PA Criteria

Prior Authorization Group	ACTIMMUNE
Drug Names	ACTIMMUNE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, atopic dermatitis.
Exclusion Criteria	
Required Medical Information	For atopic dermatitis, the condition is resistant to conservative treatments (eg, topical medications, phototherapy).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

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

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

Prior Authorization Group	ADEMPAS
Drug Names	ADEMPAS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	1) Patient is taking a nitrate or nitric oxide donor medication (eg, amyl nitrite) on a regular or intermittent basis. 2) Patient is taking a phosphodiesterase inhibitor (eg, sildenafil, tadalafil, vardenafil, dipyridamole, theophylline).

Required Medical Information	1) For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4), a. Persistent or recurrent CTEPH after pulmonary endarterectomy, OR b. Inoperable CTEPH, AND c. CTEPH was confirmed by right heart catheterization AND by CT, MRI or pulmonary angiography. 2) For pulmonary arterial hypertension (PAH) (WHO Group 1), a. PAH was confirmed by right heart catheterization, AND b. NYHA Functional Class II or III symptoms.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	AFINITOR
Drug Names	AFINITOR, AFINITOR DISPERZ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, lung neuroendocrine tumors, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma with following histologic subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangioleiomyomatosis.
Exclusion Criteria	
Required Medical Information	For advanced RCC, patient failed previous treatment with Sutent (sunitinib), Nexavar (sorafenib), or Votrient (pazopanib). For PNETs, patient has unresectable, locally advanced or metastatic disease. For breast cancer, all of the following criteria are met: 1) patient has advanced hormone receptor positive, HER2-negative disease, 2) patient was previously treated with letrozole or anastrozole and 3) Afinitor will be used in combination with exemestane. For SEGA with TSC, patient is not a candidate for curative surgical resection. For renal angiomyolipoma with TSC, patient does not require immediate surgery. For soft tissue sarcoma, patient has one of the following histologic subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, or lymphangioleiomyomatosis. OR patient has a diagnosis of either Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma or lung neuroendocrine tumors.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ALDURAZYME
Drug Names	ALDURAZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of MPS I was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by DNA testing. Patients with Scheie syndrome must have moderate to severe symptoms of MPS I.

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Appropriate medical support is readily available when Aldurazyme is administered in the event of anaphylaxis or a severe allergic reaction.
Prior Authorization Group	ALPHA1-PROTEINASE INHIBITOR
Drug Names	ARALAST NP, PROLASTIN-C, ZEMAIRA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient has selective IgA deficiency with known antibodies against IgA.
Required Medical Information	All patients must have a deficiency of alpha1-proteinase inhibitor (also known as alpha1-antitrypsin) AND clinically evident emphysema. Patients initiating therapy for the first time must have pretreatment serum alpha1-proteinase inhibitor concentration less than 11 micromoles/L (80 mg/dL) AND post-bronchodilation FEV1 between 25 percent and 80 percent predicted.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ANABOLIC STEROIDS
Drug Names	OXANDROLONE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, HIV-wasting syndrome or cachexia due to chronic disease, Turner's syndrome.
Exclusion Criteria	1) Known or suspected nephrosis (the nephrotic phase of nephritis). 2) Known or suspected hypercalcemia. 3) Known or suspected carcinoma of the breast in females with hypercalcemia. 4) Known or suspected carcinoma of the prostate or breast in male patients. 5) Pregnancy.
Required Medical Information	Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Prior Authorization Group	APOKYN
Drug Names	APOKYN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant treatment with a serotonin 5HT3 antagonist (eg, ondansetron).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ARCALYST
Drug Names	ARCALYST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)
Age Restrictions	12 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	B VS. D

Drug Names

ABELCET, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ADRUCIL, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMIFOSTINE, AMINOSYN, AMINOSYN 7%/ELECTROLYTES, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 8.5%/ELECTROL, AMINOSYN M, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-PF 7%, AMINOSYN-RF, AMPHOTERICIN B, AVASTIN, AZACITIDINE, AZATHIOPRINE, BICNU, BLEOMYCIN SULFATE, BUDESONIDE, BUSULFEX, CALCITRIOL, CARBOPLATIN, CISPLATIN, CLADRIBINE, CLINIMIX 2.75%/DEXTROSE 5, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 2, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 5%/DEXTROSE 25%, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DACARBAZINE, DAUNORUBICIN HCL, DEPO-PROVERA, DEXRAZOXANE, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HCL LIPOSOME, DRONABINOL, DURAMORPH, ELITEK, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FLUDARABINE PHOSPHATE, FLUOROURACIL, FREAMINE HBC 6.9%, FREAMINE III, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HERCEPTIN, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, IBANDRONATE SODIUM, IDARUBICIN HCL, IFEX, IFOSFAMIDE, INTRALIPID, INTRON A, INTRON A W/DILUENT, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTODAX, KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVOCARNITINE, LIDOCAINE HCL, LIDOCAINE/PRILOCAINE, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE DOSE P, METHYLPREDNISOLONE SODIUM, MIACALCIN, MITOMYCIN, MITOXANTRONE HCL, MORPHINE SULFATE, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEBUPENT, NEORAL, NEPHRAMINE, NIPENT, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PERFOROMIST, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE, PROGRAF, PROLEUKIN, PROSOL, PULMOZYME, RAPAMUNE, RECOMBIVAX HB, REMODULIN, SANDIMMUNE, SIROLIMUS, TACROLIMUS, TENIVAC, TETANUS TOXOID ADSORBED, TETANUS/DIPHTHERIA TOXOID, TOBRAMYCIN, TOPOSAR, TOPOTECAN HCL, TPN ELECTROLYTES, TRAVASOL, TREANDA, TRISENOX, TROPHAMINE, VELCADE, VENTAVIS, VINBLASTINE SULFATE, VINCASAR PFS, VINCRISTINE SULFATE, VINORELBINE TARTRATE, ZOLEDRONIC ACID, ZOMETA, ZORTRESS, ZYPREXA RELPREVV

Covered Uses	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	N/A
Other Criteria	

Prior Authorization Group	BANZEL
Drug Names	BANZEL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The patient is diagnosed with familial short QT Syndrome.
Required Medical Information	The patient is diagnosed with Lennox-Gastaut Syndrome.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	BETASERON
Drug Names	BETASERON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of MS (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (ie, multifocal white matter disease).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	BOSULIF
Drug Names	BOSULIF
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient must be positive for the Philadelphia chromosome or BCR-ABL gene AND patient meets one of the following: 1) experienced resistance or intolerance/toxicity to alternative tyrosine kinase inhibitor (imatinib, dasatinib, nilotinib, ponatinib), or 2) post hematopoietic stem cell transplant.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	

Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	BUPRENORPHINE
Drug Names	BUPRENORPHINE HCL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) For induction therapy for transition from opioid use to opioid dependence treatment OR for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone OR if the patient is a pregnant female and being prescribed buprenorphine for induction and subsequent maintenance therapy for transition from opioid use to opioid dependence treatment AND 2) The prescriber agrees not to prescribe other opioids while the patient is taking buprenorphine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Induction 3 months, Maintenance Plan Year, Pregnancy 10 months
Other Criteria	
Prior Authorization Group	BUPRENORPHINE-NALOXONE
Drug Names	BUPRENORPHINE HCL/NALOXON, SUBOXONE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The prescriber agrees not to prescribe other opioids while the patient is taking the requested drug for opioid dependence treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	CAPRELSA
Drug Names	CAPRELSA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Medullary thyroid cancer is symptomatic or progressive AND patient has unresectable locally advanced or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	CARBAGLU
Drug Names	CARBAGLU

Covered Uses	All FDA-approved indications not otherwise excluded from Part D, methylmalonic acidemia, propionic acidemia.
Exclusion Criteria	
Required Medical Information	Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CAYSTON
Drug Names	CAYSTON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing. Pseudomonas aeruginosa is present in the cultures of the airway.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

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

Prior Authorization Group	CEREZYME
Drug Names	CEREZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Type 3 Gaucher disease.

Exclusion Criteria	Concomitant therapy with miglustat (Zavesca).
Required Medical Information	Diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity. Patient has Type 1 or Type 3 Gaucher disease. Patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CHANTIX
Drug Names	CHANTIX, CHANTIX CONTINUING MONTH, CHANTIX STARTING MONTH PA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient has been advised to report any changes to the prescriber such as changes in behavior, hostility, agitation, depressed mood, and suicide related events, including ideation, behavior, and attempted suicide, while taking Chantix.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	

Prior Authorization Group	CIMZIA
Drug Names	CIMZIA, CIMZIA STARTER KIT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Axial spondyloarthritis.
Exclusion Criteria	
Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Cimzia (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance, or contraindication to MTX, OR 2) Inadequate response or intolerance to a prior biologic DMARD, OR 3) Cimzia will be used as first-line therapy for severely active RA. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response, contraindication or intolerance to at least 2 NSAIDs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CINRYZE
Drug Names	CINRYZE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, treatment of hereditary angioedema attacks.
Exclusion Criteria	
Required Medical Information	Diagnosis of HAE confirmed by laboratory tests (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CLORAZEPATE
Drug Names	CLORAZEPATE DIPOTASSIUM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the patient has experienced an inadequate treatment response to lorazepam OR for adjunctive therapy in the management of partial seizures OR symptomatic relief in acute alcohol withdrawal AND 2) If the patient is 65 years of age or older, the benefit of therapy with the prescribed medication outweighs the potential risk. (The prescribed medication is considered a "high risk medication" that is considered either ineffective in most patients 65 years of age or older or that poses an unnecessarily high risk when safer alternative therapy may be available.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Anxiety-6 mo, Other diagnoses-Plan Year
Other Criteria	

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

Prior Authorization Group	COMETRIQ
Drug Names	COMETRIQ

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe hemorrhage.
Required Medical Information	Medullary thyroid cancer is symptomatic, progressive, or metastatic.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Therapy will be discontinued if gastrointestinal perforation or fistula formation occurs.

Prior Authorization Group	COPAXONE
Drug Names	COPAXONE, GLATOPA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, first clinical episode of MS.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of MS (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (ie, multifocal white matter disease).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CYSTAGON
Drug Names	CYSTAGON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Documented history of hypersensitivity to penicillamine.
Required Medical Information	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	DIAZEPAM
Drug Names	DIAZEPAM, DIAZEPAM INTENSOL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Information	1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the patient has experienced an inadequate treatment response to lorazepam OR for symptomatic relief in acute alcohol withdrawal OR for use as an adjunct for the relief of skeletal muscle spasms OR for adjunctive therapy in the treatment of convulsive disorders AND 2) If the patient is 65 years of age or older, the benefit of therapy with the prescribed medication outweighs the potential risk. (The prescribed medication is considered a "high risk medication" that is considered either ineffective in most patients 65 years of age or older or that poses an unnecessarily high risk when safer alternative therapy may be available.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Anxiety-6 mo, Other diagnoses-Plan Year
Other Criteria	
Prior Authorization Group	ELIDEL
Drug Names	ELIDEL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Psoriasis on the eyelid or genital areas.
Exclusion Criteria	
Required Medical Information	1) Diagnosis of mild to moderate atopic dermatitis (eczema) AND 2) Patient completed a documented trial and failure of at least one medium or higher potency topical steroid or has a documented intolerance or contraindication to medium or higher potency topical steroids OR 3) Diagnosis of psoriasis on the genital or eyelid areas.
Age Restrictions	2 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	EMSAM
Drug Names	EMSAM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pheochromocytoma. Concurrent use with carbamazepine, oxcarbazepine, dextromethorphan, cyclobenzaprine, sympathomimetic agents such as amphetamines, meperidine, analgesic agents such as tramadol and methadone, St. John's Wort, other antidepressants.
Required Medical Information	1) Patient experienced an inadequate treatment response to each of any two antidepressants: selective serotonin reuptake inhibitors (SSRIs) (e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline), serotonin/norepinephrine reuptake inhibitors (SNRIs) (e.g., venlafaxine), bupropion, mirtazapine, trazodone, tricyclic/tetracyclic antidepressants (e.g., amitriptyline, nortriptyline) OR 2) Patient is unable to swallow oral formulations.

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	EPO
Drug Names	PROCRIT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa).
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer. Use to facilitate preoperative autologous blood donation.
Required Medical Information	For all uses except surgery: 1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 2) For reauthorizations (patient received erythropoietin in previous month), an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. Additional requirements for anemia due to myelosuppressive cancer chemotherapy: 1) For initial therapy, at least 2 more months of chemotherapy is expected, AND 2) For reauthorizations, current Hgb is less than 11 g/dL. Additional requirements for CKD not on dialysis reauthorization: Current Hgb is less than or equal to 10 g/dL OR Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) Patient has symptomatic anemia, AND 2) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, AND 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for HIV: 1) Concomitant use of zidovudine at a maximum dose of 4200 mg per week, AND 2) For initial therapy, pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, AND 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for anemia due to CHF, RA, hepatitis C treatment, or patients whose religious beliefs forbid blood transfusions: 1) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery, AND 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks

Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (eg, used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions.
Prior Authorization Group	ERIVEDGE
Drug Names	ERIVEDGE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient meets one of the following criteria: 1) patient has metastatic BCC, OR 2) patient has undergone surgery or radiation therapy for BCC and has residual or recurrent disease following surgery or radiation, OR 3) both surgery and radiation are contraindicated or not appropriate for the patient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	EXJADE
Drug Names	EXJADE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For chronic iron overload due to blood transfusions: Diagnosis of chronic iron overload due to blood transfusions AND Pretreatment serum ferritin level greater than 1000 mcg/L. For iron overload in patients with NON-transfusion dependent thalassemia (NTDT): 1) Diagnosis of a NON-transfusion dependent thalassemia syndrome and chronic iron overload, 2) All liver iron concentrations (LIC) are measured by liver biopsy or by an FDA-cleared or approved method for identifying patients for treatment with deferasirox therapy, 3) For initiation of Exjade: Pretreatment LIC of at least 5 mg per gram of dry weight AND Pretreatment serum ferritin levels greater than 300 mcg/L on 2 consecutive measurements 1 month apart, 4) For patients currently on Exjade therapy: Current LIC is greater than 3 mg per gram of dry weight or Exjade will be withheld until the LIC reaches above 5 mg per gram of dry weight.
Age Restrictions	Two years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	FABRAZYME
Drug Names	FABRAZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	
Required Medical Information	Diagnosis of Fabry disease is confirmed by an enzyme assay showing deficiency of alpha-galactosidase enzyme activity or by DNA testing. Patient has clinical signs and symptoms of Fabry disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	FARYDAK
Drug Names	FARYDAK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient has received at least 2 prior regimens, including bortezomib and an immunomodulatory agent. Farydak will be given in combination with bortezomib and dexamethasone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Patients may not have recent myocardial infarction or unstable angina, a history of clinically significant ST-segment or T-wave elevation, or a QTC interval greater than, or equal to, 450 ms. The patient may not have serum electrolytes outside of the normal range at baseline.

Prior Authorization Group	FENTANYL PATCH
Drug Names	FENTANYL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Significant respiratory depression. Known or suspected paralytic ileus.
Required Medical Information	1) The prescriber has considered the risks of opioid/substance abuse/or addiction in this patient while receiving fentanyl patch AND 2) The patient can be safely started on the requested dose of fentanyl patch based on the patient's current narcotic use or expected tolerance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	FIRAZYR
Drug Names	FIRAZYR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of HAE confirmed by laboratory tests (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels)

Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	FORTEO
Drug Names	FORTEO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Paget's disease of bone, unexplained elevations of alkaline phosphatase, open epiphyses (ie, pediatric or young adult patient), prior radiation therapy involving the skeleton, history of a skeletal malignancy, bone metastases, pre-existing hypercalcemia, metabolic bone disease other than osteoporosis.
Required Medical Information	Patient meets one of the following criteria (new starts only): 1) Prior fragility fracture OR 2) Had at least a 1-year trial of an oral bisphosphonate unless contraindicated or intolerant to an oral bisphosphonate OR 3) Has more than one risk factors for fracture (eg, advanced age [postmenopausal women and men 50 years of age and older], low body mass index [less than 19 kg/m2], parental history of hip fracture, current smoker, alcohol intake of 3 or more drinks per day, chronic steroid use [greater than or equal to 5 mg/day prednisone or equivalent for at least 3 months], rheumatoid arthritis, secondary causes of osteoporosis).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months (lifetime)
Other Criteria	
Prior Authorization Group	FYCOMPA
Drug Names	FYCOMPA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient and caregivers will be advised to contact the healthcare provider immediately if any serious psychiatric or behavioral reactions are observed.
Age Restrictions	12 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	GILENYA
Drug Names	GILENYA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	Recent occurrence (within the last 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, class III or IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Treatment with Class Ia or Class III anti-arrhythmic drugs.
Required Medical Information	Have a relapsing form of MS (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GILOTRIF
Drug Names	GILOTRIF
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has metastatic non-small cell lung cancer. Patient had EGFR mutation testing and is positive for EGFR exon 19 deletions or exon 21 (L858R) substitution mutations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GLEEVEC
Drug Names	GLEEVEC
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, and melanoma.
Exclusion Criteria	
Required Medical Information	For chronic myeloid leukemia (CML) and acute lymphoblastic leukemia, patient must be positive for the Ph chromosome or BCR-ABL gene. For CML, patient did not fail prior therapy with a tyrosine kinase inhibitor (dasatinib, nilotinib, bosutinib, ponatinib). For myelodysplastic/ myeloproliferative disease, disease is associated with PDGFR gene re-arrangements. For aggressive systemic mastocytosis, D816V c-Kit mutation is negative or unknown. For melanoma, c-Kit mutation is positive. Patient has one of the following diagnoses: gastrointestinal stromal tumor, hypereosinophilic syndrome, chronic eosinophilic leukemia, desmoid tumor, dermatofibrosarcoma protuberans, PVNS/TGCT, or chordoma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GRANIX-NEUPOGEN
Drug Names	GRANIX, NEUPOGEN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced FN, acute lymphocytic leukemia (ALL), leukemic relapse following allogeneic stem cell transplantation, myelodysplastic syndromes (MDS).
Exclusion Criteria	Use of the requested G-CSF product within 24 hours preceding or following chemotherapy or radiotherapy. For treatment of acute FN, patient received prophylactic Neulasta during the current chemotherapy cycle.
Required Medical Information	For prophylaxis and treatment of chemotherapy-induced FN, 1) Patient has a non-myeloid cancer AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer drugs. For treatment of chemotherapy-induced FN, 1) Patient has a non-myeloid cancer AND 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer drugs. For MDS, 1) Patient has neutropenia and recurrent or resistant infections OR 2) patient has symptomatic anemia and the requested G-CSF product will be used in combination with epoetin or darbepoetin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	GROWTH HORMONE
Drug Names	GENOTROPIN, GENOTROPIN MINIQUICK, NORDITROPIN FLEXPRO, TEV-TROPIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D including pediatric growth hormone deficiency (GHD), Turner syndrome (TS), Noonan syndrome (NS), chronic kidney disease (CKD), small for gestational age (SGA), Prader-Willi syndrome (PWS), idiopathic short stature (ISS), short stature homeobox-containing gene deficiency (SHOXD), and adult GHD.
Exclusion Criteria	Active malignancy. Pediatric patients with closed epiphyses (except in patients with PWS).

Required Medical Information	Pediatric GHD, TS, CKD, SHOXD, NS: Younger than 2.5 yrs old, when applicable: Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2.5 yrs old or older: Pre-tx 1-year ht velocity more than 2 SD below mean OR Pre-tx height more than 2 SD below mean plus 1-year ht velocity more than 1 SD below mean. Pediatric GHD: Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment (tx) OR Pre-tx IGF-1/IGFBP3 more than 2 SD below mean. TS: Confirmed by karyotyping. CKD: Not post-kidney transplant. SGA: Did not manifest catch-up growth by age 2 AND Birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks or birth wt or length below 3rd percentile for GA. PWS: Confirmed by one of the following: 1) deletion of the paternally inherited chromosomal 15q11.2-q13 region, 2) maternal uniparental disomy in chromosome 15, or 3) imprinting defects or translocations involving chromosome 15. SHOXD: Confirmed by molecular or genetic testing. ISS: Pediatric GHD ruled out by appropriate provocative test more than 10 ng/mL AND Prior to starting GH tx, ht more than 2.25 SD below mean and adult ht prediction below 5'3" for boys, 4'11" for girls. Adult GHD: Patient meets ANY of the following: 1) Failed 2 stimulation tests (peak below 5 mcg/L) prior to starting tx, 2) 3 or more pituitary hormone deficiencies or panhypopituitarism, 3) Childhood-onset GHD with known mutations, embryopathic lesions, or irreversible structural lesions/damage, or 4) Low pre-tx IGF-1 and failed 1 stimulation test (peak below 5 mcg/L) prior to starting tx.
Age Restrictions	TS and SGA: 2 years of age or older. NS and SHOXD: 3 years of age or older.
Prescriber Restrictions	Endocrinologist, Pediatric nephrologist
Coverage Duration	Plan year
Other Criteria	Renewal for pediatric GHD, TS, NS, CKD, SGA, PWS patients with open epiphyses, ISS, or SHOXD: patient is growing more than 2 cm/year. For PWS only: 1) body composition and psychomotor function have improved. Renewal for PWS patients with closed epiphyses and adult GHD patients: Current IGF-1 level is normal for age and gender.
Prior Authorization Group	HARVONI
Drug Names	HARVONI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic hepatitis C genotype 4 or 6 infection.
Exclusion Criteria	

Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting tx. For G1 infection, monotherapy: 1) Total 12 wks for tx-naive pts with or without cirrhosis. Tx for 8 wks can be considered in tx-naive pts without cirrhosis who have pre-tx HCV RNA below 6 million IU/mL. 2) For pts who failed prior tx with PEG-IFN and RBV with or without HCV PI: a) total 12 wks if no cirrhosis, b) total 24 wks for cirrhosis. 3) Total 24 wks for pts with advanced fibrosis (F3 or higher) who failed prior tx with a SOF-containing regimen. For G4 infection, monotherapy: Total 12 wks for pts who are tx-naive or failed prior tx with PEG-IFN and RBV. For G6 infection, monotherapy: Total 12 wks for pts who are tx-naive or failed prior tx with PEG-IFN and RBV. For decompensated cirrhosis (CTP class B or C), monotherapy: Total 24 wks for pts with G1 or 4 infection and documented anemia or RBV ineligibility. For recurrent HCV infection post liver txp, monotherapy: Total 24 wks for tx-naive pts with G1 or 4 infection and documented anemia or RBV ineligibility. For G1 infection, tx with RBV: 1) Total 12 wks for pts with cirrhosis who failed prior tx with PEG-IFN and RBV with or without an HCV PI. 2) Total 24 wks for pts with advanced fibrosis (F3 or higher) who failed prior tx with a SOF-containing regimen. For decompensated cirrhosis (CTP class B or C), tx with RBV: 1) Total 12 wks for pts with G1 or 4 infection. 2) Total 24 wks for pts with G1 or 4 infection who failed prior tx with a SOF-containing regimen. 3) Total 12 wks for pts with recurrent G1 or 4 infection post liver txp. For recurrent HCV infection post liver txp, tx with RBV: Total 12 wks for pts with G1 or 4 infection. For HCV/HIV coinfection, pt meets all of the following: 1) Pt meets the criteria for requested regimen above. 2) Currently receiving ART OR is ART-naive with CD4 count above 500 cells/mm3. 3) Will not receive tx with cobicistat and elvitegravir. 4) Will not receive tx with tipranavir.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12-24 wks depending on baseline host/viral factors with reminder for 8 wk option when appropriate
Other Criteria	Harvoni will not be used with other drugs containing sofosbuvir, including Sovaldi. Anemia defined as baseline hemoglobin below 10g/dL, RBV ineligibility defined as intolerance to RBV, pregnant female or male whose female partner is pregnant, hemoglobinopathy, or coadministration with didanosine. tx=treatment, G=genotype, pt=patient, PEG-IFN=peginterferon alfa, RBV=ribavirin, PI=protease inhibitor, SOF=sofosbuvir, CTP=Child Turcotte Pugh, txp=transplantation, ART=antiretroviral therapy.
Prior Authorization Group	HIGH RISK MEDICATION
Drug Names	COMBIPATCH, CYCLOBENZAPRINE HCL, DIGITEK, DIGOXIN, DISOPYRAMIDE PHOSPHATE, ESTRADIOL, LANOXIN, MEGESTROL ACETATE, NORPACE CR, TRANSDERM-SCOP

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.). AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug. AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group	HRM-ANTICONVULSANTS
Drug Names	PHENOBARBITAL, PHENOBARBITAL SODIUM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (carbamazepine, lamotrigine, topiramate) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (carbamazepine, lamotrigine, topiramate) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patients 65 years of age or older.

Prior Authorization Group	HRM-ANTIDEPRESSANTS TCA
Drug Names	AMITRIPTYLINE HCL, DOXEPIN HCL, IMIPRAMINE HCL, SURMONTIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (citalopram, duloxetine, escitalopram, fluoxetine, sertraline, venlafaxine, venlafaxine ER) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (citalopram, duloxetine, escitalopram, fluoxetine, sertraline, venlafaxine, venlafaxine ER) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.
Prior Authorization Group	HRM-ANTIPARKINSON
Drug Names	BENZTROPINE MESYLATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (amantadine) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (amantadine) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.
Prior Authorization Group	HRM-ANTIPSYCHOTICS
Drug Names	THIORIDAZINE HCL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (olanzapine, quetiapine, risperidone, ziprasidone) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (olanzapine, quetiapine, risperidone, ziprasidone) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.
Prior Authorization Group	HRM-CLOMIPRAMINE
Drug Names	CLOMIPRAMINE HCL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (fluoxetine, fluvoxamine) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (fluoxetine, fluvoxamine) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.
Prior Authorization Group	HRM-HYDROXYZINE HCL
Drug Names	HYDROXYZINE HCL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. For pruritus 1) A non-HRM formulary drug (levocetirizine) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (levocetirizine) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. For anxiety 1) A non-HRM formulary drug (duloxetine, escitalopram, venlafaxine ER) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (duloxetine, escitalopram, venlafaxine ER) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.
Prior Authorization Group	HRM-HYPNOTICS
Drug Names	ZOLPIDEM TARTRATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (temazepam 7.5mg, temazepam 15mg, Silenor 3mg, Silenor 6mg, Rozerem) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (temazepam 7.5mg, temazepam 15mg, Silenor 3mg, Silenor 6mg, Rozerem) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
Prior Authorization Group	HRM-NITROFURANTOIN
Drug Names	NITROFURANTOIN MACROCRYST, NITROFURANTOIN MONOHYDRAT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, trimethoprim) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, trimethoprim) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
Prior Authorization Group	HRM-PROMETHAZINE
Drug Names	PROMETHAZINE HCL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. For nausea/vomiting 1) A non-HRM formulary drug (ondansetron) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (ondansetron) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. For allergic rhinitis 1) A non-HRM formulary drug (levocetirizine, fluticasone nasal) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (levocetirizine, fluticasone nasal) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. For urticaria 1) A non-HRM formulary drug (levocetirizine) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (levocetirizine) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.
Prior Authorization Group	HUMIRA
Drug Names	HUMIRA, HUMIRA PEN, HUMIRA PEN-CROHNS DISEASE, HUMIRA PEN-PSORIASIS STAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis.
Exclusion Criteria	

Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Humira (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance, or contraindication to MTX, OR 2) Inadequate response or intolerance to a prior biologic DMARD, OR 3) Humira will be used as first-line therapy for severely active RA. For moderately to severely active juvenile idiopathic arthritis (new starts only): 1) Inadequate response to MTX, OR 2) Intolerance or contraindication to MTX. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response, contraindication or intolerance to at least 2 NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected, AND 2) Inadequate response to either phototherapy (eg, UVB, PUVA) or a traditional systemic agent (eg, methotrexate, cyclosporine, acitretin), unless contraindicated or intolerant to such therapies. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (eg, corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to immunosuppressant therapy (eg, corticosteroids, azathioprine, mercaptopurine) OR intolerance/contraindication to immunosuppressant therapy, AND 2) Patient is naive to TNF inhibitor therapy OR patient lost response to previous TNF inhibitor therapy due to antibody formation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	IBRANCE
Drug Names	IBRANCE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ICLUSIG
Drug Names	ICLUSIG
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Information	Diagnosis of CML or Ph+ ALL was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Patient will be monitored for evidence of thromboembolism and vascular occlusion. Cardiac and hepatic function will be monitored.

Prior Authorization Group	IMBRUVICA
Drug Names	IMBRUVICA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, small lymphocytic lymphoma, lymphoplasmacytic lymphoma.
Exclusion Criteria	
Required Medical Information	For small lymphocytic lymphoma (SLL): patient has SLL with 17p deletion OR has received at least one prior therapy. For Waldenstrom's macroglobulinemia and lymphoplasmacytic lymphoma (WM/LPL): Imbruvica is used as a single agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	INCRELEX
Drug Names	INCRELEX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Closed epiphyses.
Required Medical Information	Must meet all of the following prior to beginning Increlex therapy (new starts only): 1) height 3 or more standard deviations below the norm for children of the same age and gender, AND 2) basal IGF-1 level 3 or more standard deviations below the norm for children of the same age and gender, AND 3) stimulation test showing a normal or elevated growth hormone level. For renewal, patient is growing more than 2 cm/year AND the current IGF-1 level is normal for age and gender.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	INLYTA
Drug Names	INLYTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Information	Patient has a diagnosis of advanced renal cell carcinoma (RCC) and the cancer has progressed after at least 1 prior systemic therapy for RCC. Examples of prior systemic therapies for RCC include bevacizumab, pazopanib, sorafenib, sunitinib, temsirolimus, and cytokines (interferon alpha or interleukin-2).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ITRACONAZOLE
Drug Names	ITRACONAZOLE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Coccidioidomycosis, Cryptococcosis, Sporotrichosis, Penicilliosis, Microsporidiosis, Onychomycosis-immunocompromised, Pityriasis versicolor/Tinea versicolor - extensive superficial infections or in immunocompromised patients, Tinea corporis/Tinea cruris, Tinea manuum/Tinea pedis.
Exclusion Criteria	Evidence of ventricular dysfunction, such as congestive heart failure (CHF). Current use of certain drugs metabolized by CYP3A4.
Required Medical Information	1) If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed with a fungal diagnostic test OR 2) Extensive superficial infection of Pityriasis versicolor or Tinea versicolor or the patient is immunocompromised OR 3) If for the treatment of tinea corporis, tinea cruris, tinea manuum, tinea pedis, the patient has experienced either an inadequate treatment response, adverse event, intolerance, or contraindication to griseofulvin OR 4) Diagnosis of blastomycosis, histoplasmosis, aspergillosis, coccidioidomycosis, cryptococcosis, sporotrichosis, penicilliosis, microsporidiosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Onychomycosis, Versicolor, Tinea-3mo, Systemic infection-6mo
Other Criteria	Criteria apply to capsule dosage form only.
Prior Authorization Group	IVIG
Drug Names	BIVIGAM, CARIMUNE NANOFILTERED, FLEBOGAMMA, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM

Covered Uses	All FDA-approved indications not otherwise excluded from Part D, B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT), chronic inflammatory demyelinating polyneuropathy, dermatomyositis, fetal/neonatal alloimmune thrombocytopenia, Guillain-Barré syndrome (GBS), idiopathic thrombocytopenic purpura, Kawasaki syndrome, Lambert-Eaton myasthenic syndrome, myasthenia gravis, multifocal motor neuropathy, pediatric HIV infection, polymyositis, pure red cell aplasia (PRCA), relapsing-remitting multiple sclerosis (RRMS).
Exclusion Criteria	IgA deficiency with antibodies to IgA and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin or product components.
Required Medical Information	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: serum IgG less than 400mg/dL. For dermatomyositis and polymyositis: standard 1st line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For RRMS: standard 1st line treatments (interferon or glatiramer) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For pediatric HIV infection: serum IgG less than 400 mg/dL OR a history of recurrent bacterial infections. PRCA is secondary to parvovirus B19 infection. For all indications: patients with any of the following risk factors for acute renal failure must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: pre-existing renal insufficiency, diabetes mellitus, age over 65 years, volume depletion, sepsis, paraproteinemia, or receiving concomitant nephrotoxic drugs. For all indications: patients with any of the following risk factors for thrombosis must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: age 45 years or older, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling central vascular catheters, hyperviscosity, or cardiovascular risk factors.
Age Restrictions	For pediatric HIV infection: age 12 years or younger.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prior Authorization Group	JAKAFI
Drug Names	JAKAFI

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For myelofibrosis: patient has been diagnosed with primary myelofibrosis OR myelofibrosis due to polycythemia vera OR myelofibrosis due to essential thrombocythemia. Myelofibrosis is intermediate or high-risk. For polycythemia vera: patient has had an inadequate response to or is intolerant of hydroxyurea.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	KETOCONAZOLE
Drug Names	KETOCONAZOLE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cushing's syndrome.
Exclusion Criteria	Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, eplerenone, nisoldipine, alprazolam, oral midazolam, oral triazolam, ergot alkaloids, statins.
Required Medical Information	Patient's liver status will be assessed prior to therapy and as needed during therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	1) For blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, and paracoccidioidomycosis, other antifungal therapies are ineffective, unavailable, or not tolerated [Note: other antifungal therapy examples are itraconazole or fluconazole]. 2) For Cushing's syndrome, patient cannot tolerate surgery or surgery has not been curative.

Prior Authorization Group	KUVAN
Drug Names	KUVAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Kuvan will be used in conjunction with a phenylalanine-restricted diet. For patients who have not yet received a therapeutic trial of Kuvan: 1) Patients less than or equal to 12 years of age have a baseline blood Phe level greater than 6 mg/dL, OR 2) Patients greater than 12 years of age have a baseline blood Phe level greater than 10 mg/dL. For patients for whom this is the first treatment after a therapeutic trial of Kuvan: patient must have experienced a reduction in blood Phe level of greater than or equal to 30 percent from baseline.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 1 month. Continuation of treatment: Plan Year.
Other Criteria	

Prior Authorization Group	LENVIMA
Drug Names	LENVIMA 10MG DAILY DOSE, LENVIMA 14MG DAILY DOSE, LENVIMA 20MG DAILY DOSE, LENVIMA 24MG DAILY DOSE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	LETAIRIS
Drug Names	LETAIRIS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	LEUKINE
Drug Names	LEUKINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chemotherapy-induced febrile neutropenia (FN), myelodysplastic syndromes (MDS), acute lymphocytic leukemia (ALL).
Exclusion Criteria	Use of Leukine within 24 hours preceding or following chemotherapy or radiotherapy.
Required Medical Information	For prophylaxis of chemotherapy-induced FN, 1) Patient has a non-myeloid cancer AND 2) is currently receiving or will be receiving treatment with myelosuppressive anti-cancer drugs. For treatment of chemotherapy-induced FN, 1) Patient has a non-myeloid cancer AND 2) is currently receiving or has received treatment with myelosuppressive anti-cancer drugs. For MDS, patient has neutropenia and recurrent or resistant infections.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	LIDODERM
Drug Names	LIDOCAINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Diabetic neuropathy.
Exclusion Criteria	

Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	LOTRONEX
Drug Names	ALOSETRON HYDROCHLORIDE, LOTRONEX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient has a history of any of the following conditions: Chronic or severe constipation or sequelae from constipation. Intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions. Ischemic colitis, impaired intestinal circulation, thrombophlebitis or hypercoagulable state. Crohn's disease or ulcerative colitis. Diverticulitis. Severe hepatic impairment.
Required Medical Information	1) Lotronex is being requested for a woman with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) chronic IBS symptoms lasting for at least 6 months AND 3) gastrointestinal tract abnormalities have been ruled out AND 4) inadequate response to conventional therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	LUMIZYME
Drug Names	LUMIZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of GAA enzyme activity or by DNA testing that identifies mutations in the GAA gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Appropriate medical support is readily available when Lumizyme is administered in the event of anaphylaxis, severe allergic reaction, or acute cardiorespiratory failure.
Prior Authorization Group	LUPRON
Drug Names	LEUPROLIDE ACETATE, LUPRON DEPOT, LUPRON DEPOT-PED

Covered Uses	All FDA-approved indications not otherwise excluded from Part D, breast cancer (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg only), ovarian stromal tumors (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg only), epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer (Lupron Depot 3.75mg only), in combination with growth hormone for children with growth failure and advancing puberty (leuprolide acetate only).
Exclusion Criteria	For prostate cancer, use as neoadjuvant androgen deprivation therapy (ADT) for radical prostatectomy for clinically localized disease. Pregnancy for female patients except for children with CPP. Breastfeeding (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg). Undiagnosed abnormal vaginal bleeding (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg).
Required Medical Information	For prostate cancer, patient must meet one of the following: 1) Locally advanced, recurrent or metastatic disease OR 2) Use as neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with intermediate or high risk of recurrence. For endometriosis retreatment, patient must meet all of the following: 1) Patient has had a recurrence of symptoms AND 2) Patient will be receiving add-back therapy (eg, norethindrone) AND 3) Bone mineral density is within normal limits. For uterine fibroids, patient must meet all of the following: 1) Diagnosis of anemia (ie, hematocrit less than or equal to 30% and/or hemoglobin less than or equal to 10g/dL) AND 2) Lupron Depot will be use in conjunction with iron therapy. For uterine fibroids retreatment, bone mineral density is within normal limits. For epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: Lupron (3.75mg only) will be used as a single agent. For breast cancer (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg), patient must meet both of the following: 1) Premenopausal woman AND 2) Hormone receptor positive disease. For CPP (Lupron Depot-PED), patients not currently receiving therapy must meet all of the following: 1) Diagnosis of CPP confirmed by a) A pubertal response to a GnRH agonist OR a basal 3rd generation LH level AND b) Assessment of bone age versus chronological age AND c) Appropriate diagnostic imaging of the brain has been done to exclude an intracranial tumor, AND 2) The onset of sexual characteristics occurred prior to eight years of age for female patients OR prior to nine years of age for male patients.
Age Restrictions	For endometriosis, fibroids, breast cancer, ovarian stromal tumors, epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: 18 years of age or older. CPP: Patient must be less than 12 years old if female and less than 13 years old if male.
Prescriber Restrictions	
Coverage Duration	Fibroids: 3 mos, max 6 mos (lifetime). Endometriosis: 6 mos, max 12 mos (lifetime). Others: Plan Yr.
Other Criteria	
Prior Authorization Group	LYNPARZA

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

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

Prior Authorization Group	MEKINIST
Drug Names	MEKINIST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	As a single agent for the treatment of patients who have received prior BRAF-inhibitor therapy (eg, Zelboraf, Tafinlar).
Required Medical Information	Patient has a diagnosis of unresectable or metastatic melanoma AND the tumor is positive for either BRAF V600E or V600K mutation AND patient will use Mekinist as either a single agent or in combination with Tafinlar.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	MOZOBIL
Drug Names	MOZOBIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Mozobil will be used to mobilize hematopoietic stem cells for collection prior to autologous transplantation and will be used in combination with granulocyte-colony stimulating factor (i.e., filgrastim or pegfilgrastim).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	MYOZYME
Drug Names	MYOZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of GAA enzyme activity or by DNA testing that identifies mutations in the GAA gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Appropriate medical support is readily available when Myozyme is administered in the event of anaphylaxis, severe allergic reaction, or acute cardiorespiratory failure.

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

Prior Authorization Group	NAMENDA
Drug Names	MEMANTINE HCL, NAMENDA, NAMENDA XR, NAMENDA XR TITRATION PACK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The drug is being prescribed for the treatment of moderate to severe dementia of the Alzheimer's type.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This edit only applies to patients less than 30 years of age.

Prior Authorization Group	NEULASTA
Drug Names	NEULASTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mobilization of peripheral blood progenitor cells prior to autologous transplantation.
Exclusion Criteria	Use of Neulasta within 14 days before or 24 hours after chemotherapy.

Required Medical Information	For prophylaxis of chemotherapy-induced FN, patient has a non-myeloid cancer AND is currently receiving or will be receiving treatment with myelosuppressive anti-cancer drugs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Prior Authorization Group	NEXAVAR
Drug Names	NEXAVAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), gastrointestinal stromal tumors, angiosarcoma, desmoid tumors (aggressive fibromatosis), osteosarcoma.
Exclusion Criteria	
Required Medical Information	For RCC and HCC, patient has advanced disease. For follicular, papillary, or Hürthle cell thyroid carcinoma, patient has tumors at sites other than the central nervous system that were not responsive to radioiodine therapy. For medullary thyroid carcinoma, patient has experienced progression on vandetanib or cabozantinib OR vandetanib or cabozantinib is not an appropriate option. For GIST, patient has experienced progression on imatinib or sunitinib. For osteosarcoma, patient has relapsed/refractory or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	NUEDEXTA
Drug Names	NUEDEXTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient is currently using quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong the QT interval and are metabolized by CYP2D6 (examples: thioridazine and pimozide). Patient has a prolonged QT interval or congenital long QT syndrome (LQTS), or heart failure or a history suggestive of torsades de pointes (TdP). Patient has complete atrioventricular (AV) block without an implanted pacemaker or is at high risk of complete AV block.
Required Medical Information	Nuedexta is being requested for the treatment of pseudobulbar affect (PBA).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	NUVIGIL

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

Prior Authorization Group	OCTREOTIDE
Drug Names	OCTREOTIDE ACETATE
Covered Uses	All FDA-approved indications not otherwise covered under Part D, poorly differentiated (high-grade) neuroendocrine tumor (NET)/large or small cell, pancreatic endocrine tumors (Islet cell tumors), carcinoid tumors, lung NET, unresectable and recurrent meningiomas, thymic carcinomas.
Exclusion Criteria	
Required Medical Information	For Acromegaly, must meet all of the following: 1) Clinical evidence of acromegaly, AND 2) Pre-treatment high IGF-1 level for age/gender, AND 3) Patient had an inadequate or partial response to surgery and/or radiotherapy or there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: the IGF-1 level decreased or normalized.

Prior Authorization Group	OLYSIO
Drug Names	OLYSIO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Failed previous treatment with a HCV protease inhibitor (e.g., Incivek, Olysio, Victrelis) despite adequate dosing and duration of therapy.

Required Medical Information	Diagnosis of chronic hepatitis C infection has been confirmed by presence of HCV RNA in serum prior to starting therapy. For treatment (tx) with pegylated interferon (PegIFN) and RBV: 1) must have HCV genotype 1 (Genotype 1a or genotype 1b) or genotype 4 infection, 2) For genotype 1a infection, absence of NS3 Q80K polymorphism must be confirmed by a laboratory testing prior to starting therapy, 3) Allow a total of 12 weeks for patients with Genotype 1 infection or Genotype 4 infection who are treatment-naïve or prior relapsers to PegIFN and RBV. For tx with Sovaldi with or without RBV: 1) must have Genotype 1 infection, 2) total 24 weeks for recurrent HCV infection post liver transplantation, 3) total 12 weeks for patients without cirrhosis who are treatment naive, prior relapsers to PegIFN and RBV therapy, or prior nonresponders to PegIFN and RBV therapy, 4) total 24 weeks for patients with cirrhosis who are treatment naive, prior relapsers to PegIFN and RBV therapy, or prior nonresponders to PegIFN and RBV therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 to 24 weeks depending on genotype, treatment regimen and transplantation status.
Other Criteria	

Prior Authorization Group	ONFI
Drug Names	ONFI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has types of seizures associated with Lennox-Gastaut Syndrome (e.g., tonic, atonic, absence or myoclonic seizures).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ORAL-INTRANASAL FENTANYL
Drug Names	FENTANYL CITRATE ORAL TRA, FENTORA, LAZANDA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The oral/intranasal fentanyl product will be used to manage breakthrough pain due to a current cancer condition or cancer related complication AND 2) A long-acting opioid is being prescribed for around-the-clock treatment of the cancer pain AND 3) The patient can be safely started on the requested dose based on current narcotic use history.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	

Prior Authorization Group	ORFADIN
Drug Names	ORFADIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (eg, detection of succinylacetone in urine) and appropriate clinical picture of the patient, OR 2) DNA testing (mutation analysis). Orfadin is used in conjunction with dietary restriction of tyrosine and phenylalanine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ORKAMBI
Drug Names	ORKAMBI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient is positive for the F508del mutation on both alleles of the CFTR gene.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Orkambi will not be used in combination with Kalydeco.

Prior Authorization Group	PEGASYS
Drug Names	PEGASYS, PEGASYS PROCLICK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia (CML), giant cell tumor of the bone (GCTB).
Exclusion Criteria	Decompensated liver disease (e.g. Child-Pugh class B or C).
Required Medical Information	For Chronic Hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment (tx). For mono-tx OR dual tx w/ ribavirin (RBV), Allow a total 48 weeks (wks). For tx w/ Victrelis and RBV 1) Genotype 1 [G1] only, 2) Allow a total 48 wks. For tx w/ Incivek and RBV 1) G1 only, 2)Allow a total 48 wks. For tx w/ Olysio and RBV (G1 and G4), 1) Allow a total 24 wks for tx naïve or relapsers w/ G1, 2) HCV-RNA less than 25 IU/mL at wk 24, a) Allow a total 48 wks for G4 tx naïve or relapsers, b) Allow a total 48 wks for G1 nonresponders to prior PegIFN and RBV tx. For tx w/ Sovaldi and RBV, 1) For recurrent G1 infection post liver transplantation, allow total 24 wks, 2) G1 thru G6 pts w/ nonresponse to prior PegIFN and RBV tx (w/ or w/o a protease inhibitor), Allow total 12 wks of tx. 3) For pts w/ G1, 3, 4, 5, or 6 who are tx naïve and relapser to prior PegIFN and RBV tx, Allow total 12 wks of tx.
Age Restrictions	
Prescriber Restrictions	

Coverage Duration	HCV=12 to 48 wks depending on treatment regimen and genotype. HBV=48 wks. CML and GCTB = Plan Year.
Other Criteria	For Chronic Hepatitis B, 1) For pt with cirrhosis, Pt must have been HBsAg positive for at least 6 months AND must have serum HBV-DNA greater than or equal to 10,000 copies/mL or greater than or equal to 2,000 IU/mL regardless of HBeAg status. 2) For pts without cirrhosis, Pt must have been HBsAg positive for at least 6 months. If HBeAg positive, pt must have serum HBV-DNA greater than 100,000 copies/mL or greater than 20,000 IU/mL. If HBeAg negative, pt must have serum HBV-DNA greater than 10,000 copies/mL or greater than 2,000 IU/mL. Must have persistent or intermittently elevated ALT greater than 2 times the upper limit of normal OR liver biopsy showing chronic hepatitis with moderate to severe necroinflammation.
Prior Authorization Group	PEGINTRON
Drug Names	PEG-INTRON, PEG-INTRON REDIPEN, PEGINTRON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia.
Exclusion Criteria	Decompensated liver disease (e.g. Child-Pugh class B or C).
Required Medical Information	For Chronic Hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment (tx). For mono-tx OR dual tx w/ ribavirin (RBV), Allow a total 48 weeks (wks). For tx w/ Victrelis and RBV 1) Genotype 1 [G1] only, 2) Allow a total 48 wks. For tx w/ Incivek and RBV 1) G1 only, 2)Allow a total 48 wks. For tx w/ Olysio and RBV (G1 and G4), 1) Allow a total 24 wks for tx naïve or relapsers w/ G1, 2) HCV-RNA less than 25 IU/mL at wk 24, a) Allow a total 48 wks for G4 tx naïve or relapsers, b) Allow a total 48 wks for G1 nonresponders to prior PegIFN and RBV tx. For tx w/ Sovaldi and RBV, 1) For recurrent G1 infection post liver transplantation, allow total 24 wks, 2) G1 thru G6 pts w/ nonresponse to prior PegIFN and RBV tx (w/ or w/o a protease inhibitor), Allow total 12 wks of tx. 3) For pts w/ G1, 3, 4, 5, or 6 who are tx naïve and relapser to prior PegIFN and RBV tx, Allow total 12 wks of tx.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HCV=12 to 48 weeks depending on tx regimen and genotype. CML=Plan Year.
Other Criteria	
Prior Authorization Group	POMALYST
Drug Names	POMALYST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis.
Exclusion Criteria	

Required Medical Information	For multiple myeloma: 1) patient received prior therapy with Velcade (bortezomib) AND with either Revlimid (lenalidomide) OR Thalomid (thalidomide), AND 2) disease has progressed during or within 60 days of completion of last therapy. For systemic light chain amyloidosis: Pomalyst is used in combination with dexamethasone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	PRIVIGEN
Drug Names	PRIVIGEN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT), chronic inflammatory demyelinating polyneuropathy, dermatomyositis, fetal/neonatal alloimmune thrombocytopenia, Guillain-Barré syndrome (GBS), Kawasaki syndrome, Lambert-Eaton myasthenic syndrome, myasthenia gravis, multifocal motor neuropathy, pediatric HIV infection, polymyositis, pure red cell aplasia (PRCA), relapsing-remitting multiple sclerosis (RRMS).
Exclusion Criteria	IgA deficiency with antibodies to IgA and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin or product components. Hyperprolinemia.

Required Medical Information	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: serum IgG less than 400mg/dL. For dermatomyositis and polymyositis: standard 1st line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For RRMS: standard 1st line treatments (interferon or glatiramer) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For pediatric HIV infection: serum IgG less than 400 mg/dL OR a history of recurrent bacterial infections. PRCA is secondary to parvovirus B19 infection. For all indications: patients with any of the following risk factors for acute renal failure must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: pre-existing renal insufficiency, diabetes mellitus, age over 65 years, volume depletion, sepsis, paraproteinemia, or receiving concomitant nephrotoxic drugs. For all indications: patients with any of the following risk factors for thrombosis must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: age 45 years or older, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling central vascular catheters, hyperviscosity, or cardiovascular risk factors.
Age Restrictions	For pediatric HIV infection: age 12 years or younger.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prior Authorization Group	PROMACTA
Drug Names	PROMACTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Information	For patients with chronic or persistent ITP, the following criteria are met: 1) New starts: a) Patient has had an inadequate response or is intolerant to corticosteroids, immunoglobulins or splenectomy AND 2) platelet count at time of diagnosis is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) Continuation of therapy: platelet count response to Promacta - a) Current platelet count is 50,000-200,000/mcL, b) Current platelet count is less than 50,000/mcL and sufficient to avoid clinically important bleeding, c) Current platelet count is less than 50,000/mcL and patient has not received a maximal dose of Promacta for at least 4 weeks, OR d) Current platelet count is greater than 200,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding. For patients with thrombocytopenia associated with chronic hepatitis C, the following criteria are met: 1) New starts: Promacta is used for initiation and maintenance of interferon-based therapy AND platelet count at time of diagnosis is less than 75,000/mcL, 2) Continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): 1) For new starts: a) Patient has had an inadequate response to immunosuppressive therapy, AND b) Untransfused platelet count at time of diagnosis is less than or equal to 30,000/mcL, 2) Continuation of therapy, platelet count response to Promacta: a) Current platelet count is 50,000-200,000/mcL OR b) Current platelet count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks OR c) Current platelet count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target platelet count. Adequate platelet response = APR. Inadequate platelet response = IPR.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HCV: 6mo, ITP/AA initial: 6mo, ITP/AA APR reauth: Plan Yr, ITP IPR reauth: 3mo, AA IPR reauth: 16wks
Other Criteria	Liver function will be measured at baseline and regularly throughout treatment AND Alanine aminotransferase (ALT) levels must not be equal to or greater than 3x the upper limit of normal in patients with normal liver function or equal to or greater than 3x baseline in a patient with pre-treatment elevations in transaminases AND have any of the following characteristics: progressive, persistent for equal to or greater than 4 weeks, accompanied by increased direct bilirubin or symptoms of liver injury or evidence of hepatic decompensation.
Prior Authorization Group	QUININE SULFATE
Drug Names	QUININE SULFATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Babesiosis.
Exclusion Criteria	Prolonged QT interval. Glucose-6-phosphate dehydrogenase (G6PD) deficiency. Myasthenia gravis. Optic neuritis.
Required Medical Information	

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Prior Authorization Group	REGRANEX
Drug Names	REGRANEX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Neoplasm(s) at site(s) of application.
Required Medical Information	1) For the treatment of lower extremity diabetic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply AND 2) Good ulcer care practices including initial sharp debridement, pressure relief, and infection control will be performed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	
Prior Authorization Group	RELISTOR
Drug Names	RELISTOR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Known or suspected mechanical gastrointestinal obstruction.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 months
Other Criteria	
Prior Authorization Group	REMICADE
Drug Names	REMICADE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis, Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	

Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Remicade (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): 1) Remicade will be used in combination with MTX or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide, AND 2) Inadequate response to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., Cimzia, Enbrel, Humira or Simponi), OR 3) Intolerance or contraindication to a self-injectable TNF inhibitor. For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease, OR 2) Inadequate response to a self-injectable TNF inhibitor (eg, Cimzia or Humira), OR 3) Intolerance or contraindication to a self-injectable TNF inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (eg, corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to a self-injectable TNF inhibitor (eg, Enbrel, Humira or Simponi), OR 2) Intolerance or contraindication to a self-injectable TNF inhibitor. For chronic moderate to severe plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected, AND 2) Inadequate response, intolerance or contraindication to a self-injectable TNF inhibitor (eg, Enbrel or Humira). For juvenile idiopathic arthritis: (new starts only): 1) Inadequate response to MTX, OR 2) Intolerance or contraindication to MTX.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Prior Authorization Group	REVLIMID
Drug Names	REVLIMID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myelodysplastic syndromes (MDS) without deletion 5q, progressive solitary plasmacytoma (PSP), systemic light chain amyloidosis, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), and the following other subtypes of non-Hodgkin's lymphoma (NHL): AIDS-related diffuse large B-cell lymphoma (DLBCL), AIDS-related primary effusion lymphoma, AIDS-related lymphoma associated with Castleman's disease, DLBCL, follicular lymphoma (FL), gastric/nongastric mucosa associated lymphoid tissue (MALT) lymphoma, nodal/splenic marginal zone lymphoma, and primary cutaneous B-cell lymphoma (PCBCL).
Exclusion Criteria	

Required Medical Information	1) For myeloma or PSP: a) Revlimid is used as primary therapy in combination with dexamethasone OR with melphalan AND prednisone, OR b) Revlimid is used as maintenance monotherapy, OR c) Revlimid is used as salvage therapy. 2) For low or intermediate-1 risk MDS with 5q deletion: pt has a transfusion-dependent anemia (ie, greater than or equal to 2 units of red blood cells in the previous 8 weeks) OR symptomatic anemia. 3) For low or intermediate-1 risk MDS without 5q deletion: a) pt has symptomatic anemia AND b) pretreatment serum erythropoietin level greater than 500 mU/mL OR pretreatment serum erythropoietin level less than or equal to 500 mU/mL AND failed to respond to epoetin or darbepoetin. 4) For mantle cell lymphoma: disease is recurrent, relapsed or progressive. 5) For other NHL subtypes (AIDS-related DLBCL, AIDS-related primary effusion lymphoma, AIDS-related lymphoma associated with Castleman's disease, DLBCL, FL, gastric/nongastric MALT lymphoma, nodal/splenic marginal zone lymphoma, or PCBCL: a) disease is recurrent, relapsed or progressive AND, b) Revlimid is used as monotherapy OR in combination with rituximab. 6) For systemic light chain amyloidosis: Revlimid is used in combination with dexamethasone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	RIBAVIRIN
Drug Names	MODERIBA, MODERIBA 1200 DOSE PACK, MODERIBA 800 DOSE PACK, REBETOL, RIBASPHERE, RIBASPHERE RIBAPAK, RIBAVIRIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Information	CHC infection confirmed by presence of HCV-RNA in serum prior to starting treatment (tx). For tx w/ PegIFN/IFN, allow total 48 wks. For tx w/ PegIFN and BOC (G1 only), allow total 48 wks. For tx w/ PegIFN and TPV (G1 only), allow total 48 wks. For tx w/ PegIFN and SMP (G1,4), 1) TN or relapsers w/ G1: total 24 wks, 2) VL less than 25 IU/mL at wk 24, a)TN or relapsers w/ G4: total 48 wks, b)G1 pts w/ nonresponse to prior PegIFN and ribavirin tx: total 48 wks. For tx w/ SOV and SMP, 1) G1, 2) TN pts and relapsers to PegIFN and RBV w/ documented IFN intolerance or ineligibility: total 12 wks, 3) recurrent HCV infection post LT: total 24 wks, 4) Nonresponse to prior PegIFN and RBV therapy, total 12 wks. For tx w/ SOV and PegIFN, 1)Recurrent G1 infection post LT: total 24 wks, 2)G1-6 w/ nonresponse to prior PegIFN and RBV tx (w/ or w/o a protease inhibitor [PI]): total 12 wks, 3)G1/G3-6 pts who are TN or relapser to prior tx: total 12 wks. For tx w/ SOV, 1)Decompensated liver disease, allow total 48 wks, 2)HCC pts awaiting LT who meet MILAN criteria: total 48 wks/until LT, whichever occurs first, 3)Recurrent infection post LT w/ G1-3: total 24 wks, 4)G1/G4 pts w/ documented intolerance or ineligibility to receive IFN: total 24 wks, 5)G3: total 24 wks, 6)G2: total 12 wks, unless pt is nonresponder to prior PegIFN and RBV tx (w/ or w/o a PI) w/ cirrhosis: total 16 wks.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HCV= 12 to 48 wks total depending on tx regimen, genotype, and LT status.
Other Criteria	Abbreviations: Treatment (tx), detectable (det), undetectable (undet), genotype (G), treatment-naïve (TN), peginterferon (PegIFN), interferon (IFN), HCV-RNA (VL), Incivek (TPV), Victrelis (BOC), Olysio (SMP), Sovaldi (SOV), patients (pts), liver transplantation (LT), hepatocellular carcinoma (HCC). Poor IFN-response is defined as having less than 1.0-log10 drop in VL at wk 4. Null response is defined as less than 2-log10 drop in VL at wk 12. MILAN criteria defined as the presence of a tumor 5cm or less in diameter in pts with single hepatocellular carcinomas, and no more than 3 tumor nodules, each 3cm or less in diameter in pts with multiple tumors and no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor. Ineligibility to receive IFN is defined as having autoimmune hepatitis and other autoimmune disorders, hypersensitivity to PEG or any of its components, decompensated liver disease (Child-Pugh score 7 or above [class B or C]), history of depression, or clinical features consistent with depression, a baseline neutrophil count less than 1,500/uL, baseline platelet count less than 90,000/uL, or baseline hemoglobin less than 10g/dL or history of pre-existing cardiac disease. Decompensated liver disease is defined as Child-Pugh score 7 or above (class B or C).
Prior Authorization Group	RITUXAN
Drug Names	RITUXAN

Covered Uses	All FDA-approved indications not otherwise excluded from Part D, primary CNS lymphoma, leptomeningeal metastases, Hodgkin's lymphoma (lymphocyte-predominant), non-Hodgkin's lymphoma subtypes [marginal zone lymphomas (splenic, MALT), diffuse large B-cell lymphoma (DLBCL), Mantle cell lymphoma, Burkitt lymphoma, AIDS-related B-cell lymphoma, Hairy cell leukemia, small lymphocytic lymphoma (SLL), post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma], acute lymphoblastic leukemia, acquired blood factor VIII deficiency, autoimmune hemolytic anemia, chronic graft-versus-host disease (GVHD), multicentric Castleman's disease with HIV, refractory immune or idiopathic thrombocytopenic purpura (ITP), Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma, Sjögren syndrome, and prevention of Epstein-Barr virus (EBV)-related PTLD.
Exclusion Criteria	
Required Medical Information	Prior to initiating therapy, patient has been screened for hepatitis B virus (HBV) infection. For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response to a self-injectable tumor necrosis factor (TNF) inhibitor (eg, Cimzia, Enbrel, Humira or Simponi), OR 2) Intolerance or contraindication to a self-injectable TNF inhibitor. Hematologic malignancies must be CD20-positive. For ALL and Burkitt lymphoma, Rituxan is used as a component of a chemotherapy regimen. For DLBCL, patient meets one of the following: 1) previously untreated DLBCL in combination with chemotherapy, OR 2) previously treated DLBCL in combination with chemotherapy for a patient who is a candidate for autologous stem cell transplant, OR 3) previously treated DLBCL in a patient who is not a candidate for high-dose therapy with autologous stem cell transplant.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For rheumatoid arthritis, Rituxan is used in combination with MTX unless MTX is contraindicated or was not tolerated.
Prior Authorization Group	SABRIL
Drug Names	SABRIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For infantile spasms: Sabril is used as monotherapy. For complex partial seizures (CPS): 1) patient had an inadequate response to 2 alternative therapies (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine) for CPS AND 2) Sabril is used as adjunctive therapy.
Age Restrictions	Initial treatment infantile spasms: 1 month to 2 years. CPS: none.
Prescriber Restrictions	
Coverage Duration	Plan Year

Other Criteria	
Prior Authorization Group	SANDOSTATIN LAR
Drug Names	SANDOSTATIN LAR DEPOT
Covered Uses	All FDA-approved indications not otherwise covered under Part D, poorly differentiated (high-grade) neuroendocrine tumor (NET)/large or small cell, pancreatic endocrine tumors (Islet cell tumors), carcinoid tumors, multiple endocrine neoplasia (MEN) type 1, unresectable and recurrent meningiomas, thymic carcinomas.
Exclusion Criteria	
Required Medical Information	For Acromegaly, must meet all of the following: 1) Clinical evidence of acromegaly, AND 2) Pre-treatment high IGF-1 level for age/gender, AND 3) Patient had an inadequate or partial response to surgery and/or radiotherapy or there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: the IGF-1 level decreased or normalized.
Prior Authorization Group	SILDENAFIL
Drug Names	REVATIO, SILDENAFIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient requires nitrate therapy on a regular or intermittent basis.
Required Medical Information	NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	SIRTURO
Drug Names	SIRTURO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Sirturo being requested for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis (e.g. central nervous system), or infection caused by the non-tuberculous mycobacteria (NTM).
Required Medical Information	1) Sirturo is being requested as part of combination therapy in a patient with pulmonary multi-drug resistant tuberculosis (MDR-TB) AND 2) Another effective treatment regimen cannot be used instead of Sirturo.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	

Prior Authorization Group	SOMATULINE DEPOT
Drug Names	SOMATULINE DEPOT
Covered Uses	All FDA-Approved indications not otherwise excluded from Part D, poorly differentiated (high-grade) neuroendocrine tumors (NET)/large or small cell, pancreatic endocrine tumors (Islet cell tumors), carcinoid tumors, multiple endocrine neoplasia (MEN) type 1.
Exclusion Criteria	
Required Medical Information	For Acromegaly, must meet all of the following: 1) Clinical evidence of acromegaly, AND 2) Pre-treatment high IGF-1 level for age/gender, AND 3) Patient had an inadequate or partial response to surgery and/or radiotherapy or there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: the IGF-1 level decreased or normalized.

Prior Authorization Group	SOMAVERT
Drug Names	SOMAVERT
Covered Uses	All FDA-Approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient must meet all of the following: Clinical evidence of acromegaly, AND Pre-treatment high IGF-1 level for age/gender, AND Patient had an inadequate or partial response to surgery and/or radiotherapy unless there is a clinical reason for why the patient has not had surgery or radiotherapy, AND Patient had an inadequate response to octreotide or lanreotide unless patient is intolerant or has a contraindication to octreotide or lanreotide.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For renewal, the IGF-1 level decreased or normalized.

Prior Authorization Group	SORIATANE
Drug Names	ACITRETIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, prevention of non-melanoma skin cancers in high risk individuals.
Exclusion Criteria	Severely impaired liver function or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracycline.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Other Criteria	If the patient is female and able to bear children, female patient and/or guardian signed a Patient Agreement/Informed Consent (e.g., Do Your P.A.R.T) which includes confirmation of 2 negative pregnancy tests.
Prior Authorization Group	SOVALDI
Drug Names	SOVALDI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to starting therapy. For treatment (tx) with peginterferon (PegIFN) and RBV: 1) total 24 weeks (wks) for recurrent HCV infection post liver transplantation with Genotype (G) 1, 2) total 12 wks for G1 to 6 patients who had nonresponse to prior HCV therapy to PegIFN and RBV (with or without a protease inhibitor), 3) total 12 wks for G 1, 3, 4, 5, or 6 patients who are tx-naïve and relapsers to prior HCV therapy. For tx with Olysio with or without RBV: 1) has G1 infection, 2) total 24 wks for recurrent HCV infection post liver transplantation, 3) total 12 wks for patients with nonresponse to prior PegIFN and RBV therapy, 4) total 12 wks for tx-naïve patients and relapsers to prior PegIFN and RBV with documented intolerance or ineligibility to receive IFN. For tx with RBV: 1) total 48 wks for patients with decompensated liver disease (e.g., Child-Pugh Class B or C), 2) total 48 wks or until liver transplantation, whichever occurs first for patients with hepatocellular carcinoma awaiting for liver transplantation meeting MILAN criteria, 3) total 24 wks for recurrent HCV infection post liver transplantation with G 1, 2, or 3 infection, 4) total 24 wks for G1 or 4 with documented intolerance or ineligibility to receive IFN, 5) total 24 wks for G3, 6) for G2, total 16 wks if patient is nonresponder to prior HCV therapy with PegIFN and RBV (with or without a protease inhibitor) AND has cirrhosis. Otherwise total 12 wks.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12-48 wks depending on tx regimen, genotype, liver transplantation status and decompensation
Other Criteria	Ineligibility to receive IFN is defined as having one or more of the following: autoimmune hepatitis and other autoimmune disorders, hypersensitivity to PEG or any of its components, decompensated liver disease (eg, Child-Pugh score 7 or above [class B and C]), history of depression, or clinical features consistent with depression, history of pre-existing cardiac disease, a baseline neutrophil count less than 1,500/uL, baseline platelet count less than 90,000/uL, or baseline hemoglobin less than 10 g/dL. MILAN criteria is defined as the presence of a tumor 5cm or less in diameter in patients with single hepatocellular carcinomas, and no more than 3 tumor nodules, each 3cm or less in diameter in patients with multiple tumors and no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor.

Prior Authorization Group	SPRYCEL
Drug Names	SPRYCEL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, gastrointestinal stromal tumor (GIST).
Exclusion Criteria	
Required Medical Information	For chronic myeloid leukemia (CML) and acute lymphoblastic leukemia (ALL), patient must be positive for the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) using Sprycel as first line treatment, 2) experienced resistance or intolerance/toxicity to alternative tyrosine kinase inhibitor (imatinib, nilotinib, bosutinib, ponatinib), or 3) post hematopoietic stem cell transplant. For GIST, patient must have progressed on imatinib or sunitinib.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	STIVARGA
Drug Names	STIVARGA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient with metastatic colorectal cancer must have been previously treated with the following: fluoropyrimidine-, oxaliplatin- and irinotecan-based regimen, and an anti-EGFR agent if KRAS mutation-negative (wild-type). Patient with locally advanced, unresectable or metastatic gastrointestinal stromal tumor must have been previously treated with imatinib or sunitinib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	SUTENT
Drug Names	SUTENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), lung neuroendocrine tumors, angiosarcoma, solitary fibrous tumor or hemangiopericytoma, chordoma (bone cancer).
Exclusion Criteria	

Required Medical Information	For RCC, patient has advanced disease. For GIST, patient experienced disease progression on imatinib or was intolerant to imatinib. For PNETs, patient has well differentiated tumors and progressive unresectable locally advanced or metastatic disease. For follicular, papillary, or Hürthle cell thyroid carcinoma, patient has tumors at sites other than the central nervous system that were not responsive to radioiodine therapy. For medullary thyroid carcinoma, patient experienced progression on vandetanib or cabozantinib OR vandetanib or cabozantinib is not an appropriate option. For bone cancer, patient has chordoma subtype and has recurrent disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	SYLATRON
Drug Names	SYLATRON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, giant cell tumor of the bone.
Exclusion Criteria	
Required Medical Information	For Melanoma: must have microscopic or gross nodal involvement AND had a surgical resection of the tumor and complete lymphadenectomy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For melanoma, Sylatron must be requested within 84 days (12 weeks) of the surgical resection
Prior Authorization Group	SYMLIN
Drug Names	SYMLINPEN 120, SYMLINPEN 60
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Recurrent severe hypoglycemia that required assistance during the past 6 months. Gastroparesis. Patient requires drug therapy to stimulate gastrointestinal motility. Hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia). HbA1c level greater than 9 percent.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	1) If patient received Symlin in previous 3 months, patient demonstrated an expected reduction in HbA1c since starting Symlin therapy OR 2) The patient has inadequate glycemic control (HbA1c greater than 7 percent) and is currently receiving optimal mealtime insulin therapy.

Prior Authorization Group	TAFINLAR
Drug Names	TAFINLAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For monotherapy, patient must have a diagnosis of unresectable or metastatic melanoma AND the tumor must be positive for BRAF V600E mutation. For combination with Mekinist, patient must have a diagnosis of unresectable or metastatic melanoma AND the tumor must be positive for either BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TARCEVA
Drug Names	TARCEVA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chordoma.
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer, Tarceva is used for locally advanced, recurrent, or metastatic disease, and one of the following: a) First-line treatment in a patient who has had EGFR mutation testing AND is positive for EGFR exon 19 deletion or exon 21 (L858R) substitution mutation, OR b) maintenance treatment in a patient who responded to or remained stable after first-line chemotherapy AND Tarceva is being used as monotherapy, OR c) second- or third-line treatment AND Tarceva is being used as monotherapy. For pancreatic cancer: a) Pancreatic cancer is locally advanced, unresectable or metastatic, AND b) Tarceva is used in combination with gemcitabine. For chordoma: a) Patient has recurrent disease, AND b) Tarceva will be used as monotherapy or in combination with cetuximab.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TARGRETIN
Drug Names	BEXAROTENE, TARGRETIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary Syndrome (Capsules only), adult T-cell leukemia/lymphoma (Gel only), and primary cutaneous B-cell lymphoma (Gel only).
Exclusion Criteria	Pregnancy
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Other Criteria	
Prior Authorization Group	TASIGNA
Drug Names	TASIGNA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, acute lymphoblastic leukemia (ALL), gastrointestinal stromal tumor (GIST).
Exclusion Criteria	
Required Medical Information	For chronic myeloid leukemia (CML) and acute lymphoblastic leukemia (ALL), patient must be positive for the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) using Tasigna as first line treatment, 2) experienced resistance or intolerance/toxicity to alternative tyrosine kinase inhibitor (imatinib, dasatinib, bosutinib, ponatinib), or 3) post hematopoietic stem cell transplant. For ALL, patient has relapsed or refractory ALL. For GIST, patient must have progressed on imatinib or sunitinib.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TAZORAC
Drug Names	TAZORAC
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Diagnosis of plaque psoriasis with 20 percent body surface area involvement or less OR 2) Diagnosis of acne vulgaris AND 3) For female patients who are able to bear children, the pregnancy status of the patient has been evaluated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	1) For patients being treated for plaque psoriasis a trial of at least one topical corticosteroid (e.g., clobetasol, fluocinonide, mometasone, triamcinolone) (patient may still be using a corticosteroid product in addition to Tazorac) OR 2) Patient has an adverse event, intolerance, or contraindication to topical corticosteroids.
Prior Authorization Group	TEMAZEPAM
Drug Names	TEMAZEPAM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.
Age Restrictions	
Prescriber Restrictions	

Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
Prior Authorization Group	THALOMID
Drug Names	THALOMID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, progressive solitary plasmacytoma, myelofibrosis with myeloid metaplasia, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, HIV-related aphthous ulcers of mouth/esophagus, cancer cachexia, chronic graft-versus-host disease, AIDS-related diarrhea, and mucocutaneous lesions associated with Behcet's syndrome.
Exclusion Criteria	
Required Medical Information	1) For myeloma or progressive solitary plasmacytoma: a) Thalomid is used as primary therapy in combination with dexamethasone OR with melphalan and prednisone, OR b) Thalomid is used as maintenance monotherapy, OR c) Thalomid is used for salvage therapy. 2) For systemic light chain amyloidosis: Thalomid is used in combination with dexamethasone. 3) For Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma: Thalomid is used as monotherapy or in combination with rituximab. 4) For Behcet's syndrome: Thalomid is used for treatment of mucocutaneous lesions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TOPICAL TESTOSTERONES
Drug Names	ANDRODERM, TESTIM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Female.
Required Medical Information	The patient had or currently has a confirmed low testosterone level (according to standard lab reference values).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TRACLEER
Drug Names	TRACLEER
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	NYHA Functional Class II to IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization.

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TRELSTAR
Drug Names	TRELSTAR MIXJECT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Use as neoadjuvant androgen deprivation therapy (ADT) for radical prostatectomy for clinically localized disease.
Required Medical Information	For prostate cancer, patient must meet one of the following: 1) Locally advanced, recurrent or metastatic disease OR 2) Use as neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with intermediate or high risk of recurrence.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TYKERB
Drug Names	TYKERB
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, metastatic central nervous system (CNS) lesions from primary tumor (breast).
Exclusion Criteria	
Required Medical Information	For breast cancer, patient has recurrent or metastatic, HER2 positive disease. Tykerb must be used in combination with 1) capecitabine or trastuzumab (without cytotoxic therapy) for patients who have received prior trastuzumab-containing regimen, OR 2) aromatase inhibitor (eg, anastrozole, letrozole, exemestane) for postmenopausal women with hormone receptor positive disease. For metastatic CNS lesions, Tykerb must be used with capecitabine in patient with recurrent HER2 positive breast cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TYSABRI
Drug Names	TYSABRI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Use as monotherapy. For Crohn's disease (CD), patient must have an inadequate response or intolerance to conventional CD therapy and a TNF-inhibitor.
Age Restrictions	
Prescriber Restrictions	

Coverage Duration	MS: Plan Year. CD: initial = 3 months, renewal = Plan Year.
Other Criteria	Upon renewal for CD, patient's condition must have improved or stabilized with Tysabri treatment.
Prior Authorization Group	VALCHLOR
Drug Names	VALCHLOR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Prior Authorization Group	VERSACLOZ
Drug Names	VERSACLOZ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of clozapine-induced agranulocytosis or severe granulocytopenia. Dementia-related psychosis.
Required Medical Information	The patient is unwilling or unable to take tablets or capsules orally or is at high risk for non-compliance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	VICTRELIS
Drug Names	VICTRELIS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Failed previous treatment with a HCV protease inhibitor (i.e., Incivek, Olysio, Victrelis) despite adequate dosing and duration of therapy. HIV co-infection (Initial only).
Required Medical Information	Diagnosis of chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to starting therapy. Must have genotype 1 infection. Must be given in combination with pegylated interferon (ie, Pegasys or PegIntron) and ribavirin (RBV) only. Patient will receive 4 weeks of pegylated interferon (PEG-IFN) and RBV prior to starting Victrelis. Allow a total of 44 weeks in the following patients: 1) patients with cirrhosis, 2) patients with HIV coinfection (renewal only), 3) poorly IFN-responsive OR 4) null responders with prior therapy with PEG-IFN and RBV. For all other patients, allow a total of 32 weeks.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	32 weeks to 44 weeks
Other Criteria	

Prior Authorization Group	VOTRIENT
Drug Names	VOTRIENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, uterine sarcoma.
Exclusion Criteria	Alanine transaminase (ALT) greater than 3 times the upper limit of normal (ULN) and bilirubin greater than 2 times the ULN OR total bilirubin greater than 3 times ULN.
Required Medical Information	Patient must have one of the following diagnoses: advanced STS, advanced RCC or uterine sarcoma. For STS, patient does not have GIST or adipocytic STS AND has received a prior chemotherapy (e.g., doxorubicin, ifosfamide, epirubicin or dacarbazine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	XALKORI
Drug Names	XALKORI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, inflammatory myofibroblastic tumors, non-small cell lung cancer (NSCLC) with ROS1-positive tumors.
Exclusion Criteria	
Required Medical Information	For NSCLS, the tumor is ROS1- or ALK-positive. For IMT, the tumor is ALK-positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	XENAZINE
Drug Names	XENAZINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic tics associated with Tourette's syndrome, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Exclusion Criteria	Patients who are actively suicidal or have untreated or inadequately treated depression.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	XGEVA
Drug Names	XGEVA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Information	Patient has bone metastases from a solid tumor OR giant cell tumor of the bone OR hypercalcemia of malignancy. For giant cell tumor of the bone, patient has unresectable disease or surgical resection is likely to result in severe morbidity. For hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy (eg, zoledronic acid, pamidronate) defined as albumin-corrected serum calcium level of greater than 12.5 mg/dL despite IV bisphosphonate therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For hypercalcemia of malignancy: initial = 2 months, renewals = Plan Yr. All other dx = Plan Yr.
Other Criteria	For hypercalcemia of malignancy renewal requests: patient has demonstrated a response to Xgeva therapy defined as albumin-corrected serum calcium level of 12.5 mg/dL or less. For bone metastases from solid tumors and giant cell tumor of the bone: patient will receive calcium and vitamin D supplementation as needed to treat or prevent hypocalcemia. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prior Authorization Group	XIFAXAN
Drug Names	XIFAXAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Irritable Bowel Syndrome without constipation.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older for reduction in risk of overt hepatic encephalopathy (HE) recurrence.
Prescriber Restrictions	
Coverage Duration	Reduction in risk of overt HE recurrence - 6 mos, IBS w/o constipation -3 mos
Other Criteria	
Prior Authorization Group	XOLAIR
Drug Names	XOLAIR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Information	For allergic asthma, Xolair will be used in combination with other medications for long-term control of asthma. Patient will have a rapid-acting beta2-agonist available for rescue therapy. For initial therapy, must meet ALL of the following criteria: 1) has a diagnosis of moderate to severe persistent asthma, 2) has positive skin test (or blood test) to at least 1 perennial aeroallergen, 3) has baseline IgE level at or above 30 IU/mL, 4) asthma is inadequately controlled despite use of inhaled corticosteroid at the optimal dose, and 5) patient is optimizing the use of a long-acting inhaled beta2-agonist, leukotriene modifier, or theophylline at the optimal dose. For continuation therapy, patient must have improved asthma control while on Xolair. For chronic idiopathic urticaria, patient initiating Xolair therapy must meet ALL of the following criteria: 1) patient has been evaluated for other causes of urticaria, 2) patient has had itchy hives for at least 6 weeks, 3) patient has remained symptomatic despite H1-antihistamine treatment, and 4) the dose of antihistamine has been optimized. For continuation therapy, patient's symptom has been improved with Xolair treatment.
Age Restrictions	12 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Xolair will be administered in a controlled healthcare setting with access to emergency medications (e.g., anaphylaxis kit).
Prior Authorization Group	XTANDI
Drug Names	XTANDI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient must have metastatic prostate cancer and meet one of the following: 1) cancer is castration-resistant OR 2) Xtandi is being used to enhance the effectiveness of radiation therapy in combination with ADT OR 3) patient is ADT naive and is at risk of developing symptoms associated with androgen flare and Xtandi will be used in combination with ADT.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	XYREM
Drug Names	XYREM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Taking alcohol or sedative hypnotic agents while taking Xyrem.
Required Medical Information	For the treatment of cataplexy or excessive daytime sleepiness in a patient with narcolepsy.
Age Restrictions	
Prescriber Restrictions	

Coverage Duration	Plan Year
Other Criteria	If the request is for the continuation of Xyrem, the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.
Prior Authorization Group	ZAVESCA
Drug Names	ZAVESCA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has mild to moderate type 1 Gaucher disease. Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity. Enzyme replacement therapy is not a therapeutic option (eg, due to constraints such as allergy, hypersensitivity, or poor venous access).
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ZELBORAF
Drug Names	ZELBORAF
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, melanoma with BRAF V600K mutation.
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of melanoma AND the tumor is positive for either BRAF V600E or V600K mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ZOLINZA
Drug Names	ZOLINZA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, multiple myeloma.
Exclusion Criteria	
Required Medical Information	For multiple myeloma: Zolinza will be used as salvage therapy in combination with bortezomib (Velcade)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ZYDELIG

Drug Names	ZYDELIG
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of serious allergic reactions including anaphylaxis or toxic epidermal necrolysis.
Required Medical Information	For relapsed chronic lymphocytic leukemia, Zydelig is used in combination with rituximab. For relapsed follicular B-cell non-Hodgkin lymphoma and relapsed small lymphocytic lymphoma, patient has received at least two prior systemic therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZYKADIA
Drug Names	ZYKADIA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has metastatic disease. The tumor is ALK-positive. Patient has progressed on or is intolerant to crizotinib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZYTIGA
Drug Names	ZYTIGA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has metastatic, castration-resistant prostate cancer and Zytiga is used in combination with prednisone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	