. Amenorrhea is due to hormonal imbalance in the absence of organic pathology (e.g., submucous fibroids or uterine cancer) Secretory endometrium and desquamation: Used for production of secretory endometrium and desquamation in patients with endometrial disorder. Adenocarcinoma: Diagnosis of Stage III or IV adenocarcinoma of the uterine corpus. Estrogen production test: Used for the testing of endogenous estrogen production.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Adenocarcinoma (initial): Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
IBRANCE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Breast Cancer: Diagnosis of breast cancer. Disease is a) advanced or metastatic, b) hormone-receptor (HR)-positive, and c) human epidermal growth factor receptor 2 (HER2)-negative. One of the following: a) used in combination with an aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) and patient is a postmenopausal woman, OR b) both of the following: used in combination with Faslodex (fulvestrant) and disease has progressed following endocrine therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
**ICLUSIG (S)**

**MEDICATION(S)**
ICLUSIG

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Chronic myelogenous leukemia: Diagnosis of chronic myelogenous leukemia AND One of the following: A) Trial and failure, resistance, relapse, contraindication, or intolerance to at least TWO other tyrosine kinase inhibitors (i.e., Gleevec [imatinib], Sprycel, Tasigna, and Bosulif) or B) Patient has the T315I mutation. Acute Lymphoblastic Leukemia: Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) AND One of the following: A) Trial and failure, resistance relapse, contraindication, or intolerance to at least TWO other FDA-approved tyrosine kinase inhibitors (i.e., Gleevec [imatinib], Sprycel), or B) Patient has the T315I mutation.

**AGE RESTRICTION**
All Uses: 18 years of age or older

**PRESCRIBER RESTRICTION**
All Uses: Prescribed by or in consultation with an oncologist or hematologist

**COVERAGE DURATION**
All uses: 12 months

**OTHER CRITERIA**
All uses: Approve for continuation of prior therapy.
MEDICATION(S)
IDHIFA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Acute Myeloid Leukemia (AML): Diagnosis of AML. Disease is relapsed or refractory. Patient has an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test (e.g., Abbott RealTime IDH2 assay) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
**MEDICATION(S)**
ILARIS

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Periodic Fever Syndromes (Cryopyrin-Associated Periodic Syndromes (CAPS), Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), Familial Mediterranean Fever (FMF)). (Initial) Diagnosis of one of the autoinflammatory Periodic Fever Syndromes: CAPS (including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS)), TRAPS, HIDS/MKD, or FMF, AND The medication will not be used in combination with another biologic agent. Systemic juvenile idiopathic arthritis (sJIA) (Initial): Diagnosis of active sJIA AND The medication will not be used in combination with another biologic

**AGE RESTRICTION**
SJIA (initial): 2 years of age or older

**PRESCRIBER RESTRICTION**
Periodic Fever Syndromes (CAPS, TRAPS, HIDS/MKD, FMF) (initial): Prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist or other medical specialist

**COVERAGE DURATION**
All indications (initial, reauth): 12 months

**OTHER CRITERIA**
Periodic Fever Syndrome (CAPS, TRAPS, HIDS/MKD, FMF) ((Reauth) and SJIA (Reauth): Documentation of positive clinical response to therapy.
**IMBRUVICA (S)**

**MEDICATION(S)**
IMBRUVICA

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Mantle cell lymphoma (MCL): Diagnosis of MCL AND patient has relapsed or is refractory to at least one prior therapy for the treatment of MCL. Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Waldenstrom's macroglobulinemia: Diagnosis of Waldenstrms macroglobulinemia/lymphoplasmacytic lymphoma. Small lymphocytic lymphoma (SLL): Diagnosis of SLL. Marginal zone lymphoma (MZL): Diagnosis of MZL AND patient has received at least one prior anti-CD20-based therapy for MZL [e.g., Rituxan (rituximab), Zevalin (ibritumomab), Gazyva (obinutuzumab, etc.)].

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
All uses: Prescribed by or in consultation with an oncologist or hematologist

**COVERAGE DURATION**
All Uses: 12 months

**OTHER CRITERIA**
All Uses: Approve for continuation of prior therapy.
MEDICATION(S)
IMFINZI

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Urothelial carcinoma: 1) Diagnosis of locally advanced or metastatic urothelial carcinoma AND 2) One of the following: a) Patient has experienced disease progression during or following platinum-containing chemotherapy OR b) Patient has experienced disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. Non-Small Cell Lung Cancer (NSCLC): 1) Diagnosis of NSCLC AND 2) Disease is stage III and unresectable AND 3) Disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy
INCREASEX (S)

MEDICATION(S)
INCRELEX

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Insulin-like Growth Factor-1 (IGF-1) deficiency (initial): Diagnosis of severe primary IGF-1 deficiency. Height standard deviation score of -3.0 or less. Basal IGF-1 standard deviation score of -3.0 or less. Normal or elevated growth hormone (GH). GH gene deletion (initial): Diagnosis of GH gene deletion in patients who have developed neutralizing antibodies to GH.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial: Prescribed by or in consultation with a pediatric endocrinologist

COVERAGE DURATION
Initial, reauth: 12 months

OTHER CRITERIA
(Reauth): Evidence of positive response to therapy.
MEDICATION(S)
INFLECTRA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (initial): Dx of moderately to severely active CD or FCD. Ulcerative colitis (UC) (initial): Dx of moderately to severely active UC. Rheumatoid arthritis (RA) (initial): Diagnosis (Dx) of moderately to severely active RA. Ankylosing spondylitis (AS) (initial): Dx of active AS. Psoriatic arthritis (PsA) (initial): Dx of active PsA. Plaque psoriasis (initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. CD, FCD (initial): Trial and failure, contraindication or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine (Purinethol), azathioprine (Imuran), corticosteroids (eg, prednisone, methylprednisolone), methotrexate (Rheumatrex, Trexall). UC (initial): TF/C/I to one of the following conventional therapies: corticosteroids, aminosalicylate [eg, mesalamine (Asacol/Pentasa/Rowasa), olsalazine (Dipentum), sulfasalazine (Azulfidine/Sulfazine)], azathioprine (Imuran), 6-mercaptopurine (Purinethol). RA (initial): Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall), or TF/C/I to methotrexate. AS (initial): TF/C/I to two or more NSAIDs. All indications (initial): One of the following: 1) Trial and failure or intolerance to Remicade or 2) For continuation of prior Inflectra therapy. All indications (Initial): Excluded if patient is receiving infliximab in combination with a Biologic Disease Modifying Antirheumatic Drug (DMARD) [eg, Enbrel (etanercept), Ocrenia (abatacept), Rituxan (rituximab), Kineret (anakinra), Cimzia (certolizumab)].

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA, AS: Prescribed or recommended by a rheumatologist. PsA: Prescribed or recommended by rheumatologist or dermatologist. Crohn's Disease, Fistulizing Crohn's Disease, UC: Prescribed or recommended by a gastroenterologist. Plaque Psoriasis: Prescribed or recommended by a dermatologist.
COVERAGE DURATION
All indications (initial, reauth): 12 months

OTHER CRITERIA
Reauthorization for all indications: Documentation of positive clinical response to infliximab therapy. All indications (re-auth): Excluded if patient is receiving infliximab in combination with a Biologic Disease Modifying Antirheumatic Drug (DMARD) [eg, Enbrel (etanercept), Oremia (abatacept), Rituxan (rituximab), Kineret (anakinra), Cimzia (certolizumab)].
INGREZZA (S)

MEDICATION(S)
INGREZZA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Tardive Dyskinesia (initial): Diagnosis of moderate to severe tardive dyskinesia. One of the following: a) patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR b) patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial: Prescribed by or in consultation with a neurologist or psychiatrist.

COVERAGE DURATION
Initial: 3 months, Reauth: 12 months

OTHER CRITERIA
Tardive Dyskinesia (reauth): Documentation of positive clinical response to Ingrezza therapy.
**MEDICATION(S)**
INLYTA

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Renal cell cancer (RCC): Diagnosis of RCC. One of the following: (1) disease has relapsed or (2) both of the following: medically or surgically unresectable tumor and diagnosis of stage IV disease.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
MEDICATION(S)
INTRON A

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic hepatitis B: Diagnosis of chronic hepatitis B infection, and patient is without decompensated liver disease. Chronic Hepatitis C: Diagnosis of chronic hepatitis C, patient without decompensated liver disease, patient has not previously been treated with interferon, and one of the following - 1) used in combination with ribavirin or 2) contraindication or intolerance to ribavirin. Metastatic renal cell carcinoma (RCC): diagnosis of metastatic RCC, used in combination with Avastin (bevacizumab). Other: diagnosis of condylomata acuminata (genital or perianal), diagnosis of hairy cell leukemia, diagnosis of AIDS-related Kaposis sarcoma, diagnosis of malignant melanoma, diagnosis of Stage III or IV follicular Non-Hodgkins Lymphoma, as maintenance therapy for the treatment of multiple myeloma.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RCC: Prescribed by or in consultation with an oncologist.

COVERAGE DURATION
HepB, HepC: 48 wks. Condylomata acuminata (genital or perianal): 6 wks. Other: 12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
IRESSA (S)

**MEDICATION(S)**
IRESSA

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
MEDICATION(S)
AMNESTEEM, CLARAVIS, ISOTRETINOIN 10 MG CAPSULE, ISOTRETINOIN 20 MG CAPSULE, ISOTRETINOIN 30 MG CAPSULE, ISOTRETINOIN 40 MG CAPSULE, MYORISAN, ZENATANE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Acne (initial): Diagnosis of acne. Trial and failure, contraindication or intolerance to an adequate trial (at least 6 weeks) on both of the following conventional therapy regimens: a) topical retinoid or retinoid-like agent [eg, Retin-A/Retin-A Micro (tretinoin)] AND b) combination therapy with benzoyl peroxide and one of the following: 1) oral antibiotic [eg, Ery-Tab (erythromycin), Minocin (minocycline)] OR 2) topical antibiotic with or without benzoyl peroxide [eg, Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)].

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Acne (Initial): Prescribed by a dermatologist

COVERAGE DURATION
Acne (initial, reauth): 5 months

OTHER CRITERIA
Acne (reauth): One of the following: A) After more than 2 months off therapy, persistent or recurring severe recalcitrant nodular acne is still present, OR B) the total cumulative dose is less than 150 mg/kg (will be approved up to a total of 150 mg/kg).
MEDICATION(S)
ISTODAX

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Cutaneous T-cell lymphoma (CTCL): Diagnosis of CTCL. Patient has tried and had an inadequate response, intolerance or contraindication to at least one prior therapy (eg, retinoids, corticosteroids).
Peripheral T-cell lymphoma (PTCL): Diagnosis of PTCL. Patient has tried and had an inadequate response, intolerance or contraindication to at least one prior therapy (eg, conventional chemotherapy such as CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone), CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone), Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin), HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone) alternating with high-dose methotrexate and cytarabine).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CTCL, PTCL: Prescribed by or in consultation with an oncologist/hematologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
IVIG (S)

MEDICATION(S)
BIVIGAM, CARIMUNE NF 6 GM VIAL, FLEBOGAMMA DIF 10% VIAL, GAMMAGARD LIQUID, GAMMAGARD S-D, GAMMAKED 1 GRAM/10 ML VIAL, GAMMAPLEX, GAMUNEX-C 1 GRAM/10 ML VIAL, OCTAGAM, PRIVIGEN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
All uses (initial, reauth): Contraindications to immune globulin therapy (i.e., IgA deficiency with antibodies to IgA and a history of hypersensitivity or product specific contraindication). Privigen only: Hyperprolinemia. Octagam only: Allergy to corn. Gammaplex only: Hereditary intolerance to fructose. Infants for whom sucrose or fructose tolerance has not been established.

REQUIRED MEDICAL INFORMATION
Initial: Immune globulin (Ig) will be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis. For IVIG Ig is being used intravenously (IV) AND One of the following diagnoses: [A] Primary Immunodeficiency 1) Common variable immunodeficiency. 2) Congenital agammaglobulinemia (X-linked or autosomal recessive). 3) Severe combined immunodeficiencies. 4) Wiskott-Aldrich syndrome. OR 5) Other PI with an immunologic evaluation including IgG levels below the normal laboratory value for the patients age at the time of diagnosis and the patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine). [B] Secondary Acquired Antibody Deficiency 1) B-cell chronic lymphocytic leukemia with an Ig level less than 500 mg/dL OR history of recurrent bacterial infections. 2) HIV infection with an Ig level less than 400 mg/dL OR Patient has active bleeding or a platelet count less than 10 x 109/L. 3) Multiple myeloma in plateau phase and patient has hypogammaglobulinemia. [C] Hematological Autoimmune Disorders 1) Acquired (pure) red cell aplasia (PRCA) that is immunologic and patient had a trial and failure, contraindication, or intolerance (TF/C/I) to a corticosteroid and an immunosuppressant (i.e., cyclophosphamide, cyclosporine) OR patient has viral PRCA caused by parvovirus B19. 2) Fetal alloimmune thrombocytopenia. 3) Hemolytic disease of the newborn and the patient has established hyperbilirubinemia. 4) Idiopathic thrombocytopenic purpura and patient had a TF/C/I to a corticosteroid OR a platelet count less than 30,000 cells/mm3. 5) Post-transfusion purpura. Continued in Other Criteria Section.

AGE RESTRICTION
HIV (initial): patient is less than or equal to 12 years of age.
PRESCRIBER RESTRICTION
All uses (initial, reauth): Prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g., immunologist, hematologist, neurologist, etc.).

COVERAGE DURATION
4 months: Solid organ transplant. 12 months: all other diagnoses.

OTHER CRITERIA
[D] Neuromuscular Autoimmune Disorders 1) Chronic inflammatory demyelinating polyneuropathy. 2) Guillain-Barr syndrome. 3) Inflammatory myopathies (dermatomyositis and polymyositis) AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., azathioprine, methotrexate, cyclosporine A, cyclophosphamide, or tacrolimus). 4) Lambert-Eaton myasthenic syndrome AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (e.g., azathioprine). 5) Multifocal motor neuropathy. 6) Myasthenia gravis with severe exacerbations or myasthenic crises AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., azathioprine, cyclosporine, cyclophosphamide, or mycophenolate mofetil). 7) Stiff person syndrome AND Patient had a TF/C/I to at least 2 standard therapies (i.e., benzodiazepines, muscle relaxants, or anti-convulsants). [E] Other Disorders 1) Autoimmune blistering disease AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., azathioprine, cyclosporine, cyclophosphamide, or mycophenolate mofetil). 2) Kawasaki syndrome. 3) Solid organ transplant and IVIG is being used for CMV prophylaxis, or patient is a kidney transplant recipient and has donor specific antibodies, or patient has steroid-resistant rejection and had a TF/C/I to standard therapies. For SCIG (Gamunex-C, Gammagard Liquid, Gammaked only)- Immune globulin is being used subcutaneously AND One of the following PI diagnoses: 1) Common variable immunodeficiency. 2) Congenital agammaglobulinemia (X-linked or autosomal recessive). 3) Severe combined immunodeficiencies. 4) Wiskott-Aldrich syndrome. OR 5) Other PI with an immunologic evaluation including IgG levels below the normal laboratory value for the patients age at the time of diagnosis and patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine). All products: Subject to Part B vs. Part D review. For non-oncology renewal, the patient has experienced an objective improvement on immune globulin therapy and the immune globulin will be administered at the minimum effective dose (by decreasing the dose, increasing the frequency, or implementing both strategies) for maintenance therapy.
MEDICATION(S)
JAKAFI

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Myelofibrosis: Diagnosis of primary myelofibrosis, OR post-polycythemia vera myelofibrosis, OR post-essential thrombocythemia myelofibrosis. Polycythemia vera: Diagnosis of polycythemia vera, AND trial and failure, contraindication, or intolerance to hydroxyurea.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist

COVERAGE DURATION
Myelofibrosis, Polycythemia vera: 12 months.

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
JEVTANA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
JUXTAPID

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Homozygous familial hypercholesterolemia (HoFH) (initial): Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH), or b) both of the following: 1) either untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. Patient has been receiving at least 12 consecutive weeks of ONE LDL-C lowering prescription therapy and will continue to receive an LDL-C lowering prescription therapy. Trial and failure after 12 consecutive weeks or intolerance to Repatha therapy. One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 30 days: LDL-C greater than or equal to 100 mg/dL with ASCVD OR LDL-C greater than or equal to 130 mg/dL without ASCVD. Not used in combination with Kynamro (mipomersen). Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient is not pregnant. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests. Patient is not concomitantly on moderate or strong CYP 3A4 inhibitors (eg, clarithromycin).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HoFH (initial, reauth): Prescribed by a cardiologist, endocrinologist, or lipid specialist.

COVERAGE DURATION
HoFH (initial): 6 months. (reauth): 12 months

OTHER CRITERIA
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LAST UPDATED 11/2018
HoFH (reauthorization): Patient continues to receive statin at the maximally tolerated dose (or other LDL-C lowering prescription therapy if patient is unable to take a statin). Submission of medical records (eg, laboratory values) documenting a sustained LDL-C reduction from pre-treatment baseline (ie, prior Juxtapid therapy) while on Juxtapid therapy. Not used in combination with Kynamro (mipomersen). Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient is not pregnant. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests. Patient is not concomitantly on moderate or strong CYP 3A4 inhibitors (eg, clarithromycin).
**MEDICATION(S)**
KADCYLA

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Breast cancer: A) Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive recurrent or metastatic breast cancer AND B) Patient has been previously treated with Herceptin (trastuzumab) and a taxane (eg, docetaxel, paclitaxel).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
MEDICATION(S)
KALYDECO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION

AGE RESTRICTION
CF (Initial): 2 years of age or older

PRESCRIBER RESTRICTION
CF (Initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist

COVERAGE DURATION
CF (initial, reauth): 12 months

OTHER CRITERIA
CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).
MEDICATION(S)
KANUMA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
**MEDICATION(S)**
KEVEYIS

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

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

**COVERAGE DURATION**
All uses (Initial): 3 months. (Reauth): 12 months

**OTHER CRITERIA**
All uses (Reauth): Documentation of positive clinical response to Keveyis therapy.
MEDICATION(S)
KEVZARA 150 MG/1.14 ML SYRINGE, KEVZARA 200 MG/1.14 ML SYRINGE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis (RA) (initial): Diagnosis of moderately to severely active RA. One of the following:
a) Trial and failure, contraindication, or intolerance (TF/C/I) to both Enbrel (etanercept) and Humira (adalimumab),
b) or attestation demonstrating a trial may be inappropriate, OR
c) For continuation of prior Kevzara therapy. (Initial, Reauth): Patient is not receiving Kevzara in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial: Prescribed by or in consultation with a rheumatologist

COVERAGE DURATION
Initial, Reauth: 12 months

OTHER CRITERIA
RA (reauth): Documentation of positive clinical response to Kevzara therapy.
**MEDICATION(S)**
KEYTRUDA

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Melanoma: Diagnosis (dx) of melanoma and disease is unresectable or metastatic. Non-Small Cell Lung Cancer (NSCLC): Dx of metastatic NSCLC. One of the following: A) Tumors express high PD-L1 [Tumor Proportion Score (TPS) greater than or equal to 50%] as determined by an FDA-approved test, absence of epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberrations, and used as first-line treatment. OR B) Tumors express PD-L1 [Tumor Proportion Score (TPS) greater than or equal to 1%] as determined by an FDA-approved test, patient had a trial and failure, contraindication, or intolerance to platinum-containing therapy (eg, cisplatin, carboplatin), AND one of the following: 1) absence of EGFR mutation or ALK rearrangement, OR 2) both of the following: presence of EGFR or ALK genomic tumor aberrations AND trial and failure, contraindication, or intolerance to FDA-approved therapy for these aberrations [e.g., Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib), Xalkori (crizotinib)]. OR C) Both of the following: prescribed medication is being used for first line treatment in patients with nonsquamous NSCLC AND prescribed medication is being used in combination with pemetrexed and carboplatin. Recurrent or metastatic head and neck squamous cell carcinoma (HNSCC): Patient has a diagnosis of recurrent or metastatic HNSCC AND patient has disease progression on or after platinum-containing therapy. Classical Hodgkin lymphoma: Diagnosis of classical Hodgkin lymphoma AND One of the following: A) disease is refractory or B) disease has relapsed after 3 or more prior lines of therapy. Primary Mediastinal Large B-Cell Lymphoma (PMBCL): Dx of PMBCL. One of the following: A) disease is refractory, or B) disease has relapsed after 2 or more prior lines of therapy.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
cHL, PMBCL: Prescribed by or in consultation with a hematologist/oncologist. All Other Uses: Prescribed by or in consultation with an oncologist.
COVERAGE DURATION
12 months.

OTHER CRITERIA
Urothelial Carcinoma: Dx of locally advanced or metastatic urothelial carcinoma AND one of the following: 1) Patient is not eligible for cisplatin-containing chemotherapy, 2) Disease progression during or following platinum-containing chemotherapy, or 3) Disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. Microsatellite Instability-High Cancer (MSI-H): One of the following: 1) Dx of unresectable or metastatic, MSI-H or mismatch repair deficient solid tumors AND disease progression following prior treatment AND patient has no satisfactory alternative treatment options, OR 2) Dx of unresectable or metastatic, MSI-H or mismatch repair deficient colorectal cancer AND patient has experienced progression following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan. Gastric Cancer: Dx of gastric or gastroesophageal junction adenocarcinoma AND disease is locally advanced, recurrent, or metastatic AND tumors express PD-L1 (Combined Positive Score [CPS] greater than or equal to 1) as determined by an FDA-approved test AND disease progression on or after two or more prior lines of therapy including fluoropyrimidine- and platinum-containing chemotherapy AND HER2/neu-targeted therapy if the patient is HER2/neu positive. Cervical Cancer (CC): Dx of CC. Disease is recurrent or metastatic. Disease progression on or after chemotherapy. Tumor(s) express PD-L1 (CPS greater than or equal to 1) as determined by an FDA-approved test. All Indications: Approve for continuation of prior therapy.
KINERET (S)

MEDICATION(S)
KINERET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
All Uses (initial, reauth): 12 months

OTHER CRITERIA
All Uses (Reauth): Documentation of positive clinical response to Kineret therapy. All Uses (Reauth): Documentation of positive clinical response to Kineret therapy.
**KISQALI (S)**

**MEDICATION(S)**
KISQALI

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Breast cancer: Diagnosis of advanced or metastatic breast cancer. Patient is a postmenopausal woman. Cancer is hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative. Kisqali is used in combination with an aromatase inhibitor [(e.g., Femara (letrozole)].

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy
MEDICATION(S)
KISQALI FEMARA CO-PACK

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Breast cancer: Diagnosis of advanced or metastatic breast cancer. Patient is a postmenopausal woman. Cancer is hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy
KORLYM (S)

MEDICATION(S)
KORLYM

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Cushing’s syndrome (Initial): Diagnosis of endogenous Cushings syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Diagnosis of either type 2 diabetes mellitus or diagnosis of glucose intolerance. Patient has either failed surgery or patient is not a candidate for surgery. Patient is not pregnant.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial: Prescribed by or in consultation with an endocrinologist.

COVERAGE DURATION
Initial, reauth: 6 months

OTHER CRITERIA
Reauthorization: Documentation of one of the following: patient has improved glucose tolerance while on Korlym therapy or patient has stable glucose tolerance while on Korlym therapy.
MEDICATION(S)
KUVAN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient will have blood Phe levels measured after 1 week of therapy (new starts to therapy only) and periodically for up to 2 months of therapy to determine response.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
PKU (Init): 2 months (Reauth): 12 months

OTHER CRITERIA
PKU (reauth): Patient has had an objective response to therapy, defined as a 30% or greater reduction in phenylalanine (Phe) blood levels from baseline. Patient will continue to have blood Phe levels measured periodically during therapy.
KYNAMRO (S)

MEDICATION(S)
KYNAMRO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Homozgyous familial hypercholesterolemia (HoFH) (initial): Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH), or b) both of the following: 1) either untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. Patient has been receiving at least 12 consecutive weeks of ONE LDL-C lowering prescription therapy and will continue to receive an LDL-C lowering prescription therapy. Trial and failure after 12 consecutive weeks or intolerance to Repatha therapy. One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 30 days: LDL-C greater than or equal to 100 mg/dL with ASCVD OR LDL-C greater than or equal to 130 mg/dL without ASCVD. Not used in combination with Juxtapid (lomitapide). Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HoFH (initial, reauth): Prescribed by a cardiologist, endocrinologist, or lipid specialist.

COVERAGE DURATION
HoFH (initial): 6 months. (reauth): 12 months

OTHER CRITERIA
HoFH (reauthorization): Patient continues to receive statin at the maximally tolerated dose (or other
LDL-C lowering prescription therapy if patient is unable to take a statin). Submission of medical records (eg, laboratory values) documenting a sustained LDL-C reduction from pre-treatment baseline (ie, prior Juxtapid therapy) while on Kynamro therapy. Not used in combination with Juxtapid (lomitapide). Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests.
**MEDICATION(S)**
KYPROLIS 30 MG VIAL, KYPROLIS 60 MG VIAL

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Multiple Myeloma (MM): Diagnosis of MM. Disease is relapsed or refractory. Patient has received at least one prior therapy for MM.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist/hematologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
MEDICATION(S)
LARTRUVO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Soft Tissue Sarcoma (STS): Diagnosis of STS. All of the following: A) One of the following: 1) Disease is not amenable to curative treatment with radiotherapy or 2) Disease is not amenable to curative treatment with surgery AND B) Used in combination with doxorubicin for the first 8 cycles of treatment.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy
LENVIMA (S)

MEDICATION(S)
LENVIMA 10 MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE,
LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Differentiated thyroid cancer (DTC): Diagnosis of DTC. Disease is locally recurrent or metastatic.
Patient has symptomatic or progressive disease. Disease is refractory to radioactive iodine treatment.
Renal Cell Carcinoma (RCC): Diagnosis of advanced RCC following one prior anti-angiogenic therapy.
Used in combination with everolimus.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
**MEDICATION(S)**
LETAIRIS

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

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

**COVERAGE DURATION**
PAH (Initial): 6 months. PAH (Reauth): 12 months

**OTHER CRITERIA**
PAH (Reauth): Documentation of positive clinical response to therapy.
LEUKINE (S)

MEDICATION(S)
LEUKINE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist except HIVN: Prescribed by or in
consultation with a hematologist/oncologist or infectious disease specialist

**COVERAGE DURATION**
BMSCT, AML, CFN, SPFN, NDDC: 3mo or duration of tx. HIVN: 6mo. FN (treatment), ARS: 1 mo.

**OTHER CRITERIA**
HIV-related neutropenia (HIVN)(off-label): Patients infected with HIV, and ANC less than or equal to 1000 (cells/mm^3).
MEDICATION(S)
LIDOCAINE 5% PATCH

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of post-herpetic neuralgia

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
**LONSURF (S)**

**MEDICATION(S)**
LONSURF

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Colorectal Cancer: Diagnosis of metastatic colorectal cancer AND trial and failure, contraindication, or intolerance to at least one component in the following: fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI) AND trial and failure, contraindication, or intolerance to at least one anti-VEGF therapy (e.g., Avastin) AND One of the following: A) patient has KRAS wild-type tumors and trial and failure, contraindication, or intolerance to at least one anti-EGFR therapy (e.g., Vectibix, Erbitux) OR Patient has KRAS mutant tumors.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
MEDICATION(S)
ALOSETRON HCL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Severe Diarrhea-Predominant Irritable Bowel Syndrome (IBS) in Women (initial): All of the following: 1) diagnosis of severe diarrhea-predominant IBS, 2) symptoms for at least 6 months, 3) female patient, AND 4) trial and failure, contraindication, or intolerance to an antidiarrheal agent [eg, loperamide].

AGE RESTRICTION
Initial: 18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
IBS (initial): 12 weeks. IBS (reauth): 6 mo.

OTHER CRITERIA
IBS (reauthorization): Symptoms of IBS continue to persist, AND documentation of positive clinical response to Lotronex therapy.
MEDICATION(S)
LUMIZYME

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Pompe disease: Diagnosis of Pompe disease [acid alpha-glucosidase (GAA) deficiency].

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
LUPANETA PACK

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Endomet (init, reauth): 6 months

OTHER CRITERIA
Endometriosis (reauthorization): Patient is experiencing recurrence of symptoms after an initial course of therapy.
MEDICATION(S)
LEUPROLIDE 1 MG/0.2 ML VIAL, LEUPROLIDE 2WK 1 MG/0.2 ML KIT, LEUPROLIDE 2WK 14 MG/2.8 ML KT, LEUPROLIDE 2WK 14 MG/2.8 ML VL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Central Precocious Puberty (CPP) (initial): Diagnosis of CPP (idiopathic or neurogenic). Early onset of secondary sexual characteristics in females less than age 8 or males less than age 9. Advanced bone age of at least one year compared with chronologic age. One of the following: a) patient has undergone gonadotropin-releasing hormone agonist (GnRHa) testing AND Peak luteinizing hormone (LH) level above pre-pubertal range, or b) patient has a random LH level in the pubertal range.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CPP (initial, reauth): Prescribed by or in consultation with a pediatric endocrinologist.

COVERAGE DURATION
CPP (initial, reauth), Prostate CA: 12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
LUPRON DEPOT (S)

MEDICATION(S)
LUPRON DEPOT, LUPRON DEPOT (LUPANETA), LUPRON DEPOT-PED 11.25 MG 3MO, LUPRON DEPOT-PED 7.5 MG KIT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prostate Cancer (7.5 mg, 22.5 mg, 30 mg, 45 mg): Diagnosis of advanced or metastatic prostate cancer. Endometriosis (3.75 mg, 11.25 mg) (initial): Diagnosis of endometriosis. One of the following: Patient has had surgical ablation to prevent recurrence, or trial and failure, contraindication, or intolerance to one NSAID and one oral contraceptive. Uterine Leiomyomata (UL) (3.75 mg, 11.25 mg): a) For use prior to surgery to reduce size of fibroids to facilitate a surgical procedure (eg, myomectomy, hysterectomy) OR b) all of the following: treatment of anemia, anemia is caused by uterine leiomyomata (fibroids), and for use prior to surgery.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Prostate CA: 12 mo. Endomet (init, reauth):6mo. UL (anemia):3 mo (fibroids):4 mo

OTHER CRITERIA
Approve for continuation of prior therapy.
**MEDICATION(S)**
LUPRON DEPOT-PED 11.25 MG KIT, LUPRON DEPOT-PED 15 MG KIT, LUPRON DEPOT-PED 30 MG 3MO KIT

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Central Precocious Puberty (CPP) (initial): Diagnosis of CPP (idiopathic or neurogenic). Early onset of secondary sexual characteristics in females less than age 8 or males less than age 9. Advanced bone age of at least one year compared with chronologic age. One of the following: a) patient has undergone gonadotropin-releasing hormone agonist (GnRHa) testing AND Peak luteinizing hormone (LH) level above pre-pubertal range, or b) patient has a random LH level in the pubertal range.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
CPP (initial, reauth): Prescribed by or in consultation with a pediatric endocrinologist.

**COVERAGE DURATION**
CPP (init, reauth): 12 months

**OTHER CRITERIA**
CPP (reauthorization): LH levels have been suppressed to pre-pubertal levels.
LYNPARZA (S)

MEDICATION(S)
LYNPARZA 50 MG CAPSULE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Ovarian Cancer: Diagnosis of advanced ovarian cancer. Presence of deleterious or suspected deleterious germline BRCA-mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. Trial and failure, contraindication, or intolerance to three or more prior lines of chemotherapy (e.g., paclitaxel with cisplatin).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
LYNPARZA TABLET (S)

MEDICATION(S)
LYNPARZA 100 MG TABLET, LYNPARZA 150 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Ovarian cancer, advanced disease with known or suspected BRCA mutation with 3 or more prior lines of chemotherapy: Diagnosis of advanced ovarian cancer. Presence of deleterious or suspected deleterious germline BRCA-mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. Trial and failure, contraindication, or intolerance to three or more prior lines of chemotherapy (e.g., paclitaxel with cisplatin). Maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of one of the following: recurrent epithelial ovarian cancer, recurrent fallopian tube cancer, or recurrent primary peritoneal cancer. Used for maintenance treatment in patients who are in a complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
All indications: Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MAKENA (S)

MEDICATION(S)
MAKENA 250 MG/ML VIAL, MAKENA 275 MG/1.1 ML AUTOINJCT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Preterm birth prophylaxis: 21 weeks

OTHER CRITERIA
N/A
MARINOL (S)

MEDICATION(S)
DRONABINOL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. Trial and failure, contraindication, or intolerance to one 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). Trial and failure, contraindication, or intolerance to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine). AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
CINV: 6 months. AIDS anorexia: 3 months.

OTHER CRITERIA
Subject to Part B vs. Part D review. CINV: Approve for continuation of therapy for treatment covered under Part B when patient is receiving cancer chemotherapy.
MEDICATION(S)
MAVYRET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: Diagnosis of chronic hepatitis C, patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and patient is not receiving Mavyret in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].

AGE RESTRICTION
N/A

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

COVERAGE DURATION
8 to 16 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline

OTHER CRITERIA
N/A
MEKINIST (S)

MEDICATION(S)
MEKINIST

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT) as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Involvement of lymph nodes following complete resection. Used as adjunctive therapy. Medication is used in combination with Tafinlar (dabrafenib). Non-small Cell Lung Cancer (NSCLC): All of the following: diagnosis of metastatic non-small cell lung cancer AND cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND medication is used in combination with Tafinlar (dabrafenib). Anaplastic Thyroid Cancer (ATC): Diagnosis of locally advanced or metastatic ATC. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Cancer may not be treated with standard locoregional treatment options. Medication is used in combination with Tafinlar (dabrafenib).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
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LAST UPDATED 11/2018
Approve for continuation of prior therapy.
MEDICATION(S)
METADATE ER, METHYLPHENIDATE ER 10 MG TAB, METHYLPHENIDATE ER 20 MG TAB, METHYLPHENIDATE SR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to members 19 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
RASUVO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(initial): Both of the following: 1) One of the following diagnoses: a) Severe, active rheumatoid arthritis, OR b) active polyarticular juvenile idiopathic arthritis, OR c) severe psoriasis, AND 2) trial and failure or intolerance to oral methotrexate.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
(initial, reauth): 12 months

OTHER CRITERIA
(reauth): Documentation of positive clinical response to therapy.
MEDICATION(S)
METHYLPHENIDATE 10 MG CHEW TAB, METHYLPHENIDATE 2.5 MG CHEW TB,
METHYLPHENIDATE 5 MG CHEW TAB

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to members 19 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
METHYLPHENIDATE 10 MG TABLET, METHYLPHENIDATE 10 MG/5 ML SOL, METHYLPHENIDATE 20 MG TABLET, METHYLPHENIDATE 5 MG TABLET, METHYLPHENIDATE 5 MG/5 ML SOLN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to members 19 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
METHYLPHENIDATE ER (S)

MEDICATION(S)
METHYLPHENIDATE ER 10 MG CAP, METHYLPHENIDATE ER 18 MG TAB, METHYLPHENIDATE ER 20 MG CAP, METHYLPHENIDATE ER 27 MG TAB, METHYLPHENIDATE ER 30 MG CAP, METHYLPHENIDATE ER 36 MG TAB, METHYLPHENIDATE ER 40 MG CAP, METHYLPHENIDATE ER 54 MG TAB, METHYLPHENIDATE ER 72 MG TAB, METHYLPHENIDATE HCL CD, METHYLPHENIDATE HCL ER, METHYLPHENIDATE LA, RITALIN LA 10 MG CAPSULE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
PA applies to members 19 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
MIRVASO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Rosacea (init, reauth): 12 months

OTHER CRITERIA
Rosacea (reauth) Documentation of positive clinical response to Mirvaso therapy.
MEDICATION(S)
MOZOBIL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Hematopoietic Stem Cell (HSC) Mobilization: Patient with non-Hodgkin's lymphoma (NHL) or multiple myeloma (MM) who will be undergoing autologous HSC transplantation. Used in combination with granulocyte-colony stimulating factor (G-CSF).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist

COVERAGE DURATION
One course of therapy up to 4 days

OTHER CRITERIA
N/A
**MEDICATION(S)**
AVONEX, AVONEX PEN, BETASERON 0.3 MG KIT, EXTAVIA, PLEGRIDY, PLEGRIDY PEN, REBIF, REBIF REBIDOSE

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
N/A
**MEDICATION(S)**
MYALEPT

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Initial: Prescribed by or in consultation with an endocrinologist

**COVERAGE DURATION**
Initial and reauth: 12 months

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

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Acute myeloid leukemia (AML): One of the following diagnoses: Newly diagnosed AML or relapsed/refractory (R/R) AML. Disease is CD33-positive.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
NAGLAZYME (S)

MEDICATION(S)
NAGLAZYME

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Mucopolysaccharidosis (MPS VI): Diagnosis of MPS VI (Maroteaux-Lamy Syndrome)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
MPS VI: 12 months

OTHER CRITERIA
N/A
MEDICATION(S)
NATPARA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Hypocalcemia (Initial): Diagnosis of hypocalcemia due to chronic hypoparathyroidism. NATPARA is not being used in the setting of acute post-surgical hypoparathyroidism. Patient does not have a known calcium-sensing receptor mutation. Patient has a documented parathyroid hormone concentration that is inappropriately low for the level of calcium, recorded on at least two occasions within the previous 12 months. Patient has been optimized on adequate doses of oral calcium (more than 2,000 mg daily) and vitamin D (calcitriol at least 1 microgram/day) supplementation. Patient has normal thyroid-stimulating hormone concentrations if not on thyroid hormone replacement therapy (or if on therapy, the dose had to have been stable for greater than or equal to 3 months). Patient has normal magnesium and serum 25-hydroxyvitamin D concentrations. Creatinine clearance is at least 30 mL/min on two separate measurements, or greater than 60 mL/min (one measurement) with an accompanying serum creatinine concentration of less than 1.5 mg/dL. NATPARA will be used as an adjunct to calcium and vitamin D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hypocalcemia (Initial): Prescribed by or in consultation with an endocrinologist.

COVERAGE DURATION
Initial: 4 months. Reauth: 12 months

OTHER CRITERIA
N/A
NERLYNX (S)

MEDICATION(S)
NERLYNX

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Breast cancer: Diagnosis (dx) of early stage breast cancer. Disease is human epidermal growth factor receptor 2 (HER2)-positive. Patient has received adjuvant Herceptin (trastuzumab)-based therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy
MEDICATION(S)
NEULASTA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
All uses: Prescribed by or in consultation with a hematologist/oncologist

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

OTHER CRITERIA
N/A
NEXAVAR (S)

MEDICATION(S)
NEXAVAR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renal cell carcinoma (RCC): Diagnosis of RCC. One of the following: Relapsed disease OR both medically/surgically unresectable tumor and dx of Stage IV disease. Hepatocellular carcinoma (HCC): Diagnosis of HCC. One of the following: patient has metastatic disease, or patient has extensive liver tumor burden, or patient is inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only), or disease is unresectable. Differentiated thyroid carcinoma (DTC): Diagnosis of DTC (ie, follicular carcinoma, Hurthle cell carcinoma, or papillary carcinoma). One of the following: locally recurrent disease or metastatic disease. One of the following: patient has symptomatic disease or patient has progressive disease. Disease is refractory to radioactive iodine (RAI) treatment. Medullary thyroid carcinoma (MTC): Diagnosis of MTC. One of the following: 1) Disease is progressive or 2) Patient has symptomatic disease. Trial and failure, contraindication, or intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
DTC, MTC: Prescribed by or in consultation with an oncologist. RCC: Prescribed by or in consultation with one of the following: oncologist or nephrologist. HCC: Prescribed by or in consultation with one of the following: an oncologist, hepatologist, or gastroenterologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
NINLARO (S)

MEDICATION(S)
NINLARO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple myeloma: Diagnosis of multiple myeloma. Used in combination with Revlimid (lenalidomide) and dexamethasone. Patient has received at least one prior therapy for multiple myeloma [eg, Revlimid (lenalidomide), Thalomid (thalidomide), Velcade (bortezomib)].

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
NON-PREFERRED TIRF (S)

MEDICATION(S)
ABSTRAL, FENTORA, LAZANDA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
NORTHERA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Neurogenic orthostatic hypotension (NOH) (init): Diagnosis of symptomatic NOH. NOH is caused by one of the following conditions: primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, non-diabetic autonomic neuropathy. Trial and failure, contraindication, or intolerance to one of the following agents: fludrocortisone acetate, midodrine.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NOH (init): Prescribed by or in consultation with a cardiologist, neurologist, or nephrologist

COVERAGE DURATION
NOH (init): 1 month (reauth): 12 months

OTHER CRITERIA
NOH (reauth): Documentation of positive clinical response to therapy
**MEDICATION(S)**
MITOXANTRONE HCL

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Multiple Sclerosis (MS): Diagnosis (dx) of one of the following: secondary progressive MS: gradually worsening disability with or without superimposed relapses, progressive relapsing MS: progression of disability from the onset with superimposed relapses, or worsening relapsing-remitting MS: neurological status remains significantly abnormal in between MS relapses. Disease progression despite one of the following therapies: Avonex, Aubagio, Betaseron, Copaxone/Glatopa, Extavia, Gilenya, Lemtrada, Ocrevus, Plegridy, Rebif, Tecfidera, Tysabri, Zinbryta. Left ventricular ejection fraction (LVEF) greater than or equal to 50%. Neutrophil count greater than or equal to 1500 cell/mm^3. Lifetime cumulative dose less than 140 mg/m^2. Prostate Cancer (PC): Dx of advanced hormone-refractory (castration-resistant) PC. Used in combination with corticosteroids (eg, prednisone, methylprednisolone). LVEF greater than or equal to 50%. Neutrophil count greater than or equal to 1500 cell/mm^3. Acute Non-Lymphocytic Leukemia (ANLL): Dx of ANLL (eg, myelogenous, promyelocytic, monocytic, and erythroid). Used in combination with other medications used for the treatment of ANLL. LVEF greater than or equal to 50%.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
All Uses: 6 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
NUCALA (S)

MEDICATION(S)
NUCALA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Severe asthma (init): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by one of the following: baseline peripheral blood eosinophil levels are greater than or equal to 150 cells/microliter or peripheral blood eosinophil levels were greater than or equal to 300 cells/microliter within the past 12 months. Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids within the past 12 months or Patient has had any prior intubation for an asthma exacerbation or Patient has had a prior asthma-related hospitalization within the past 12 months. Patient is currently being treated with both a high-dose inhaled corticosteroid (ICS) [eg, greater than 500 mcg fluticasone propionate equivalent/day] and an additional asthma controller medication [eg, leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline] or one maximally-dosed combination ICS/LABA product [eg, Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)], unless there is a contraindication or intolerance to these medications. Eosinophilic Granulomatosis with Polyangiitis (EGPA) (init): Diagnosis of EGPA. Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy). Patient is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone).

AGE RESTRICTION
Severe asthma (init): Age greater than or equal to 12 years

PRESCRIBER RESTRICTION
Severe asthma (init): Prescribed by or in consultation with a pulmonologist or allergy/immunology specialist. EGPA (init): Prescribed by or in consultation with a pulmonologist, rheumatologist or allergist/immunologist.

COVERAGE DURATION
Severe asthma (init, reauth): 12 months. EGPA (init, reauth): 12 months
OTHER CRITERIA
Severe asthma (reauth): Documentation of positive clinical response (eg, reduction in exacerbations). Patient is currently being treated with both a inhaled corticosteroid (ICS) and an additional asthma controller medication [eg, leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline] or a combination ICS/LABA product [eg, Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)], unless there is a contraindication or intolerance to these medications. EGPA (reauth): Documentation of positive clinical response to therapy (e.g., increase in remission time).
MEDICATION(S)
NULOJIX

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Kidney transplant: The medication is being used for prevention of kidney transplant organ rejection AND The patient is immune to the Epstein-Barr virus (i.e. EBV seropositive) AND The patient is prescribed concurrent therapy with mycophenolate and corticosteroids

AGE RESTRICTION
Kidney transplant: 18 years of age or older

PRESCRIBER RESTRICTION
Kidney transplant: Prescriber is experienced in immunosuppressive therapy and management of transplant patients

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
NUPLAZID (S)

MEDICATION(S)
NUPLAZID 17 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Parkinson’s disease psychosis: Diagnosis of Parkinson’s disease. Patient has at least one of the following: hallucinations or delusions.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
OCALIVA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Primary Biliary Cholangitis (PBC) (initial): Diagnosis of PBC (aka primary biliary cirrhosis). One of the following: a) patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal (ULN) after at least 12 consecutive months of treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol) AND used in combination with UDCA, OR b) contraindication or intolerance to UDCA. Patients with moderate to severe hepatic impairment (Child-Pugh class B or C) will be subject to a quantity limit of 5 mg or 10 mg twice weekly (MDD = 0.34).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PBC (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist.

COVERAGE DURATION
PBC (initial): 6 months, (reauth): 12 months

OTHER CRITERIA
PBC (reauthorization): Submission of medical records (eg, laboratory values) documenting a reduction in ALP level from pre-treatment baseline (ie, prior Ocaliva therapy) while on Ocaliva therapy. Patients with moderate to severe hepatic impairment (Child-Pugh class B or C) will be subject to a quantity limit of 5 mg or 10 mg twice weekly (MDD = 0.34).
MEDICATION(S)
ODOMZO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Basal cell carcinoma: Diagnosis of locally advanced basal cell carcinoma AND One of the following: 1) Cancer has recurred following surgery or radiation therapy or 2) Patient is not a candidate for surgery or radiation therapy

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist or dermatologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
OFEV

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Idiopathic pulmonary fibrosis (IPF) (initial): Both of the following: 1) diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity) AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF, AND 2) not used in combination with Esbriet (pirfenidone).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
IPF (initial): Prescribed by a pulmonologist

COVERAGE DURATION
Initial, reauth: 12 months

OTHER CRITERIA
IPF (reauth): Documentation of positive clinical response to Ofev therapy.
OLUMIANT (S)

MEDICATION(S)
OLUMIANT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Trial and failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), or attestation demonstrating a trial may be inappropriate, OR patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-IV-TR F40.2 for specific phobia diagnostic criteria), OR for continuation of prior Olumiant therapy. Patient is not receiving Olumiant in combination with a potent immunosuppressant (e.g., azathioprine, cyclosporine) or with other janus kinase inhibitors (e.g., Xeljanz).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial: Prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION
Initial, reauth: 12 months

OTHER CRITERIA
Reauth: Documentation of positive clinical response to Olumiant therapy. Patient is not receiving Olumiant in combination with a potent immunosuppressant (e.g., azathioprine, cyclosporine) or with other janus kinase inhibitors (e.g., Xeljanz).
OLYSIO (S)

MEDICATION(S)
OLYSIO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria will be applied consistent with current AASLD/IDSA guideline. Both of the following: A) Submission of medical records (e.g., chart notes, laboratory values) documenting a diagnosis of chronic hepatitis C (CHC) virus AND B) Patient is without decompensated liver disease (defined as Child-Pugh Class B or C). For Olysio plus peginterferon and ribavirin: One of the following: 1) Diagnosis of genotype 1a infection AND patient does not have the NS3 Q80K polymorphism OR 2) Diagnosis of genotype 1b infection OR 3) Diagnosis of genotype 4 infection. One of the following: 1) Trial and failure, intolerance or contraindication to both of the following: a) Harvoni OR Epclusa and b) Mavyret, or 2) for continuation of prior Olysio therapy. All Olysio plus Sovaldi therapy: One of the following: 1) Trial and failure, intolerance, or contraindication to both of the following: a) Harvoni OR Epclusa and b) Mavyret, 2) Both of the following: Trial and failure of a NS5A containing regimen (e.g., Harvoni, Epclusa, Zepatier) and patient has NS5A inhibitor resistant-associated variants detected using commercially available assays, or 3) for continuation of prior Olysio therapy.

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A
ONMEL (S)

MEDICATION(S)
ONMEL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
All of the following: 1) Diagnosis of onychomycosis of the toenail as confirmed by one of the following: a) positive potassium hydroxide (KOH) preparation, OR b) culture, OR c) histology, AND 2) patient has had a trial and inadequate response, intolerance or hypersensitivity to oral terbinafine.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
N/A
MEDICATION(S)
OPDIVO 100 MG/10 ML VIAL, OPDIVO 40 MG/4 ML VIAL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Melanoma: Diagnosis (dx) of melanoma and one of the following: a) disease is unresectable, or b) disease is metastatic, or c) Opdivo will be used in the adjuvant setting following complete resection of Stage IIIIB/C or Stage IV disease. Non-small cell lung cancer (NSCLC): Dx of NSCLC, disease is metastatic, trial and failure, contraindication, or intolerance (TF/C/I) to platinum-based chemotherapy (eg, cisplatin, carboplatin), and one of the following: 1) absence of epidermal growth factor receptor (EGFR) mutation or anaplastic lymphoma kinase (ALK) rearrangement, OR 2) presence of EGFR or ALK genomic tumor aberrations AND TF/C/I to FDA-approved therapy for these aberrations [e.g., Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib), Xalkori (crizotinib)]. Renal cell carcinoma (RCC): Dx of RCC. Disease is advanced, relapsed, or Stage IV disease that is surgically unresectable. One of the following: A) TF/C/I to at least one anti-angiogenic or tyrosine kinase inhibitor therapy (eg, Inlyta [axitinib], Votrient [pazopanib], Sutent [sorafenib], Nexavar [sunitinib]) or B) All of the following: 1) intermediate- or poor-prognosis risk, 2) previously untreated disease, and 3) used in combination with Yervoy (ipilimumab). Classical Hodgkin Lymphoma (cHL): Dx of cHL. One of the following: A) Patient has had relapse or progression after autologous hematopoietic stem cell transplantation and Adcetris (brentuximab vedotin), OR B) Patient has had relapse or progression after 3 or more lines of systemic therapy that includes autologous HSCT, OR C) Used as palliative therapy and patient is greater than 60 years of age. Head and Neck Squamous Cell Carcinoma (HNSCC): Dx of recurrent or metastatic HNSCC. Patient has disease progression on or after platinum-containing therapy.

AGE RESTRICTION
Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) Metastatic Colorectal Cancer: Patient is 12 years of age or older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist.
COVERED DURATION
12 months.

OTHER CRITERIA
Urothelial Carcinoma: Diagnosis of urothelial carcinoma. Disease is locally advanced or metastatic. One of the following: Patient has disease progression during or following platinum-containing chemotherapy OR Patient has disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy. Microsatellite Instability-High (MSI-H) or Mismatch Repair Deficient (dMMR) Metastatic Colorectal Cancer: Dx of microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer (CRC). Patient has experienced progression following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan. Hepatocellular Carcinoma (HCC): Dx of HCC AND previously treated with Nexavar (sorafenib). All indications: Approve for continuation of prior therapy.
MEDICATION(S)
OPSUMIT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
PAH (Reauth): Documentation of positive clinical response to therapy.
ORENCIA IV (S)

MEDICATION(S)
ORENCIA 250 MG VIAL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Juvenile Idiopathic Arthritis (JIA) (Initial): Diagnosis of moderately to severely active polyarticular JIA. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. All indications (Initial): One of the following: Trial and failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), or attestation demonstrating a trial may be inappropriate, OR for continuation of prior Orencia therapy. All indications (Initial, reauth): Patient is not receiving Orencia in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

AGE RESTRICTION
N/A

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

COVERAGE DURATION
All indications (Initial, reauth): 12 months

OTHER CRITERIA
All indications (Reauth): Documentation of positive clinical response to Orencia therapy.
ORENCIA SC (S)

MEDICATION(S)
ORENCIA 125 MG/ML SYRINGE, ORENCIA 50 MG/0.4 ML SYRINGE, ORENCIA 87.5 MG/0.7 ML SYRINGE, ORENCIA CLICKJECT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Juvenile Idiopathic Arthritis (JIA) (Initial): Diagnosis of moderately to severely active polyarticular JIA. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. All indications (Initial): One of the following: Trial and failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), or attestation demonstrating a trial may be inappropriate, OR for continuation of prior Orencia therapy. Patient is not receiving Orencia in combination with a biologic disease modifying antirheumatic drug (DMARD) [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

AGE RESTRICTION
N/A

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

COVERAGE DURATION
All indications (Initial, reauth): 12 months

OTHER CRITERIA
All indications (Reauth): Documentation of positive clinical response to Orencia therapy. Patient is not receiving Orencia in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].
MEDICATION(S)
ORENITRAM ER

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
PAH (Reauth): Documentation of positive clinical response to therapy.
MEDICATION(S)
ORKAMBI 100 MG-125 MG TABLET, ORKAMBI 200 MG-125 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by an FDA-cleared cystic fibrosis mutation test or Clinical Laboratory Improvement Amendments-approved facility.

AGE RESTRICTION
CF (Initial): Patient is 6 years of age or older

PRESCRIBER RESTRICTION
CF (Initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist

COVERAGE DURATION
CF (initial, reauth): 12 months

OTHER CRITERIA
CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations)
OTEZLA (S)

MEDICATION(S)
OTEZLA 30 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Psoriatic arthritis (PsA, initial): Diagnosis of active PsA. Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. PsA, plaque psoriasis (initial): Trial and failure, contraindication, or intolerance to both Humira and Enbrel, or attestation demonstrating a trial may be inappropriate, OR for continuation of prior Otezla therapy.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Initial, Reauth: 12 months

OTHER CRITERIA
Reauthorization (all indications): Documentation of positive clinical response to Otezla therapy.
OXANDRIN (S)

MEDICATION(S)
OXANDROLONE 10 MG TABLET, OXANDROLONE 2.5 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Promote weight gain (initial): Medication will be used as an adjunct therapy to promote weight gain AND One of the following: Extensive surgery, Chronic infections, Severe trauma, Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons. Counterbalance protein catabolism (initial): Oxandrin will be used to counterbalance protein catabolism associated with chronic corticosteroid administration. Bone pain (initial): Diagnosis of bone pain associated with osteoporosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
bone pain (initial, reauth): 1 month. Others (initial, reauth): 3 months

OTHER CRITERIA
All diagnoses (reauth): patient has experienced an objective improvement (i.e. weight gain, increase in lead body mass, or reduction in muscle pain/weakness)
MEDICATION(S)
ABELCET, ACETYLCYSTEINE 10% VIAL, ACETYLCYSTEINE 20% VIAL, ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML VIAL, ADRIAMYCIN 20 MG/10 ML VIAL, ADRUCIL 500 MG/10 ML VIAL, ALBUTEROL 15 MG/3 ML SOLUTION, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL 20 MG/4 ML SOLUTION, ALBUTEROL 5 MG/ML SOLUTION, ALBUTEROL SUL 0.63 MG/3 ML SOL, ALBUTEROL SUL 1.25 MG/3 ML SOL, ALBUTEROL SUL 2.5 MG/3 ML SOLN, AMBISOME, AMINOSYN II 10% IV SOLUTION, AMINOSYN II 7% IV SOLUTION, AMINOSYN II WITH ELECTROLYTES, AMINOSYN WITH ELECTROLYTES, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-RF, AMPHOTERICIN B 50 MG VIAL, ANZEMET, APREPITANT, AZASAN, AZATHIOPRINE 50 MG TABLET, AZATHIOPRINE SODIUM, BETHKIS, BLEOMYCIN SULFATE 30 UNIT VIAL, BROVANA, BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, CLADRBINE, CLINIMIX, CLINIMIX E, CROMOLYN 20 MG/2 ML NEB SOLN, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 100 MG/ML SOLN, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE MODIFIED, CYTARABINE 2 G/20 ML VIAL, CYTARABINE 20 MG/ML VIAL, DOXORUBICIN 50 MG/25 ML VIAL, EMEND 125 MG POWDER PACKET, ENGERIX-B 20 MCG/ML SYRN, ENGERIX-B PEDIATRIC-ADOLESCENT, FLUOROURACIL 1,000 MG/20 ML VL, FLUOROURACIL 2,500 MG/50 ML VL, FLUOROURACIL 2.5 GM/50 ML BTL, FLUOROURACIL 2.5 GM/50 ML VIAL, FLUOROURACIL 5 GM/100 ML BTL, FLUOROURACIL 5 GM/100 ML VIAL, FLUOROURACIL 5,000 MG/100 ML, FLUOROURACIL 500 MG/10 ML VIAL, FREAMINE HBC, GABLOFEN 40,000 MCG/20 ML VIAL, GANCICLOVIR 500 MG VIAL, GENGRAF, GRANISTETRON HCL 1 MG TABLET, HEPATAMINE, IMOVA PRABIES VACCINE, INTRALIPID 20% IV FAT EMUL, IPRATROPIUM BR 0.02% SOLN, IPRATROPIUM-ALBUTEROL, LEVALBUTEROL CONCENTRATE, LEVALBUTEROL HCL, LIORESAL INTRATECAL, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID, NEBUPENT, NEPHRAMINE, NUTRILIPID, ONDANSETRON 4 MG/5 ML SOLUTION, ONDANSETRON HCL 24 MG TABLET, ONDANSETRON HCL 4 MG TABLET, ONDANSETRON HCL 8 MG TABLET, ONDANSETRON ODT, PERFOROMIST, PREMASOL, PROCALAMINE, PROSOL, RABAVERB, RAPAMUNE 1 MG/ML ORAL SOLN, RECOMBIVAX HB 10 MCG/ML SYR, RECOMBIVAX HB 10 MCG/ML VIAL, RECOMBIVAX HB 40 MCG/ML VIAL, RECOMBIVAX HB 5 MCG/0.5 ML SYR, SANDIMMUNE 100 MG/ML SOLN, SIROLIMUS 0.5 MG TABLET, SIROLIMUS 1 MG TABLET, SIROLIMUS 2 MG TABLET, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 1 MG CAPSULE, TACROLIMUS 5 MG CAPSULE, TOBRAMYCIN 300 MG/5 ML AMPULE, TRAVISOL, TROPHAMINE 10% IV SOLUTION, VINBLASTINE SULFATE, VINCASAR PFS 1 MG/ML VIAL, VINCRISTINE 1 MG/ML VIAL

DETAILS
This drug may be covered under Medicare Part B or D depending on the circumstances. Information
may need to be submitted describing the use and setting of the drug to make the determination.
MEDICATION(S)
PEGASYS, PEGASYS PROCLICK

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic hepatitis B: Diagnosis of chronic hepatitis B infection, and patient is without decompensated liver disease. Chronic Hepatitis C: Criteria will be applied consistent with current AASLD-IDSA guidance

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

OTHER CRITERIA
N/A
MEDICATION(S)
DICLOFENAC 1.5% TOPICAL SOLN, KLOFENSAID II

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Initial, reauth: History of severe allergic-type reactions after taking aspirin or other non-steroidal anti-inflammatory (NSAIDs), including urticaria and asthma (aspirin-sensitive asthma).

REQUIRED MEDICAL INFORMATION
Osteoarthritis of the knees (initial): Diagnosis of osteoarthritis of the knees and diclofenac will not be used in the treatment of peri-operative pain in the setting of coronary artery bypass graft surgery. Patient meets one of the following: 1) Treatment failure with at least two prescription strength oral non-steroidal anti-inflammatory drugs (NSAIDs) OR 2) Documented swallowing disorder OR 3) History of peptic ulcer disease/gastrointestinal bleed OR 4) Patient is older than 65 years of age with one additional risk factor for gastrointestinal adverse events (e.g. use of anticoagulants, chronic corticosteroids).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial, reauth: 12 months

OTHER CRITERIA
Osteoarthritis of the knees (reauth): Patient has experienced a response to therapy (e.g., improvement in pain symptoms of osteoarthritis).
MEDICATION(S)
PERJETA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
POMALYST

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple Myeloma (MM): Diagnosis of MM. Used in combination with dexamethasone. Patient has received two prior therapies, including Revlimid (lenalidomide) and a proteasome inhibitor [eg, Velcade (bortezomib) or Kyprolis (carfilzomib)] or has a contraindication or intolerance to Revlimid and proteasome inhibitors. Patient has experienced disease progression on or within 60 days of completion of last therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist/hematologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
PRALUENT (S)

MEDICATION(S)
PRALUENT PEN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial: One of the following diagnoses: A) Heterozygous familial hypercholesterolemia (HeFH) as confirmed by one of the following: (1) Submission of medical records (MR) (e.g., chart notes, laboratory values) documenting assessment of patient using Dutch Lipid Clinic Network diagnostic criteria with a cumulative score greater than or equal to 9 points (ie, definite FH), (2) both of the following: a) One of the following: i) Presence of tendinous xanthomas and/or arcus cornealis in first degree relative, or second degree relative, ii) Family history (hx) of myocardial infarction (MI) in first-degree relative less than 60 years of age, iii) Family hx of MI in second-degree relative less than 50 years of age, iv) Family hx of LDL-C greater than 190 mg/dL in first- or second-degree relative, v) Family hx of FH in first- or second-degree relative, AND b) Untreated/pre-treatment LDL-C greater than 190 mg/dL in an adult, (3) Submission of MR (e.g., chart notes, laboratory values) documenting genetic confirmation of a mutation in the LDL receptor, ApoB, or PCSK9, or (4) Untreated/pre-treatment LDL-C greater than 190 mg/dL in an adult AND submission of MR (e.g., chart notes, laboratory values) documenting presence of tendinous xanthoma in patient or arcus cornealis before age 45. OR B) Atherosclerotic cardiovascular disease (ASCVD) as confirmed by acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin. One of the following: set A) Both of the following: a)One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 120 days: (1) LDL-C greater than or equal to 100 mg/dL with ASCVD. (2) LDL-C greater than or equal to 130 mg/dL without ASCVD.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial, reauth: Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist
COVERAGE DURATION
Initial: 6 months. Reauth: 12 months

OTHER CRITERIA
Set A (continued, initial): AND b) One of the following: (1) Patient (pt) has been receiving at least 12 consecutive weeks of one high-intensity (HI) statin therapy (tx) and will continue to receive a HI statin [ie, atorvastatin 40-80 mg, Crestor (rosuvastatin) 20-40 mg] at maximally tolerated dose, OR (2) Both of the following: A) Pt is unable to tolerate HI statin as evidenced by intolerable and persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN]), AND B) One of the following: a) Pt has been receiving at least 12 consecutive weeks of one moderate-intensity or low-intensity statin tx and will continue to receive a MODERATE-INTENSITY or LOW-INTENSITY statin [ie, atorvastatin 10-20 mg, Crestor (rosuvastatin) 5-10 mg, simvastatin 10-40 mg, pravastatin 10-80 mg, lovastatin 20-40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 20-40 mg, or Livalo (pitavastatin) 1-4 mg] at maximally tolerated dose, OR b) Pt is unable to tolerate moderate-intensity or low-intensity statin tx as evidenced by intolerable and persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN]), OR (3) Submission of MR documenting pt has a labeled contraindication to all statins, OR (4) Pt has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN on one statin tx. OR set B) Both of the following: a) One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 120 days: (1) LDL-C b/t 70 and 99 mg/dL with ASCVD. (2) LDL-C b/t 100 and 129 mg/dL without ASCVD. AND b) Both of the following: (1) One of the following: i) Pt has been receiving at least 12 consecutive weeks of one maximally-tolerated statin tx and will continue to receive a statin at maximally tolerated dose, ii) pt is unable to tolerate statin tx as evidenced by intolerable and persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times ULN, iii) Submission of MR documenting patient has a labeled contraindication to all statins, or iv) Pt has experienced rhabdomyolysis or muscle symptoms with statin tx with CK elevations greater than 10 times ULN on one statin tx and (2) Pt has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) tx as adjunct to maximally tolerated statin tx OR Pt has a history of contraindication or intolerance to ezetimibe. Reauth: Pt continues to receive statin at the maximally tolerated dose (unless pt has documented inability to take statins). Submission of MR (eg, chart notes, lab values) documenting LDL-C reduction while on Praluent therapy. Initial, reauth: Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.
**MEDICATION(S)**
PROCYSBI

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
1 year of age or older

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
N/A
PROMACTA (S)

MEDICATION(S)
PROMACTA

COVEREDUSES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSIONCRITERIA
N/A

REQUIREDMEDICALINFORMATION
Chronic immune (idiopathic) thrombocytopenic purpura (ITP) (initial): Diagnosis of relapsed/refractory chronic ITP for greater than 6 months. Baseline platelet count is less than 50,000/mcL. Patient’s degree of thrombocytopenia and clinical condition increase the risk of bleeding. One of the following: A) Trial and failure, intolerance, contraindication to corticosteroids or immune globulin OR B) Trial and failure or contraindication to splenectomy. Chronic hepatitis C (initial): Diagnosis of chronic hepatitis C. Patient has thrombocytopenia defined as platelets less than 90,000/mcL for initiation (pre-treatment) of interferon therapy. Severe aplastic anemia (initial): Diagnosis of severe aplastic anemia. Patient has a platelet count less than 30,000/mcL. Trial and failure, intolerance, or contraindication to immunosuppressive therapy with antithymocyte globulin and cyclosporine.

AGERESTRICTION
N/A

PRESCRIBERRESTRICTION
N/A

COVERAGEDURATION

OTHERCRITERIA
ITP (reauth): After at least 4 weeks of therapy at the maximum weekly dose (10 mcg/kg), the platelet count increased to a sufficient level to avoid clinically important bleeding. Hepatitis C (reauth): Platelets less than 75,000/mcL for maintenance of optimal interferon-based therapy. Aplastic anemia (reauth): Patient has experienced an increase in platelet count.
MEDICATION(S)
MODAFINIL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
OSAHS/MS/dep(init), SWSD (init,reauth): 3 mo. OSAHS/dep(reauth): 12 mo. MS (reauth): 6 mo. Other:
OTHER CRITERIA
MEDICATION(S)
PULMOZYME

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Cystic Fibrosis (CF) (Initial, Reauth): Diagnosis of CF

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
CF (initial, reauth): 12 months

OTHER CRITERIA
Part B vs D determination applies. CF (reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).
QUALAQUIN (S)

MEDICATION(S)
QUININE SULFATE 324 MG CAPSULE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Malaria: Diagnosis of uncomplicated malaria. One of the following: 1) Treatment in areas of chloroquine-sensitive malaria, and trial and failure, contraindication, or intolerance to chloroquine or hydroxychloroquine, OR 2) Treatment in areas of chloroquine-resistant malaria. Not used for the treatment or prevention of nocturnal leg cramps.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
7 days

OTHER CRITERIA
N/A
MEDICATION(S)
RADICAVA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Amyotrophic lateral sclerosis (ALS) (initial): Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including: imaging, nerve conduction studies, laboratory values) to support a diagnosis of "definite" or "probable" ALS per the revised El Escorial diagnostic criteria. Patient has scores of greater than or equal to 2 in all items of the ALS Functional Rating Scale-Revised (ALSFRS-R) criteria at the start of treatment. Patient has a percent forced vital capacity (%FVC) of greater than or equal to 80% at the start of treatment.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ALS (initial): Prescribed by or in consultation with a neurologist.

COVERAGE DURATION
(Initial and reauth): 6 months

OTHER CRITERIA
ALS (reauthorization): Documentation of a benefit from therapy (e.g., slowing in the decline of functional abilities), and Patient is not dependent on invasive ventilation or tracheostomy.
**RAVICTI (S)**

**MEDICATION(S)**
RAVICTI

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Urea cycle disorders (UCDs) (Initial): Diagnosis of UCDs.

**AGE RESTRICTION**
UCDs (Initial): Age greater than or equal to 2 months

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
UCDs (Initial, reauth): 12 months

**OTHER CRITERIA**
UCDs (reauth): Documentation of positive clinical response to Ravigiti therapy.
**RELISTOR (S)**

**MEDICATION(S)**
RELISTOR 12 MG/0.6 ML KIT, RELISTOR 12 MG/0.6 ML SYRINGE, RELISTOR 12 MG/0.6 ML VIAL, RELISTOR 8 MG/0.4 ML SYRINGE

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Opioid-induced constipation (OIC) (Initial): Diagnosis of OIC. Patient has used opioid medication for a minimum of 4 weeks. Patient is experiencing fewer than 3 bowel movements in a week or no bowel movement for longer than 2 days. One of the following: A) Patient has chronic non-cancer pain, or chronic pain related to prior cancer or its treatment AND patient had a trial and failure, contraindication, or intolerance to Amitiza (lubiprostone), OR B) Patient is receiving palliative care for an advanced illness or pain caused by active cancer.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
OIC (initial, reauth): 4 months

**OTHER CRITERIA**
OIC (Reauth): Diagnosis of OIC. One of the following: A) Patient has chronic non-cancer pain, or chronic pain related to prior cancer or its treatment, OR B) Both of the following: Patient is receiving palliative care for an advanced illness or pain caused by active cancer AND Patient has responded to therapy (e.g., increase in bowel movements).
RELISTOR TABLETS (S)

MEDICATION(S)
RELISTOR 150 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Opioid-induced constipation (OIC) (non-cancer pain, initial): Diagnosis of OIC. Patient has chronic non-cancer pain, or chronic pain related to prior cancer or its treatment. Patient has used an opioid medication for a minimum of 4 weeks. Patient is experiencing fewer than 3 bowel movements in a week or no bowel movement for longer than 2 days. Trial and failure, contraindication, or intolerance to Amitiza (lubiprostone).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
OIC (Reauth): Diagnosis of OIC. Patient has chronic non-cancer pain, or chronic pain related to prior cancer or its treatment. Documentation of a positive clinical response to Relistor therapy (e.g., increase in bowel movements).
**MEDICATION(S)**
REMICADE

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (Initial): Diagnosis (Dx) of moderately to severely active CD or FCD. Failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, Imuran (azathioprine), corticosteroid (eg, prednisone, methylprednisolone), methotrexate (Rheumatrex/Trexall). Ulcerative colitis (UC) (Initial): Dx of moderately to severely active UC. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, Imuran (azathioprine), corticosteroid (eg, prednisone, methylprednisolone), aminosalicylate [eg, mesalamine (Asacol/Pentasa/Rowasa), Dipentum (olsalazine), Azulfidine (sulfasalazine)]. Rheumatoid arthritis (RA) (Initial): Dx of moderately to severely active RA. One of the following: Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall), OR TF/C/I to methotrexate (Rheumatrex/Trexall). Ankylosing spondylitis (AS) (Initial): Dx of active AS. TF/C/I to two NSAIDs. Psoriatic arthritis (PsA) (Initial): Dx of active PsA. Plaque psoriasis (Initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. Sarcoidosis (initial): TF/C/I to one immunosuppressant [eg, methotrexate (Rheumatrex/Trexall), cyclophosphamide, or azathioprine (Imuran)] AND TF/C/I to one corticosteroid (eg, prednisone). All indications (Initial): Patient is not receiving Remicade in combination with a biologic DMARD [eg, Enbrel (etanercept), Rituxan (rituximab), Orencia (abatacept), Kineret (anakinra)].

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
CD, FCD, UC (Initial): Prescribed by or in consultation with a gastroenterologist. RA, AS (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with rheumatologist or dermatologist. Plaque Psoriasis (Initial): Prescribed by or in consultation with a dermatologist. Sarcoidosis (Initial): Prescribed by or in consultation with a pulmonologist, dermatologist, ophthalmologist.
COVERAGE DURATION
All indications (initial, reauth): 12 months

OTHER CRITERIA
Reauthorization for all indications: Documentation of positive clinical response to infliximab therapy. All indications (re-auth): Excluded if patient is receiving infliximab in combination with a Biologic Disease Modifying Antirheumatic Drug (DMARD) [eg, Enbrel (etanercept), Ocrevus (abatacept), Rituxan (rituximab), Kineret (anakinra), Cimzia (certolizumab)].
REMODULIN (S)

MEDICATION(S)
REMODULIN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
Subject to Part B vs. D Review. PAH (Reauth): Documentation of positive clinical response to therapy.
MEDIICATION(S)
RENFLEXIS

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (initial): Diagnosis (Dx) of moderately to severely active CD or FCD. Ulcerative colitis (UC) (initial): Dx of moderately to severely active UC. Rheumatoid arthritis (RA) (initial): Dx of moderately to severely active RA. Ankylosing spondylitis (AS) (initial): Dx of active AS. Psoriatic arthritis (PsA) (initial): Dx of active PsA. Plaque psoriasis (initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. Reauthorization for all indications: Documentation of positive clinical response to infliximab therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. CD, FCD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION
All indications (Initial, reauth): 12 months

OTHER CRITERIA
CD, FCD (initial): Trial and failure, contraindication or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine (Purinethol), azathioprine (Imuran), corticosteroids (eg, prednisone, methylprednisolone), methotrexate (Rheumatrex, Trexall). UC (initial): TF/C/I to one of the following conventional therapies: corticosteroids, aminosalicylate [eg, mesalamine (Asacol/Pentasa/Rowasa), olsalazine (Dipentum), sulfasalazine (Azulfidine/Sulfazine)], azathioprine (Imuran), 6-mercaptopurine (Purinethol). RA (initial): Receiving concurrent therapy with methotrexate.
(Rheumatrex/Trexall), or TF/C/I to methotrexate. AS (initial): TF/C/I to two or more NSAIDs. All indications (initial): One of the following: 1) Trial and failure or intolerance to Remicade or 2) For continuation of prior Renflexis therapy. All indications (Initial and re-auth): Excluded if patient is receiving infliximab in combination with a Biologic Disease Modifying Antirheumatic Drug (DMARD) [eg, Enbrel (etanercept), Orencia (abatacept), Rituxan (rituximab), Kineret (anakinra), Cimzia (certolizumab)].
REPATHA (S)

MEDICATION(S)
REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HeFH/ASCVD (init): One of the following dx: HeFH as confirmed by one of the following: (1) Submission (Sub) of medical records (MR) (e.g., chart notes, lab values) Documenting assessment of patient (pt) using Dutch Lipid Clinic Network diagnostic criteria w/ a cum.score greater than or equal to 9 points (ie, definite FH), or (2) both of the following: a) One of the following: i) Presence of tendinous xanthomas and/or arcus cornealis in 1st degree relative, or 2nd degree relative, ii) Family history (hx) of MI in 1st degree relative less than 60 yo, iii) Family hx of MI in 2nd degree relative less than 50 yo, iv) Family hx of LDL greater than 190 mg/dL in 1st or 2nd degree relative, and v) Family hx of FH in 1st or 2nd degree relative, AND b) Untreated/pre-treatment LDL greater than 190 in an adult, or (3) Sub of MR (e.g., chart notes, lab values) documenting gen confirmation of a mutation in the LDL receptor, ApoB, or PCSK9, or (4) Untreated/pre-treatment LDL greater than 190 in an adult AND sub of MR (e.g., chart notes, lab values) documenting presence of tendinous xanthoma in pt or arcus cornealis before age 45. OR B) ASCVD as confirmed by ACS, hx of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin. HoFH (initial): Sub of MR (eg, chart notes, lab values) documenting dx of HoFH as confirmed by one of the following: (1) Gen confirmation of 2 mutations in LDL receptor, ApoB, PCSK9, or LDLRAP1 or ARH, or (2) either untreated LDL greater than 500 or treated LDL greater than 300, AND either xanthoma before 10 yo or evidence of HeFH in both parents. HeFH/ASCVD (init): One of the following: set A) Both of the following: a) One of the following LDL values while on max tolerated lipid-lowering regimen w/in the last 120 days: (1) LDL greater than or equal to 100 w/ ASCVD, or (2) LDL greater than or equal to 130 w/o ASCVD.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HeFH/ASCVD/HoFH (init, reauth): Prescribed by or in consultation with a cardiologist, endocrinologist,
or lipid specialist

**COVERAGE DURATION**

**OTHER CRITERIA**
Set A (continued, initial): AND b) One of the following: (1) Pt has been receiving at least 12 consecutive wks of one max-tolerated statin tx and will continue to receive a statin at max tolerated dose, or (2) Pt is unable to tolerate statin as evidenced by intolerable and persistent (ie, more than 2 wks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times ULN), or (3) Sub of MR documenting pt has a labeled contraindication to all statins, or (4) Pt has experienced rhabdomyolysis or muscle symptoms with statin tx with CK elevations greater than 10 times ULN on one statin tx. OR set B) Both of the following: a) One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 120 days: (1) LDL-C b/t 70 and 99 mg/dL with ASCVD. (2) LDL-C b/t 100 and 129 mg/dL without ASCVD. AND b) Both of the following: (1) One of the following: i) Pt has been receiving at least 12 consecutive weeks of one maximally-tolerated statin tx and will continue to receive a statin at maximally tolerated dose, ii) pt is unable to tolerate statin tx as evidenced by intolerable and persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times ULN, iii) Sub of MR documenting pt has a labeled contraindication to all statins, or iv) Pt has experienced rhabdomyolysis or muscle symptoms with statin tx with CK elevations greater than 10 times ULN on one statin tx and (2) Pt has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) tx as adjunct to maximally tolerated statin tx OR Pt has a history of contraindication or intolerance to ezetimibe. HoFH (initial): Pt is receiving other lipid-lowering tx (e.g., statin, ezetimibe). HeFH/ASCVD (reauth): Pt continues to receive statin at the max tolerated dose (unless pt has documented inability to take statins). HoFH (reauth): Pt continues to receive other lipid-lowering tx (e.g., statin, ezetimibe). HeFH/ASCVD/HoFH (reauth): Sub of MR (eg, chart notes, lab values) documenting LDL-C reduction while on Repatha tx. HeFH/ASCVD/HoFH (Initial, reauth): Not used in combination with another PCSK9 inhibitor. HoFH (Initial, reauth): Not used in combination with Juxtapid (lomitapide) or Kynamro (mipomersen).
REVATIO (S)

MEDICATION(S)
REVATIO 10 MG/ML ORAL SUSP, SILDENAFIL, SILDENAFIL 10 MG/12.5 ML VIAL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. For formulary sildenafil citrate injection only (Initial): Patient is unable to take oral medications. For Revatio oral suspension only (initial): One of the following: A) Intolerance to generic Revatio tablets, OR B) Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to one of the following: age, oral-motor difficulties, or dysphagia.

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
PAH (Reauth): Documentation of positive clinical response to therapy
REVLIMID (S)

MEDICATION(S)
REVLIMID

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple myeloma (MM): Diagnosis of MM. Either used as 1) combination therapy with dexamethasone, or 2) maintenance therapy following autologous hematopoietic stem cell transplantation (auto-HSCT).
Myelodysplastic syndromes (MDS): Patient has transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with a deletion. Mantle cell lymphoma (MCL): Diagnosis of MCL. Disease has relapsed, refractory, or progressed after at least one prior therapy (eg, bortezomib, bendamustine, cladribine, rituximab).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist/hematologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
RILUZOLE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Amyotrophic lateral sclerosis (ALS): Diagnosis of amyotrophic lateral sclerosis (ALS)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
ALS: 12 months

OTHER CRITERIA
N/A
MEDICATION(S)
RITUXAN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Rheumatoid Arthritis (RA) (init): Patient is not receiving Rituxan in combination with a biologic DMARD [e.g., Enbrel (etanercept), Orenzia (abatacept), Kineret (anakinra)].

REQUIRED MEDICAL INFORMATION
Non-Hodgkin’s Lymphoma (NHL): As first-line treatment of diffuse large B-cell, CD20-positive, NHL in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens, or as first-line treatment of follicular, CD20-positive, B-cell NHL in combination with chemotherapy, or as a single-agent maintenance therapy for the treatment of follicular, CD20-positive, B-cell NHL in patients achieving a complete or partial response to Rituxan in combination with chemotherapy, or for the treatment of low-grade, CD20-positive, B-cell NHL in patients with stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy or who achieve a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy, or diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin’s lymphoma. Rheumatoid Arthritis (RA) (init): Concurrently on or contraindication, or intolerance to methotrexate. Trial and failure, contraindication, or intolerance (TF/C/I) to a TNF antagonist (e.g., adalimumab, etanercept, infliximab). Wegener’s Granulomatosis (WG) and Microscopic Polyangiitis (MPA): Patient is concurrently on glucocorticoids (e.g., prednisone) OR contraindication or intolerance to glucocorticoids (e.g., prednisone). Immune or idiopathic thrombocytopenic purpura (ITP): TF/C/I to one of the following: corticosteroids, immunoglobulins, or splenectomy. Documented platelet count of less than 50x10^9/L. Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Pemphigus Vulgaris (PV): Diagnosis of moderate to severe PV.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ITP: Prescribed by or in consultation with a hematologist or oncologist. RA: Prescribed by or in consultation with a rheumatologist. WG, MPA: Prescribed by or in consultation with a nephrologist,
pulmonologist, or rheumatologist. PV: Prescribed by or in consultation with a dermatologist

**COVERAGE DURATION**
All uses except RA, WG, MPA: 12 mos. RA: 3 months. WG, MPA: 3 months only.

**OTHER CRITERIA**
Approve for continuation of prior therapy.
RUBRACA (S)

MEDICATION(S)
RUBRACA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Ovarian cancer: Diagnosis of ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. One of the following: 1) Both of the following: a) Presence of deleterious BRCA mutation as detected by an FDA-approved diagnostic test (e.g., FoundationFocus CDxBRCA Assay) or performed at a Clinical Laboratory Improvement Amendments-approved facility and b) Trial and failure, contraindication, or intolerance to two or more chemotherapies (e.g., cisplatin, carboplatin), OR 2) Both of the following: a) Disease is recurrent and b) Used for maintenance treatment in patients who are in a complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy
MEDICATION(S)
RUCONEST

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
HAE: Prescribed by or in consultation with an immunologist, allergist, or rheumatologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
RYDAPT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Acute Myeloid Leukemia (AML): Newly diagnosed acute myeloid leukemia (AML), FMS-like tyrosine kinase 3 (FLT3) mutation-positive as detected by a U.S. Food and Drug Administration (FDA)-approved test, used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. Aggressive Systemic Mastocytosis (ASM), Systemic Mastocytosis with Associated Hematological Neoplasm (SM-AHN), Mast Cell Leukemia (MCL): Diagnosis of one of the following: aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
All indications: Prescribed by or in consultation with a hematologist or oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy
**MEDICATION(S)**
SABRIL, VIGABATRIN

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Complex Partial Seizures (CPS): For use as adjunctive therapy. Failure, contraindication, or intolerance to two formulary anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)]. Infantile Spasms (IS): Diagnosis of infantile spasms.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
SANDOSTATIN (S)

MEDICATION(S)
OCTREOTIDE 1,000 MCG/5 ML VIAL, OCTREOTIDE 1,000 MCG/ML VIAL, OCTREOTIDE 5,000 MCG/5 ML VIAL, OCTREOTIDE ACET 0.05 MG/ML VL, OCTREOTIDE ACET 100 MCG/ML AMP, OCTREOTIDE ACET 100 MCG/ML VL, OCTREOTIDE ACET 200 MCG/ML VL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE ACET 50 MCG/ML VIAL, OCTREOTIDE ACET 500 MCG/ML AMP, OCTREOTIDE ACET 500 MCG/ML VL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Acromegaly (initial): Diagnosis of acromegaly AND One of the following: A) History of failure to surgical resection and/or pituitary irradiation OR B) patient is not a candidate for surgical resection or pituitary irradiation AND Trial and failure or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses. Carcinoid tumor (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
All Uses (Initial and reauth): 12 months

OTHER CRITERIA
Acromegaly (reauth): Patient has had a clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size). Carcinoid tumor (reauth): patient has improvement in number of diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (reauth): patient has improvement in number of diarrhea episodes.
MEDICATION(S)
SANDOSTATIN LAR, SANDOSTATIN LAR DEPOT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Acromegaly (initial): Diagnosis of acromegaly AND One of the following: A) Failure to surgical resection and/or pituitary irradiation OR B) patient is not a candidate for surgical resection or pituitary irradiation AND Trial and failure or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses AND Patient had a trial of short-acting octreotide and responded to and tolerated therapy. Carcinoid tumor (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes AND Patient had a trial of short-acting octreotide and responded to and tolerated therapy. Vasoactive peptide tumor (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea AND Patient had a trial of short-acting octreotide and responded to and tolerated therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
All Uses (Initial and reauth): 12 months

OTHER CRITERIA
Acromegaly (reauth): Patient has had a clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size). Carcinoid tumor (reauth): patient has improvement in number of diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (reauth): patient has improvement in number of diarrhea episodes.
MEDICATION(S)
SEROSTIM

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Initial: 3 months, Reauth: 6 months

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

**MEDICATION(S)**
SIGNIFOR

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Cushing's disease (initial): Diagnosis of Cushings disease AND failure to or patient is not a candidate for pituitary surgery.

**AGE RESTRICTION**
Initial: 18 years of age or older

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Initial: 3 months. Reauth: 12 months.

**OTHER CRITERIA**
Cushing's disease (reauth): a clinically meaningful reduction in 24-hour urinary free cortisol levels or improvement in signs or symptoms of the disease
MEDICATION(S)
SIGNIFOR LAR 20 MG KIT, SIGNIFOR LAR 20 MG VIAL, SIGNIFOR LAR 40 MG KIT, SIGNIFOR LAR 40 MG VIAL, SIGNIFOR LAR 60 MG KIT, SIGNIFOR LAR 60 MG VIAL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Acromegaly (initial): Diagnosis of acromegaly AND failure to surgery or patient is not a candidate for surgery

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 6 months. Reauth: 12 months.

OTHER CRITERIA
Acromegaly (reauth): patients growth hormone (GH) level or insulin-like growth factor 1 (IGF-1) level for age and gender has normalized/improved
MEDICATION(S)
SILIQ

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Trial and failure, contraindication, or intolerance to both Cosentyx (secukinumab) and either Enbrel (etanercept) or Humira (adalimumab), OR for continuation of prior Siliq therapy. Patient is not receiving Siliq in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Initial, reauth: 12 months

OTHER CRITERIA
Plaque psoriasis (Reauth): Documentation of positive clinical response to Siliq therapy. Patient is not receiving Siliq in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].
**MEDICATION(S)**

SIMPONI ARIA

**COVERED USES**

All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**

N/A

**REQUIRED MEDICAL INFORMATION**

Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall), OR trial and failure, contraindication, or intolerance (TF/C/I) to methotrexate (Rheumatrex/Trexall). One of the following: trial and failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), or attestation demonstrating a trial may be inappropriate, OR for continuation of prior therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: TF/C/I to both Enbrel (etanercept) and Humira (adalimumab), or attestation demonstrating a trial may be inappropriate, OR for continuation of prior therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: TF/C/I to both Enbrel (etanercept) and Humira (adalimumab), or attestation demonstrating a trial may be inappropriate, OR for continuation of prior Simponi therapy. All indications (initial): Patient is not receiving Simponi Aria in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)].

**AGE RESTRICTION**

N/A

**PRESCRIBER RESTRICTION**

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

**COVERAGE DURATION**

RA (Initial, reauth): 12 months

**OTHER CRITERIA**

All Indications (Reauth): Documentation of positive clinical response to Simponi therapy. Patient is not receiving Simponi Aria in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira...
(adalimumab), Cimzia (certolizumab), Orencia (abatacept).
SIMVASTATIN (S)

MEDICATION(S)
SIMVASTATIN 80 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has been taking simvastatin 80 mg per day chronically (12 months or more) and no evidence of muscle toxicity/myopathy (e.g., muscle pain, muscle tenderness, muscle weakness) on simvastatin 80 mg per day.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
SOMATULINE DEPOT (S)

MEDICATION(S)
SOMATULINE DEPOT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Acromegaly: Diagnosis of acromegaly AND One of the following: A) Failure to one of the following: surgery or radiotherapy, OR B) not a candidate for one of the following: surgery or radiotherapy.
Gastroenteropancreatic neuroendocrine tumors (GEP-NETs): Diagnosis of unresectable, well- or moderately-differentiated, locally advanced or metastatic GEP-NETs. Carcinoid syndrome (120mg/0.5mL): Diagnosis of carcinoid syndrome. Used to reduce the frequency of short-acting somatostatin analog rescue therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
All Indications: 12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
SOMAVERE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Acromegaly (initial): Diagnosis of acromegaly AND Failure to surgery and/or radiation therapy and/or other medical therapies (such as dopamine agonists [e.g., bromocriptine, cabergoline]) unless patient is not a candidate for these treatment options AND trial and failure or intolerance to generic octreotide (a somatostatin analogue)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial and reauth: 12 months

OTHER CRITERIA
Acromegaly (reauth): Patient has experienced an objective response to therapy (biochemical control, decrease or normalization of IGF-1 levels).
MEDICATION(S)
SOVALDI

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria will be applied consistent with current AASLD/IDSA guideline. For genotype (GT) 1 patients, Sovaldi plus Olysio: Patient is without decompensated liver disease (defined as Child-Pugh Class B or C). All GT1 (except Sovaldi plus Olysio therapy, or Sovaldi plus Daklinza therapy in liver transplant (tx) patients) and GT4: 1) trial and failure, intolerance or contraindication (TF/I/C) to both of the following: a) Harvoni OR Epclusa and b) Mavyret therapy OR 2) For continuation of prior Sovaldi therapy. For GT2 (except liver tx patients, or pediatric patients 12 years of age and older or weighing at least 35 kg) or GT3 patients (except pediatric patients 12 years of age and older or weighing at least 35 kg), using Sovaldi plus ribavirin: TF/I/C to a) Epclusa OR Mavyret OR b) for continuation of prior Sovaldi therapy. All Sovaldi plus Olysio therapy: one of the following: 1) TF/I/C to both of the following: a) Harvoni OR Epclusa and b) Mavyret OR 2) both of the following: a) trial and failure of a NS5A-containing regimen (e.g., Harvoni, Epclusa, OR Zepatier) AND b) the patient has NS5A inhibitor resistant-associated variants detected using commercially available assays, OR 3) For continuation of prior Sovaldi plus Olysio therapy.(continued in Other Criteria)

AGE RESTRICTION
N/A

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

COVERAGE DURATION
12 to 48 wks. Criteria will be applied consistent with current AASLD/IDSA guideline

OTHER CRITERIA
All Sovaldi plus Daklinza therapy: One of the following: 1) Patient has not failed a prior HCV NS5A-
containing regimen (eg, Daklinza) therapy, OR 2) patient has failed prior therapy with an NS5A-containing regimen AND submission of medical records (eg, chart notes) documenting that the patient does not have NS5A inhibitor resistance-associated variants detected using commercially available assays. For GT2 and GT3 (except liver tx patients) patients, using Sovaldi plus Daklinza: TF/I/C to Epclusa OR Mavyret, OR for continuation of prior Sovaldi therapy. For GT2 or 3 liver tx recipients without cirrhosis, ONE of the following: 1) Patient has had a TF/I/C to Mavyret OR 2) For continuation of prior Daklinza therapy. For GT2 or 3 liver tx recipients with decompensated cirrhosis, ONE of the following: 1) Patient has had a TF/I/C to Epclusa OR 2) For continuation of prior Daklinza therapy. For GT1 liver tx patients using Sovaldi plus Daklinza, TF/I/C to a) Harvoni OR Mavyret OR b) continuation of prior Sovaldi therapy.
MEDICATION(S)
ITRACONAZOLE 100 MG CAPSULE, SPORANOX 10 MG/ML SOLUTION

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
One of the following: 1) patient has a systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis), OR 2) patient is resistant to topical antifungal treatment and has one of the following diagnoses: a) tinea corporis (ringworm), OR b) tinea cruris (jock itch), OR c) tinea pedis (athlete’s foot), OR d) tinea capitis (scalp ringworm), OR e) pityriasis versicolor, OR 3) all of the following: a) patient has a diagnosis of onychomycosis confirmed by one of the following (CAPSULE ONLY): i) positive potassium hydroxide (KOH) preparation, OR ii) culture, OR iii) histology, AND b) patient has had a trial and inadequate response, intolerance or hypersensitivity to oral terbinafine, OR 4) patient has a diagnosis of candidiasis (esophageal or oropharyngeal) that is refractory to treatment with fluconazole (ORAL SOLUTION ONLY).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
systemic fungal infxn:6mo.(candidiasis,fingernail onycho.):1 mo.(toenail onycho, other):3mo.

OTHER CRITERIA
N/A
MEDICATION(S)
SPRYCEL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Philadelphia chromosome positive/BCR ABL positive (Ph+/BCR ABL+) chronic myelogenous leukemia (CML): Diagnosis of Ph+/BCR ABL+ CML. Ph+/BCR ABL+ acute lymphoblastic leukemia (ALL): Diagnosis of Ph+/BCR ABL+ ALL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
All Uses: Prescribed by or in consultation with an oncologist or hematologist

COVERAGE DURATION
All Uses: 12 months

OTHER CRITERIA
All Uses: Approve for continuation of prior therapy.
MEDICATION(S)
STELARA 130 MG/26 ML VIAL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of moderately to severely active Crohn's disease. One of the following: a) trial and failure, contraindication, or intolerance to Humira (adalimumab), or (b) trial and failure, contraindication, or intolerance to treatment with at least one immunomodulator or corticosteroid [e.g., Purinethol (6-mercaptopurine), Imuran (azathioprine), Sandimmune (cyclosporine A), Prograf (tacrolimus), MTX (methotrexate)]. Patient is not receiving Stelara in combination a biologic DMARD [e.g, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION
One time

OTHER CRITERIA
Stelara is to be administered as an intravenous induction dose. Stelara induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg.
STIVARGA (S)

MEDICATION(S)
STIVARGA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Metastatic colorectal cancer (mCRC): All of the following: 1) diagnosis of mCRC, AND 2) trial and failure, contraindication or intolerance to fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, AND 3) trial and failure, contraindication or intolerance to an anti-VEGF therapy (e.g. Avastin [bevacizumab]), AND 4) one of the following: a) KRAS mutation, OR b) both of the following: KRAS wild-type and trial and failure, contraindication or intolerance to an anti-EGFR therapy [e.g. Vectibix (panitumumab), Erbitux (cetuximab)]. Gastrointestinal stromal tumor (GIST): All of the following: 1) diagnosis of locally advanced, unresectable or metastatic GIST, AND 2) trial and failure, contraindication or intolerance to both of the following: a) Gleevec (imatinib mesylate), AND b) Sutent (sunitinib malate). Hepatocellular Carcinoma (HCC): Diagnosis of HCC. Trial and failure or intolerance to Nexavar (sorafenib tosylate).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
mCRC, GIST: Prescribed by or in consultation with an oncologist. HCC: Prescribed by or in consultation with an oncologist, hepatologist, or gastroenterologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
STRENSIQ

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Hypophosphatasia: 12 months

OTHER CRITERIA
N/A
MEDICATION(S)
SUTENT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
All Indications: Prescribed by or in consultation with an oncologist

COVERAGE DURATION
All Indications: 12 months

OTHER CRITERIA
All Indications: Approve for continuation of prior therapy
**SYLATRON (S)**

**MEDICATION(S)**
SYLATRON, SYLATRON 4-PACK

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Melanoma: Diagnosis of melanoma with microscopic or gross nodal involvement AND The prescribed medication will be used as adjuvant therapy within 84 days of definitive surgical resection, including complete lymphadenectomy.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist or dermatologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy
MEDICATION(S)
SYLVANT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
MCD (initial, reauth): 6 months

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

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Initial: 1) Diagnosis of cystic fibrosis. 2) One of the following: Patient is homozygous for the F508del mutation as detected by a FDA-cleared cystic fibrosis mutation test or Clinical Laboratory Improvement Amendments (CLIA) -approved facility OR Patient has one of the following mutations on at least one allele in the CF transmembrane conductance regulator (CFTR) gene as detected by FDA-cleared cystic fibrosis mutation test or Clinical Laboratory Improvement Amendments (CLIA) -approved facility:

AGE RESTRICTION
Patient is 12 years of age or older

PRESCRIBER RESTRICTION
Initial: Prescribed by or in consultation with pulmonologist or specialist affiliated with a CF care center

COVERAGE DURATION
12 months

OTHER CRITERIA
Reauth: Documentation of a positive clinical response to Symdeko (tezacaftor/ivacaftor) therapy (e.g., improvement in lung function or decreased number of pulmonary exacerbations)
**MEDICATION(S)**
SYMLINPEN 120, SYMLINPEN 60

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
One of the following diagnoses: A) Type 1 diabetes OR B) Type 2 diabetes.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
N/A
MEDICATION(S)
SYNAGIS

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient will use palivizumab for immunoprophylaxis of respiratory syncytial virus (RSV) during the peak months of infection in the patients geographic region AND Patient meets one of the following criteria: 1) Infants born at 28 weeks, six days gestation or earlier and who are younger than 12 months of age at the start of the RSV season OR 2) Diagnosis of chronic lung disease of prematurity, born before 32 weeks, 0 days gestation, received greater than 21% oxygen for at least the first 28 days after birth, and one of the following: a) 12 months of age or younger at the start of the RSV season OR b) greater than 12 months of age to 24 months of age at the start of the RSV season and received medical support (i.e., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) within 6 months before the start of the second RSV season. OR 3) Patient is 12 months of age or younger at the start of the RSV season and has one of the following: a) acyanotic heart failure that will require a cardiac surgical procedure and the patient is receiving medication to control congestive heart failure, OR b) moderate to severe pulmonary hypertension OR c) cyanotic heart defect. OR 4) patient is younger than 24 months of age and will or has undergone a cardiac transplantation during the RSV season. OR 5) Patient is 12 months of age or younger at the start of the RSV season with a congenital abnormality or neuromuscular disorder and has an impaired ability to clear secretions from the upper airway due to an ineffective cough. OR 6) Patient is younger than 24 months of age with a lymphocyte count below the normal range for patients age and has received or will receive a solid organ transplant, hematopoietic stem cell transplant recipient, or chemotherapy during the RSV season.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a pediatric specialist (i.e., pulmonologist, neonatologist, neurologist, cardiologist, pediatric intensivist, or infectious disease specialist).
COVERAGE DURATION
12 months

OTHER CRITERIA
Approve 5 doses based on patient body weight for all other indications.
SYNDROS (S)

MEDICATION(S)
SYNDROS

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. Trial and failure, contraindication, or intolerance (TF/C/I) to a 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). TF/C/I to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine). AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
CINV: 6 months. AIDS anorexia: 3 months.

OTHER CRITERIA
Subject to Part B vs. Part D review. CINV: Approve for continuation of therapy for treatment covered under Part B when patient is receiving chemotherapy.
**MEDICATION(S)**
SYNRIBO

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Chronic myelogenous leukemia (CML): Diagnosis of CML in the chronic or accelerated phase AND Patient has tried and has had resistance, relapse, inadequate response, intolerance or is contraindicated to TWO tyrosine kinase inhibitors (i.e., Gleevec [imatinib], Sprycel, Tasigna, and Bosulif, Iclusig)

**AGE RESTRICTION**
CML: 18 years of age or older

**PRESCRIBER RESTRICTION**
CML: Prescribed by or in consultation with a hematologist/oncologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy
MEDICATION(S)
TAFINLAR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT) as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Involvement of lymph nodes following complete resection. Used as adjunctive therapy. Medication is used in combination with Mekinist (trametinib). Non-small Cell Lung Cancer (NSCLC): All of the following: diagnosis of metastatic non-small cell lung cancer AND cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND medication is used in combination with Mekinist (trametinib). Anaplastic Thyroid Cancer (ATC): Diagnosis of locally advanced or metastatic anaplastic thyroid cancer. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Cancer may not be treated with standard locoregional treatment options. Medication is used in combination with Mekinist (trametinib).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA

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Approve for continuation of prior therapy.
MEDICATION(S)
TAGRISSO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. One of the following: 1) Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions, OR 2) Tumors are positive for EGFR exon 21 L858R mutations, OR 3) Both of the following: a) Tumors are positive for EGFR T790M mutation and b) The patient has experienced disease progression on or after one of the following EGFR Tyrosine Kinase Inhibitors (TKIs): Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
TALTZ AUTOINJECTOR, TALTZ AUTOINJECTOR (2 PACK), TALTZ AUTOINJECTOR (3 PACK), TALTZ SYRINGE, TALTZ SYRINGE (2 PACK), TALTZ SYRINGE (3 PACK)

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Trial and failure, contraindication, or intolerance to both Cosentyx (secukinumab) and either Enbrel (etanercept) or Humira (adalimumab), OR for continuation of prior Taltz therapy. Psoriatic Arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: Trial and failure, contraindication, or intolerance to Cosentyx (secukinumab), OR for continuation of prior Taltz therapy. All indications (initial): Patient is not receiving Taltz in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Initial, reauth: 12 months

OTHER CRITERIA
All indications (Reauth): Documentation of positive clinical response to Taltz therapy. Patient is not receiving Taltz in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].
MEDICATION(S)
TARCEVA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Non-small cell lung cancer (NSCLC): Diagnosis of locally advanced or metastatic (Stage III or IV) NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. Pancreatic Cancer: Diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer AND TARCEVA will be used in combination with gemcitabine.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
All Indications: Prescribed by or in consultation with an oncologist

COVERAGE DURATION
All Indications: 12 months

OTHER CRITERIA
All Indications: Approve for continuation of prior therapy.
MEDICATION(S)
BEXAROTENE, TARGRETIN 1% GEL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Cutaneous T-Cell Lymphoma (CTCL): Diagnosis of CTCL. Trial and failure, contraindication, or intolerance to at least one prior therapy (including skin-directed therapies [eg, corticosteroids {ie, clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate}] or systemic therapies [eg, interferons]).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist or dermatologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
TASIGNA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Philadelphia chromosome positive/BCR ABL positive (Ph+/BCR ABL+) chronic myelogenous leukemia (CML): Diagnosis of Ph+/BCR ABL+ CML

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist or hematologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
TAVALISSE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic Idiopathic Thrombocytopenic Purpura (ITP) (initial): Diagnosis of chronic immune ITP or relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL. Trial and failure, contraindication, or intolerance to at least one of the following: corticosteroids, immunoglobulins, splenectomy, thrombopoietin receptor agonists (e.g., Nplate, Promacta), or Rituxan (rituximab). Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ITP (initial): Prescribed by or in consultation with a hematologist/oncologist.

COVERAGE DURATION
ITP (initial, reauth): 12 months

OTHER CRITERIA
ITP (reauth): Documentation of positive clinical response to Tavalisse therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.
MEDICATION(S)
TECENTRIQ

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Urothelial Carcinoma: Diagnosis of locally advanced or metastatic urothelial carcinoma. One of the following: A) Both of the following: Tumors express PD-L1 (PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5% of the tumor area), as determined by an FDA-approved test (e.g., Ventana PD-L1 Assay) and Patient is not eligible for cisplatin-containing chemotherapy, B) Patient is not eligible for any platinum-containing chemotherapy regardless of PD-L1 status, C) Patient has disease progression during or following any platinum-containing chemotherapy, OR D) Patient has disease progression within 12 months of neoadjuvant or adjuvant chemotherapy. Non-Small Cell Lung Cancer: All of the following: A) Diagnosis of metastatic non-small cell lung cancer (NSCLC), and B) Patient has disease progression during or following platinum-containing chemotherapy, and C) One of the following: 1) Patient does not have epidermal growth factor receptor (EGFR) mutation or anaplastic lymphoma kinase (ALK) rearrangement OR 2) Both of the following: patient has an EGFR mutation AND trial and failure, contraindication, or intolerance to at least one anti-EGFR therapy (e.g., Gilotrif [afatinib], Iressa [gefitinib], Tarceva [erlotinib]) OR 3) Both of the following: patient has ALK rearrangement AND trial and failure, contraindication, or intolerance to at least one ALK inhibitor (e.g., Xalkori [crizotinib]).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 Months

OTHER CRITERIA
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Approve for continuation of prior therapy.
TECFIDERA (S)

MEDICATION(S)
TECFIDERA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
TECHNIVIE (S)

MEDICATION(S)
TECHNIVIE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
All of the following: A) Criteria will be applied consistent with current AASLD/IDSA guideline, AND B) Patient is not receiving Technivie in combination with another HCV direct acting antiviral agent [eg, Harvoni (ledipasvir-sofosbuvir), Sovaldi (sofosbuvir), Olysio (simeprevir)], AND C) ONE of the following: Trial and failure, intolerance, or contraindication to a) Harvoni OR Epclusa and b) Mavyret, OR for continuation of prior Technivie therapy.

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A
TESTOSTERONE (S)

MEDICATION(S)
ANDRODERM, ANDROGEL 1.62% GEL PUMP, ANDROGEL 1.62%(1.25G) GEL PCKT, ANDROGEL 1.62%(2.5G) GEL PCKT, TESTOSTERONE 30 MG/1.5 ML PUMP, TESTOSTERON CYP 1,000 MG/10 ML, TESTOSTERON CYP 2,000 MG/10 ML, TESTOSTERONE CYP 100 MG/ML, TESTOSTERONE CYP 200 MG/ML

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than reference range for the lab OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome). Gender Identity Disorder or Gender Dysphoria (GID/GD) (off-label): Dx of GID/GD. Patient is a female-to-male transsexual.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

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

**MEDICATION(S)**
TESTOSTERON ENAN 1,000 MG/5 ML, TESTOSTERONE ENAN 200 MG/ML

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following:
1) Two pre-treatment serum total testosterone (T) levels less than reference range for the lab OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome). Delayed puberty (DP): Dx of DP AND male patient at birth. Breast cancer (BC): Dx of inoperable BC AND used for palliative treatment AND female patient at birth. Gender Identity Disorder or Gender Dysphoria (GID/GD) (off-label): Dx of GID/GD. Patient is a female-to-male transsexual.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**

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

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple myeloma (MM): Diagnosis of MM. Used in combination with dexamethasone, unless the patient has an intolerance to steroids. Erythema nodosum leprosum (ENL): Diagnosis of moderate to severe ENL with cutaneous manifestations. Thalomid is not used as monotherapy if moderate to severe neuritis is present.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
MM: Prescribed by or in consultation with an oncologist/hematologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
TOPICAL RETINOIDS (S)

MEDICATION(S)
AVITA, TRETINOIN 0.01% GEL, TRETINOIN 0.025% CREAM, TRETINOIN 0.025% GEL, TRETINOIN 0.05% CREAM, TRETINOIN 0.05% GEL, TRETINOIN 0.1% CREAM, TRETINOIN MICROSPHERE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
One of the following: Acne: Diagnosis of acne.

AGE RESTRICTION
PA applies to members 26 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
TRELSTAR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
TREMFYA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: set A) 1) Trial and failure, contraindication, or intolerance (TF/C/I) to Enbrel (etanercept) or Humira (adalimumab) AND 2) TF/C/I to Cosentyx (secukinumab), OR set B) for continuation of prior Tremfya therapy. Patient is not receiving Tremfya in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab pegol), Simponi (golimumab)].

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Plaque psoriasis (Initial, reauth): 12 months

OTHER CRITERIA
Plaque psoriasis (Reauth): Documentation of positive clinical response to Tremfya therapy. Patient is not receiving Tremfya in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab pegol), Simponi (golimumab)].
MEDICATION(S)
TYKERB

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Breast Cancer: Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive metastatic or recurrent breast cancer. Used in combination with one of the following: Herceptin (trastuzumab), Xeloda (capecitabine), or aromatase inhibitors [eg, Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)].

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
TYMLOS

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient is a postmenopausal woman. Either of the following: set I) diagnosis of osteoporosis defined as bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND one of the following: a) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm or b) trial and failure, contraindication, or intolerance to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia (denosumab)), or set II) diagnosis of osteopenia defined as BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) and one of the following: a) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or b) both of the following: history of failure, contraindication, or intolerance to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) and one of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities: major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or hip fracture is 3% or more in the U.S., or the country-specific threshold in other countries or regions. Treatment duration of parathyroid hormones (Forteo, Tymlos (abaloparatide)) has not exceeded a total of 24 months during the patient's lifetime.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
24 months

OTHER CRITERIA
N/A
**MEDICATION(S)**

TYSABRI

**COVERED USES**

All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**

N/A

**REQUIRED MEDICAL INFORMATION**

Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses). One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following: Aubagio (teriflunomide), Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone or Glatopa (glatiramer acetate), Extavia (interferon beta-1b), Gilenya (fingolimod), Lemtrada (alemtuzumab), Ocrevus (ocrelizumab), Plegridy (peginterferon beta-1a), Rebif (interferon beta-1a), Tecfidera (dimethyl fumarate), or Zinbryta (daclizumab), 2) Patient is not a candidate for any of the drugs listed as prerequisites due to the severity of their MS, or 3) For continuation of prior therapy. Patient is not taking Tysabri in combination with another MS agent [eg, Aubagio (teriflunomide), Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone (glatiramer acetate), Glatopa (glatiramer acetate), Extavia (interferon beta-1b), Gilenya (fingolimod), Lemtrada (alemtuzumab), Rebif (interferon beta-1a), or Tecfidera (dimethyl fumarate)].

Crohn’s Disease (CD) (initial): Diagnosis of moderate to severe CD with evidence of inflammation (eg, elevated C-reactive protein [CRP], elevated erythrocyte sedimentation rate, presence of fecal leukocytes). Inadequate response or intolerance to one of the following conventional therapies: corticosteroids, 6-mercaptopurine (6MP [Purinethol], azathioprine (Imuran), methotrexate, aminosalicylates (eg, sulfasalazine, mesalamine, olsalazine). Inadequate response or intolerance to a TNF-inhibitor (eg, Cimzia [certolizumab pegol], Humira [adalimumab], Remicade [infliximab]). CD (initial and reauth): Patient is not taking Tysabri in combination with an immunosuppressant (eg, 6-MP, azathioprine, cyclosporine, or methotrexate) or a TNF-inhibitor (eg, Enbrel [etanercept], Humira [adalimumab], or Remicade [infliximab]).

**AGE RESTRICTION**

N/A

**PRESCRIBER RESTRICTION**

N/A
COVERAGE DURATION
MS: 12mo. CD (Init): 3 mo. CD (Reauth): 6 mo if not on steroids. Otherwise, 3 mo.

OTHER CRITERIA
CD (reauth): Diagnostic and/or clinical documentation (eg, improved disease activity index) that indicates patient has experienced clinical benefit from receiving (induction) Tysabri therapy by week 12.
MEDICATION(S)
UPTRAVI

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Pulmonary arterial hypertension (PAH) (initial): Diagnosis of PAH AND Patient is symptomatic AND
One of the following: a) Diagnosis of PAH was confirmed by right heart catheterization OR b) patient is
currently on any therapy for the diagnosis of PAH. One of the following: a) History of trial and failure,
contraindication, or intolerance to a PDE5 inhibitor (ie, Adcirca, Revatio) or Adempas (riociguat), and
History of trial and failure, contraindication, or intolerance to an endothelin receptor antagonist [e.g.
Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)] OR b) For continuation of prior
Uptravi therapy. Not taken in combination with a prostanoid/prostacyclin analogue (eg, epoprostenol,
iloprost, treprostinil).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist

COVERAGE DURATION
Initial: 6 months Reauth: 12 months

OTHER CRITERIA
PAH (Reauth): Documentation of positive clinical response to Uptravi therapy. Not taken in
combination with a prostanoid/prostacyclin analogue (eg, epoprostenol, iloprost, treprostinil)
MEDICATION(S)
VALCHLOR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Mycosis fungoides-type cutaneous T-cell lymphoma (MF-CTCL) (initial): All of the following: 1) diagnosis of Stage IA MF-CTCL, OR diagnosis of Stage IB MF-CTCL, AND 2) patient has received at least one prior skin-directed therapy [e.g., topical corticosteroids, bexarotene topical gel (Targretin topical gel), topical nitrogen mustard, etc.].

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist or dermatologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
VARIZIG 125 UNIT/1.2 ML VIAL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months (approve one dose only)

OTHER CRITERIA
N/A
**MEDICATION(S)**
VELCADE

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Multiple myeloma (MM): Diagnosis of MM. Mantle cell lymphoma (MCL): Diagnosis of MCL.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
MM, MCL: Prescribed by or in consultation with an oncologist/hematologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
**MEDICATION(S)**
VENCLEXTA, VENCLEXTA STARTING PACK

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL): Diagnosis of CLL or SLL. Patient has received at least one prior therapy for CLL/SLL [e.g., Cytoxan (cyclophosphamide), Fludara (fludarabine), Rituxan (rituximab), etc.].

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with a hematologist or oncologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
VENTAVIS (S)

**MEDICATION(S)**
VENTAVIS

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

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

**COVERAGE DURATION**
PAH (Initial): 6 months. (Reauth): 12 months

**OTHER CRITERIA**
Subject to Part B vs D review. PAH (Reauth): Documentation of positive clinical response to therapy.
**VERZENIO (S)**

**MEDICATION(S)**
VERZENIO

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Breast Cancer: Diagnosis of advanced or metastatic breast cancer. Disease is hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative. One of the following: a) used in combination with an aromatase inhibitor (e.g., Arimidex [anastrozole], Aromasin [exemestane], Femara [letrozole]) and patient is a postmenopausal woman, OR b) used in combination with Faslodex (fulvestrant) and disease has progressed following endocrine therapy, OR c) used as monotherapy and disease has progressed following endocrine therapy and patient has already received at least one prior chemotherapy regimen.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist.

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
**MEDICATION(S)**
VIEKIRA PAK, VIEKIRA XR

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

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

**AGE RESTRICTION**
N/A

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

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

**OTHER CRITERIA**
N/A
MEDICATION(S)
VOSEVI

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of chronic hepatitis C, patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and patient is not receiving Vosevi in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier]. For GT 1a patients who failed a Sovaldi-based regimen WITHOUT an NS5A inhibitor: trial and failure, contraindication, or intolerance to Mavyret OR for continuation of prior Vosevi therapy.

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A
VOTRIENT (S)

MEDICATION(S)
VOTRIENT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renal cell carcinoma (RCC): Diagnosis of advanced/metastatic RCC. Soft tissue sarcoma: Diagnosis of advanced soft tissue sarcoma and patient received at least one prior chemotherapy (e.g., ifosfamide, doxorubicin, cisplatin, dacarbazine, docetaxel, oxaliplatin, etc.)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
All Uses: Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
VPRIV

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Gaucher disease: 12 months

OTHER CRITERIA
N/A
MEDICATION(S)
EZETIMIBE-SIMVASTATIN 10-80 MG

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient has been taking simvastatin 80 mg per day chronically (12 months or more) and no evidence of muscle toxicity/myopathy (eg, muscle pain, muscle tenderness, muscle weakness) on simvastatin 80 mg per day.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A
MEDICATION(S)
VYXEOS

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Newly diagnosed therapy related acute myeloid leukemia (t-AML): Diagnosis of t-AML. Acute myeloid leukemia myelodysplasia-related changes (AML-MRC): Diagnosis of AML-MRC.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy
MEDICATION(S)
XALKORI

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Non-small cell lung cancer (NSCLC): Diagnosis of locally advanced or metastatic (stage IIIB or IV) NSCLC AND One of the following: A) Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility or B) Patient has MET amplification- or ROS1 rearrangements-positive tumor as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NSCLC: Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy
MEDICATION(S)
XELJANZ, XELJANZ XR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Xeljanz/Xeljanz XR: Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. RA/PsA (initial): One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), or attestation demonstrating a trial may be inappropriate, OR patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-IV-TR 300.29 for specific phobia diagnostic criteria), OR for continuation of prior tofacitinib therapy.
Xeljanz only: Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine (Purinethol), aminosalicylate [e.g., mesalamine (Asacol, Pentasa, Rowasa), olsalazine (Dipentum), sulfasalazine (Azulfidine, Sulfazine)], azathioprine (Imuran), or corticosteroids (e.g., prednisone, methylprednisolone). Trial and failure, contraindication, or intolerance to Humira (adalimumab), OR patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-V-TR F40.2 for specific phobia diagnostic criteria), OR for continuation of prior Xeljanz therapy. All indications (initial): Patient is not receiving tofacitinib in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. UC (initial): Prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION
RA/PsA (initial, reauth): 12 months. UC (init): 4 mo. UC (reauth): 12 mo.
OTHER CRITERIA
All Indications (Reauth): Documentation of positive clinical response to tofacitinib therapy. Patient is not receiving tofacitinib in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine).
MEDICATION(S)
TETRABENAZINE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION

AGE RESTRICTION
Tardive dyskinesia (Initial): Age greater than or equal to 18 years.

PRESCRIBER RESTRICTION
HD (Initial): Prescribed by or in consultation with a neurologist. Tardive dyskinesia, Tourette's syndrome (Initial): Prescribed by or in consultation with neurologist or psychiatrist.

COVERAGE DURATION
All indications: (Initial) 3 months, (Reauth) 12 months.

OTHER CRITERIA
All indications (Reauth): Documentation of clinical response and benefit from therapy.
MEDICATION(S)
XERMELO

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Carcinoid syndrome diarrhea (Initial): Diagnosis of carcinoid syndrome diarrhea AND diarrhea is inadequately controlled by a stable dose of somatostatin analog (SSA) therapy (e.g., octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot]) for at least 3 months AND used in combination with SSA therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial: Prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist

COVERAGE DURATION
Initial: 6 months, Reauth: 12 months

OTHER CRITERIA
Carcinoid syndrome diarrhea (Reauthorization): Documentation of a positive clinical response to Xermelo therapy AND Xermelo will continue to be used in combination with SSA therapy.
MEDICATION(S)
XGEVA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Multiple Myeloma (MM)/Bone metastasis from solid tumors (BMST): One of the following: 1) Diagnosis of multiple myeloma OR 2) diagnosis of solid tumors (eg, breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer), AND documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Both of the following: 1) diagnosis of giant cell tumor of bone AND 2) One of the following: a) tumor is unresectable, OR b) surgical resection is likely to result in severe morbidity. Hypercalcemia of malignancy (HCM): Both of the following: 1) diagnosis of hypercalcemia of malignancy, AND 2) Trial and failure, contraindication, or intolerance to one intravenous bisphosphonate (eg, Aredia (pamidronate), Zometa (zoledronic acid)).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
GCTB, HCM: Prescribed by or in consultation with an oncologist

COVERAGE DURATION
MM/BMST, GCTB: 12 mo. HCM: 2 mo.

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
XIFAXAN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
TD: One time only. HE (prophylaxis, treatment): 12 months. IBS-D (initial, reauth): 2 weeks.

OTHER CRITERIA
IBS-D (reauth): Patient experiences IBS-D symptom recurrence.
MEDICATION(S)
XOLAIR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Asthma (init): Diagnosis of moderate to severe persistent allergic asthma. Positive skin test or in vitro reactivity to a perennial aeroallergen. Pretreatment serum immune globulin (Ig)E level between 30 to 700 IU/mL. Symptoms are not adequately controlled on a high-dose inhaled corticosteroid and a long-acting beta2-agonist combination for at least 3 months, unless there is a contraindication or intolerance to these therapies. Chronic Idiopathic Urticaria (CIU): Diagnosis of CIU. Persistent symptoms (itching and hives) for at least 4 consecutive weeks despite titrating to an optimal dose with a second generation H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines. Patient has tried and had an inadequate response or intolerance or contraindication to at least one of the following additional therapies: H2 antagonist, leukotriene receptor antagonist, H1 antihistamine, hydroxyzine, doxepin. Used concurrently with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Asthma (init): Prescribed by or in consultation with an allergist, immunologist, or pulmonologist. CIU (init): Prescribed by or in consultation with an allergist, immunologist, or dermatologist

COVERAGE DURATION
Asthma (init, reauth): 6 months CIU (init): 3 months (reauth) 6 months

OTHER CRITERIA
Asthma (reauth): Patient has experienced one or more of the following: Reduction in number of asthma exacerbations from baseline (eg, asthma exacerbation requiring treatment with systemic corticosteroids or doubling of inhaled corticosteroid [ICS] dose from baseline) or Improvement in forced
expiratory volume in 1 second (FEV1) from baseline or Decreased use of rescue medications from baseline. CIU (reauth): Patients disease status has been re-evaluated since the last authorization to confirm the patients condition warrants continued treatment. Patient has experienced one or both of the following: Reduction in itching severity from baseline or Reduction in the number of hives from baseline.
XTANDI (S)

MEDICATION(S)
XTANDI

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Metastatic castration-resistant prostate cancer (mCRPC): Diagnosis of mCRPC.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed or in consultation with an oncologist or urologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
XURIDEN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Hereditary orotic aciduria (Initial): Diagnosis of hereditary orotic aciduria.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Initial: Prescribed by or in consultation with a medical geneticist or other specialist that treats inborn errors of metabolism

COVERAGE DURATION
Initial, reauth: 12 months

OTHER CRITERIA
Hereditary orotic aciduria (reauth): Documentation of positive clinical response to Xuriden therapy
MEDICATION(S)
XYREM

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepresible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepresible need to sleep or daytime lapses into sleep) are present, AND trial and failure, contraindication, or intolerance to one of the following: 1) amphetamine-based stimulant (eg, amphetamine, dextroamphetamine), OR 2) methylphenidate-based stimulant.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
All uses (initial, reauth): 12 months

OTHER CRITERIA
Narcolepsy Type 1 (reauth): Documentation demonstrating a reduction in the frequency of cataplexy attacks associated with Xyrem therapy, OR documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with Xyrem therapy. Narcolepsy Type 2 (reauth): Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with Xyrem therapy.
YERVOY (S)

**MEDICATION(S)**
YERVOY 50 MG/10 ML VIAL

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Unresectable or metastatic melanoma: Diagnosis of unresectable, metastatic melanoma. Cutaneous melanoma: Diagnosis of cutaneous melanoma with pathologic involvement of regional lymph nodes of more than 1 mm. Patient has undergone resection, including total lymphadenectomy. Renal Cell Carcinoma (RCC): Diagnosis of renal cell carcinoma. Disease is advanced, relapsed, or stage IV disease that is surgically unresectable. Intermediate- or poor-prognosis risk. Previously untreated disease. Used in combination with Opdivo (nivolumab).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy.
**YONSA (S)**

**MEDICATION(S)**
YONSA

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Prostate Cancer: Diagnosis of metastatic castration-resistant (chemical or surgical) or recurrent prostate cancer. Used in combination with methylprednisolone. One of the following: 1) Used in combination with a gonadotropin-releasing hormone (GnRH) analog or 2) Patient received a bilateral orchiectomy. Trial and failure or intolerance to Xtandi (enzalutamide).

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with an oncologist or urologist

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Approve for continuation of prior therapy
MEDICATION(S)
ZALTRAP 100 MG/4 ML VIAL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
MIGLUSTAT, ZAVESCA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Gaucher disease: Diagnosis of mild to moderate type 1 Gaucher disease. Patient is unable to receive enzyme replacement therapy due to one of the following conditions: allergy or hypersensitivity to enzyme replacement therapy, poor venous access, unavailability of enzyme replacement therapy (e.g., Cerezyme, VPRIV).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Gaucher disease: 12 months

OTHER CRITERIA
N/A
MEDICATION(S)
ZEJULA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of recurrent epithelial ovarian cancer, recurrent fallopian tube cancer, or recurrent primary peritoneal cancer. Used for maintenance treatment in patients who are in a complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy
MEDICATION(S)
ZELBORAF

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT) as detected by an FDA-approved test (eg, cobas 4600 BRAFV600 Mutation Test) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Erdheim-Chester Disease: Diagnosis of Erdheim-Chester disease AND Disease is BRAFV600 mutant type (MT).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Melanoma: Prescribed by or in consultation with an oncologist. Erdheim-Chester Disease: Prescribed by or in consultation with a hematologist/oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
All indications: Approve for continuation of therapy.
MEDICATION(S)
ZEPATIER

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
All of the following: A) Criteria will be applied consistent with current AASLD/IDSA guideline AND B) ONE of the following: 1) Patient has a trial and failure, contraindication or intolerance to a) Harvoni OR Epclusa AND b) Mavyret, OR 2) For continuation of prior Zepatier therapy AND C) Patient is not receiving Zepatier in combination with another HCV direct acting antiviral agent, AND D) patient does not have moderate to severe hepatic impairment (eg, Child-Pugh Class B or C), AND E) For genotype 1a, patient has been tested for the presence of NS5A resistance-associated polymorphisms (ie, polymorphisms at amino acid positions 28, 30, 31, or 93).

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A
ZOLINZA (S)

MEDICATION(S)
ZOLINZA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Cutaneous T-cell lymphoma (CTCL): Diagnosis of CTCL. Progressive, persistent or recurrent disease on or contraindication or intolerance to two systemic therapies (e.g., bexarotene, romidepsin, etc.).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a hematologist/oncologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
ZORBTIVE (S)

MEDICATION(S)
ZORBTIVE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION
SBS: 4 weeks.

OTHER CRITERIA
N/A
**ZORTRESS (S)**

**MEDICATION(S)**
ZORTRESS 0.25 MG TABLET, ZORTRESS 0.5 MG TABLET, ZORTRESS 0.75 MG TABLET

**COVERED USES**
All medically accepted indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Prevention of kidney transplant organ rejection: The medication is being used for prevention of kidney transplant organ rejection. Patient is at low-to-moderate immunologic risk. Patient is prescribed concurrent therapy with reduced doses of cyclosporine AND corticosteroids. Prevention of liver transplant organ rejection: The medication is being used for prevention of liver transplant organ rejection. Thirty (30) or more days have passed since the transplant procedure. Patient is prescribed concurrent therapy with reduced doses of tacrolimus and corticosteroids.

**AGE RESTRICTION**
All indications: 18 years of age or older

**PRESCRIBER RESTRICTION**
All indications: Prescriber is experienced in immunosuppressive therapy and management of transplant patients.

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Subject to Part B vs. Part D review. Approve for continuation of prior therapy.
ZYDELIG (S)

MEDICATION(S)
ZYDELIG

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Used in combination with Rituxan (rituximab). The patient has relapsed on at least one prior therapy (eg, purine analogues [fludarabine, pentostatin, cladribine], alkylating agents [chlorambucil, cyclophosphamide], or monoclonal antibodies [rituximab]). Patient is a candidate for Rituxan (rituximab) monotherapy due to presence of other comorbidities (eg, coronary artery disease, peripheral vascular disease, diabetes mellitus, pulmonary disease [COPD]). Follicular Lymphoma (FL): Diagnosis of FL. The patient has relapsed on at least two prior systemic therapies (eg, rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicine], purine analogs [fludarabine]). Small lymphocytic lymphoma (SLL): Diagnosis of SLL. The patient has relapsed on at least two prior systemic therapies (eg, rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicine], purine analogs [fludarabine]).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
All uses: Prescribed by or in consultation with an oncologist/hematologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
ZYKADIA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC that is metastatic or recurrent. Tumor is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Approve for continuation of prior therapy.
MEDICATION(S)
ZYTIGA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prostate Cancer: One of the following: 1) Diagnosis of metastatic castration-resistant (chemical or surgical) or recurrent prostate cancer or 2) Diagnosis of metastatic high-risk castration-sensitive prostate cancer. Used in combination with prednisone.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prostate Cancer: Prescribed by or in consultation with an oncologist or urologist

COVERAGE DURATION
Prostate Cancer: 12 months

OTHER CRITERIA
Approve for continuation of prior therapy