Harvard Pilgrim Health Care
Stride[SM] Basic Rx (HMO),
Stride[SM] Value Rx (HMO),
Stride[SM] Value Rx Plus (HMO) and
Stride[SM] Gain Rx (HMO)

Prior Authorization Requirements

Effective 10/1/2019

Updated 9/2019

ACTEMRA

Products Affected

- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	RENEWAL: EVIDENCE OF SYMPTOM IMPROVEMENT WITH ONGOING ACTEMRA TREATMENT
Age Restrictions	RA: 18 YEARS OF AGE OR OLDER. SJIA, PJIA: 2 YEARS OF AGE OR OLDER.
Prescriber Restrictions	RHEUMATOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	RHEUMATOID ARTHRITIS: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE OF THE FOLLOWING DMARDS: METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE OR SULFASALAZINE. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, METHOTREXATE OR AN NSAID (E.G. IBUPROFEN, NAPROXEN) PLUS A CORTICOSTEROID (E.G. PREDNISONE, METHYLPREDINISOLONE).

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	INITIAL FOR PAH AND CTEPH: PATIENT IS CONCURRENTLY TAKING NITRATES OR NITRIC OXIDE DONORS (E.G. AMYL NITRATE), PHOSPHODIESTERASE INHIBITORS (E.G. SILDENAFIL, TADALAFIL, OR VARDENAFIL), OR NON-SPECIFIC PDE INHIBITORS (E.G. DIPYRIDAMOLE, THEOPHYLLINE).
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS. DIAGNOSIS OF PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) WHO GROUP 4. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS. INITIAL FOR CTEPH: PATIENT IS NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH. PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL FOR PAH: PREVIOUS TRIAL OF OR CONTRAINDICATION TO A PHOSPHODIESTERASE-5 INHIBITOR (E.G., REVATIO [SILDENAFIL] OR ADCIRCA [TADALAFIL]). RENEWAL FOR PAH AND CTEPH: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH AN ONCOLOGIST OR NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED RENAL CELL CARCINOMA (RCC): TREATMENT FAILURE OR CONTRAINDICATION TO SUNITINIB (SUTENT) OR SORAFENIB (NEXAVAR). ADVANCED HORMONE RECEPTOR-POSITIVE, HER2-NEGATIVE BREAST CANCER (ADVANCED HR+BC): CONCOMITANT USE OF EXEMESTANE AND TREATMENT FAILURE OR CONTRAINDICATION TO LETROZOLE OR ANASTROZOLE. QUANTITY LIMIT MAY APPLY.

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTED DIAGNOSIS OF ANAPLASTIC LYMPHOMA KINASE (ALK)-POSITIVE METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) AS DETECTED BY AN FDA-APPROVED TEST.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ALUNBRIG

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT MAY APPLY.

AMPYRA

Products Affected

- AMPYRA
- *dalfampridine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	PATIENT IS AMBULATORY AND IS ON CONCOMITANT THERAPY WITH A DISEASE-MODIFYING AGENT (E.G. INTERFERON BETA AGENTS, COPAXONE, GILENYA, TECFIDERA, ETC.). RENEWAL: DOCUMENTATION OF MAINTENANCE OF, OR IMPROVEMENT IN, WALKING SPEED DURING TREATMENT WITH AMPYRA.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST OR MULTIPLE SCLEROSIS SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT MAY APPLY.

APTIOM

Products Affected

- APTIOM

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PARTIAL-ONSET SEIZURES AND HAS HAD AN INSUFFICIENT RESPONSE OR INTOLERANCE TO TWO OR MORE MEDICATIONS INDICATED FOR ADJUNCT PARTIAL SEIZURES (E.G. BRIVIACT, FELBAMATE, FYCOMPA, GABAPENTIN, LAMOTRIGINE, LYRICA, LEVITERACETAM, OXCARBAZEPINE, TIAGABINE, TOPIRAMATE, VIMPAT, AND/OR ZONISAMIDE).
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ARANESP

Products Affected

- ARANESP (IN POLYSORBATE) INJECTION SOLUTION
- ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 25 MCG/0.42 ML, 300 MCG/0.6 ML, 40 MCG/0.4 ML, 500 MCG/ML, 60 MCG/0.3 ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	INITIAL: CHRONIC RENAL FAILURE (CRF) REQUIRES HEMOGLOBIN LEVEL LESS THAN 10G/DL, CANCER CHEMOTHERAPY REQUIRES HEMOGLOBIN LESS THAN 11G/DL OR HEMOGLOBIN LEVEL HAS DECREASED AT LEAST 2G/DL BELOW BASELINE. RENEWAL: CHRONIC RENAL FAILURE REQUIRES THAT THE PATIENT MEETS ONE OF THE FOLLOWING: IF THE PATIENT IS CURRENTLY RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 11G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 11G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. IF THE PATIENT IS NOT RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO EFFECTS OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY REQUIRES HEMOGLOBIN LEVELS BETWEEN 10G/DL AND 12G/DL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF A CRYOPYRIN-ASSOCIATED PERIODIC SYNDROME (CAPS), INCLUDING FAMILIAL COLD AUTOINFLAMMATORY SYNDROME (FCAS) OR MUCKLE-WELLS SYNDROME (MWS).
Age Restrictions	12 YEARS OF AGE OR OLDER.
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A RHEUMATOLOGIST, ALLERGIST, IMMUNOLOGIST OR DERMATOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ARIKAYCE

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	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. NEBULIZER THERAPY IS COVERED UNDER PART B FOR PATIENTS WHO ARE USING THE MEDICATION VIA A NEBULIZER IN THEIR OWN HOME. THOSE WHO ARE NOT USING IT IN THEIR HOME WILL BE COVERED UNDER PART D. QUANTITY LIMITS MAY APPLY.

AUBAGIO

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST OR MULTIPLE SCLEROSIS SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	HISTORY OF TREATMENT FAILURE WITH AT LEAST ONE AGENT INDICATED FOR THE TREATMENT OF MULTIPLE SCLEROSIS (E.G. COPAXONE, REBIF, TECFIDERA). QUANTITY LIMIT MAY APPLY.

AURYXIA

Products Affected

- AURYXIA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	WHEN USED AS AN IRON REPLACEMENT PRODUCT FOR THE TREATMENT OF IRON DEFICIENCY ANEMIA.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

AUSTEDO

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH A NEUROLOGIST OR PSYCHIATRIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

AVONEX

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST OR MULTIPLE SCLEROSIS SPECIALIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMIT MAY APPLY.

BALVERSA

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FORM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	MONOTHERAPY FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS OR SEVERE ACTIVE CENTRAL NERVOUS SYSTEM LUPUS, OR FOR MEMBERS WHO ARE AUTOANTIBODY NEGATIVE OR WHEN USED IN COMBINATION WITH OTHER BIOLOGICS OR INTRAVENOUS CYCLOPHOSPHAMIDE.
Required Medical Information	DOCUMENTED DIAGNOSIS OF ACTIVE, AUTOANTIBODY-POSITIVE (E.G. ANA, ANTI-DS-DNA, ANTI-SM) SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) AND IS RECEIVING STANDARD THERAPY FOR SLE (E.G., ANTIMALARIALS, CORTICOSTEROIDS, OR IMMUNOSUPPRESSIVES).
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A RHEUMATOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

BOSULIF

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF CHRONIC, ACCELERATED OR BLAST PHASE PHILADELPHIA CHROMOSOME-POSITIVE (PH+) CHRONIC MYELOGENOUS LEUKEMIA (CML) WITH A DOCUMENTED RESISTANCE OR INTOLERANCE TO PRIOR THERAPY OR NEWLY DIAGNOSED WITH CHRONIC PHASE PH+ CML.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

BRAFTOVI

Products Affected

- BRAFTOVI ORAL CAPSULE 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

BRIVIACT

Products Affected

- BRIVIACT ORAL TABLET 100 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PARTIAL-ONSET SEIZURES AND HAS HAD AN INSUFFICIENT RESPONSE OR INTOLERANCE TO TWO OR MORE MEDICATIONS INDICATED FOR ADJUNCT PARTIAL SEIZURES (E.G. BRIVIACT, FELBAMATE, FYCOMPA, GABAPENTIN, LAMOTRIGINE, LYRICA, LEVITERACETAM, OXCARBAZEPINE, TIAGABINE, TOPIRAMATE, VIMPAT, AND/OR ZONISAMIDE).
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

C1 ESTERASE INHIBITORS

Products Affected

- CINRYZE
- HAEGARDA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF HEREDITARY ANGIOEDEMA.
Age Restrictions	N/A
Prescriber Restrictions	ALLERGIST, HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMIT MAY APPLY.

CABOMETYX

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF ADVANCED RENAL CELL CARCINOMA (RCC).
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

CALQUENCE

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

CAPRELSA

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF SYMPTOMATIC OR PROGRESSIVE MEDULLARY THYROID CANCER WITH UNRESECTABLE LOCALLY ADVANCED OR METASTATIC DISEASE.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ENDOCRINOLOGIST OR AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

CARBAGLU

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	SPECIALIST IN METABOLIC DISORDERS
Coverage Duration	12 MONTHS
Other Criteria	N/A

CELECOXIB

Products Affected

- *celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg*

PA Criteria	Criteria Details
Covered Uses	ALL FDA ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	PATIENT IS AT HIGH RISK FOR GASTROINTESTINAL DAMAGE AS DEFINED BY THE FOLLOWING: AGE GREATER THAN OR EQUAL TO 65, PRIOR HISTORY OF A GI EVENT (E.G. PEPTIC ULCER DISEASE, GASTROINTESTINAL BLEEDING, GASTROINTESTINAL OBSTRUCTION OR GASTROINTESTINAL PERFORATION), CONCOMITANT USE OF ASPIRIN, ANTICOAGULANT, ANTIPLATELET, CORTICOSTEROIDS, SSRIS OR BISPHOSPHONATES.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 YEARS
Other Criteria	QUANTITY LIMIT APPLIES: 50, 100, 200MG STRENGTHS 60 CAPSULES PER 30 DAYS, 400MG STRENGTH 30 CAPSULES PER 30 DAYS.

CERDELGA

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTATION THAT CYP2D6 GENOTYPE HAS BEEN DETERMINED AND PATIENT IS AN EXTENSIVE METABOLIZER (EM), INTERMEDIATE METABOLIZER (IM) OR POOR METABOLIZER (PM)
Age Restrictions	18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMIT MAY APPLY.

CGRP

Products Affected

- AIMOVIG AUTOINJECTOR
- AIMOVIG AUTOINJECTOR (2 PACK)
- AJOVY
- EMGALITY PEN
- EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML, 300 MG/3 ML (100 MG/ML X 3)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, SEVERITY OR DURATION WITH THERAPY.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL (FOR MIGRAINE DIAGNOSIS ONLY): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE ALTERNATIVE AGENT FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL. QUANTITY LIMITS MAY APPLY.

CHOLBAM

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	EXTRAHEPATIC MANIFESTATIONS OF BILE ACID SYNTHESIS DISORDERS DUE TO SINGLE ENZYME DEFECTS (SEDS) OR PEROXISOMAL DISORDERS (PDS), INCLUDING ZELLWEGER SPECTRUM DISORDERS.
Required Medical Information	DIAGNOSIS OF BILE ACID SYNTHESIS DISORDERS DUE TO SINGLE ENZYME DEFECTS (SEDS) OR PEROXISOMAL DISORDERS (PDS), INCLUDING ZELLWEGER SPECTRUM DISORDERS, WHO EXHIBIT MANIFESTATIONS OF HEPATIC DISEASE, STEATORRHEA, OR COMPLICATIONS FROM DECREASED FAT SOLUBLE VITAMIN ABSORPTION.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

CIALIS

Products Affected

- CIALIS ORAL TABLET 2.5 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA (BPH)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE YEAR
Other Criteria	APPLIES TO THE 2.5MG AND 5MG STRENGTHS ONLY. QUANTITY LIMIT OF 30 TABLETS PER 30 DAYS.

COMETRIQ

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PROGRESSIVE, METASTATIC MEDULLARY THYROID CANCER.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

COPIKTRA

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

CORLANOR

Products Affected

- CORLANOR ORAL SOLUTION
- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF SYMPTOMATIC CHRONIC HEART FAILURE (NYHA CLASS II-IV) WITH A LEFT VENTRICULAR EJECTION FRACTION (EF) LESS THAN OR EQUAL TO 35%, RESTING HEART RATE IS GREATER THAN OR EQUAL TO 70 BEATS PER MINUTE
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 60 TABLETS PER 30 DAYS.

COSENTYX

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	RENEWAL: EVIDENCE OF SYMPTOM IMPROVEMENT WHILE ON COSENTYX THERAPY
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	PLAQUE PSORIASIS: DERMATOLOGIST. PSORIATIC ARTHRITIS: RHEUMATOLOGIST OR DERMATOLOGIST. ANKYLOSING SPONDYLITIS: RHEUMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	PLAQUE PSORIASIS: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE COURSE OF SYSTEMIC THERAPY FOR PSORIASIS (E.G. ACITRETIN, AZATHIPROINE, METHOTREXATE). PSORIATIC ARTHRITIS: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE OF THE FOLLOWING DMARDS: METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUIEN, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE PRESCRIPTION NSAID (E.G. DICLOFENAC, IBUPROFEN, MELOXICAM).

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR V600K MUTATION AND COTELLIC WILL BE USED IN COMBINATION WITH ZELBORAF (VEMURAFENIB).
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

DARAPRIM

Products Affected

- DARAPRIM

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	N/A

DAURISMO

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

DUPIXENT

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	INITIAL: PATIENT HAS MINIMUM BODY SURFACE AREA (BSA) INVOLVEMENT OF AT LEAST 10%, ECZEMA AREA AND SEVERITY INDEX (EASI) SCORE OF AT LEAST 16, OR PHYSICIAN GLOBAL ASSESSMENT (PGA) SCORE OF AT LEAST 3. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST,OR IMMUNOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL:12 MONTHS.
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO THE FOLLOWING: TOPICAL CORTICOSTEROIDS AND TOPICAL CALCINEURIN INHIBITORS [E.G., ELIDEL (PIMECROLIMUS), GENERIC TACROLIMUS OINTMENT].

EGRIFTA

Products Affected

- EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF HIV-ASSOCIATED LIPODYSTROPHY WITH EXCESS ABDOMINAL FAT.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ENBREL

Products Affected

- ENBREL
- ENBREL SURECLICK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	RENEWAL: EVIDENCE OF SYMPTOM IMPROVEMENT WHILE ON ENBREL TREATMENT
Age Restrictions	N/A
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: RHEUMATOLOGIST. PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: DERMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSORIATIC ARTHRITIS (PSA): HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE OF THE FOLLOWING DMARDS: METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE COURSE OF SYSTEMIC THERAPY FOR PSORIASIS (E.G. ACITRETIN, AZATHIOPRINE, METHOTREXATE). ANKYLOSING SPONDYLITIS: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE PRESCRIPTION NSAID (E.G. DICLOFENAC, IBUPROFEN, MELOXICAM).

ENDARI PA

Products Affected

- ENDARI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	HEMATOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	INITIAL: ADULTS (18 YRS OR OLDER): PHYSICIAN ATTESTATION OF: AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR OR SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING OR HISTORY OF RECURRENT ACUTE CHEST SYNDROME (ACS). RENEWAL: PHYSICIAN ATTESTATION PATIENT HAS MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE. HISTORY OF TREATMENT FAILURE OR INTOLERANCE OF HYDROXYUREA.

ENTRESTO

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF CHRONIC HEART FAILURE (NYHA CLASS II-IV) WITH A LEFT VENTRICULAR EJECTION FRACTION (EF) LESS THAN OR EQUAL TO 40%
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 60 TABLETS PER 30 DAYS.

EPCLUSA

Products Affected

- EPCLUSA
- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PROVIDER ATTESTATION THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). PATIENT IS CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR OR TOPOTECAN. PATIENT HAS SEVERE RENAL IMPAIRMENT, ESRD OR IS ON HEMODIALYSIS.
Required Medical Information	DIAGNOSIS OF CHRONIC HEPATITIS C, GENOYTPE 1, 2, 3, 4, 5, OR 6 AND PRE-TREATMENT HCV RNA-LEVEL (WITHIN PAST 3 MONTHS).
Age Restrictions	18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).
Coverage Duration	AUTHORIZED TREATMENT DURATION WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. QUANTITY LIMIT 28 TABLETS PER 28 DAYS.

EPIDIOLEX PA

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	LENNOX-GASTAUT SYNDROME: TRIAL OF OR CONTRAINDICATION TO TOPIRAMATE OR LAMOTRIGINE AND CLOBAZAM (TABLET OR SUSPENSION).

EPOETIN ALFA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	INITIAL: CHRONIC RENAL FAILURE (CRF) AND ANEMIA RELATED TO ZIDOVUDINE THERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ELECTIVE NON-CARDIAC OR NON-VASCULAR SURGERY REQUIRES A HEMOGLOBIN LEVEL LESS THAN 13G/DL. RENEWAL: CHRONIC RENAL FAILURE REQUIRES THAT THE PATIENT MEETS ONE OF THE FOLLOWING: IF THE PATIENT IS CURRENTLY RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 11G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 11G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. IF THE PATIENT IS NOT RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO ZIDOVUDINE THERAPY REQUIRES HEMOGLOBIN LEVELS BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.

PA Criteria	Criteria Details
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF METASTATIC BASAL CELL CARCINOMA , OR WITH LOCALLY ADVANCED BASAL CELL CARCINOMA THAT HAS RECURRED FOLLOWING SURGERY OR WHO ARE NOT CANDIDATES FOR SURGERY OR RADIATION.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ERLEADA

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ESBRIET

Products Affected

- ESBRIET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	NOT APPROVED FOR PATIENTS WITH KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER). NOT APPROVED IF THE PATIENT HAS NOT OBTAINED LIVER FUNCTION TESTS.
Required Medical Information	PATIENT WITH USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	

FABRAZYME

Products Affected

- FABRAZYME INTRAVENOUS RECON SOLN 5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF FABRY DISEASE.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

FARYDAK

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF MULTIPLE MYELOMA AND HAS RECEIVED AT LEAST TWO PRIOR THERAPIES INCLUDING BORTEZOMIB AND AN IMMUNOMODULATORY AGENT, AND FARYDAK IS BEING USED IN COMBINATION WITH DEXAMETHASONE AND BORTEZOMIB.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

FIRAZYR

Products Affected

- FIRAZYR
- *icatibant*

PA Criteria	Criteria Details
Covered Uses	PA Criteria: Pending CMS Approval
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval

FIRDAPSE

Products Affected

- FIRDAPSE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

FLECTOR

Products Affected

- *diclofenac epolamine*
- FLECTOR

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	ACUTE PAIN DUE TO MINOR STRAINS, SPRAINS AND CONTUSIONS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE YEAR
Other Criteria	

FORTEO (TERIPARATIDE)

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	HISTORY OF HYPERCALCEMIA, HYPERPARATHYROIDISM, SKELETAL MALIGNANCY (I.E. OSTEOSARCOMA), PAGET'S DISEASE OR RADIATION THERAPY, ALREADY COMPLETED A 24-MONTH COURSE OF FORTEO
Required Medical Information	LOW BMD WITH A T-SCORE LESS THAN -2.5 AND AT HIGH RISK FOR FRACTURE AS DEFINED BY EITHER A HISTORY OF OSTEOPOROTIC FRACTURE OR MULTIPLE RISK FACTORS FOR FRACTURE (E.G. ADVANCED AGE, FRAILTY, INCREASED FALL RISK, GLUCOCORTICOID THERAPY) OR FAILED AT LEAST A 6 MONTH TRIAL OF, OR HAS CONTRAINDICATION TO, OR CANNOT TOLERATE BISPHOSPHONATES, CALCITONIN OR EVISTA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 MONTHS MAXIMUM
Other Criteria	

GALAFOLD

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

GATTEX

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF SHORT BOWEL SYNDROME (SBS) AND IS DEPENDENT ON PARENTERAL NUTRITION (PN).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

GILENYA

Products Affected

- GILENYA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST OR MULTIPLE SCLEROSIS SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT 28 CAPSULES PER 28 DAYS

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) AND DOCUMENTED NON-RESISTANT EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) MUTATIONS AS DETECTED BY AN FDA-APPROVED TEST OR A DOCUMENTED DIAGNOSIS OF METASTATIC, SQUAMOUS CELL NSCLC AND DOCUMENTATION THAT THE DISEASE HAS PROGRESSED FOLLOWING PLATINUM-BASED CHEMOTHERAPY.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

GLATIRAMER

Products Affected

- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST OR MULTIPLE SCLEROSIS SPECIALIST.
Coverage Duration	12 MONTHS.
Other Criteria	20MG/ML: QUANTITY LIMIT OF 30 SYRINGES PER 30 DAYS. 40MG/ML: QUANTITY LIMIT OF 12 SYRINGES PER 28 DAYS.

GLATOPA

Products Affected

- *glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST OR MULTIPLE SCLEROSIS SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 30 SYRINGES PER 30 DAYS

GROWTH HORMONE

Products Affected

- NORDITROPIN FLEXPRO
- OMNITROPE

PA Criteria	Criteria Details
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	INTRAUTERNIE GROWTH RETARDATION (IUGR) OR SMALL FOR GESTATIONAL AGE (SGA): BIRTH WEIGHT OR LENGTH LESS THAN 2 STANDARD DEVIATIONS BELOW THE MEAN (OR BELOW THE 3RD PERCENTILE) FOR GESTATIONAL AGE AND HAS FAILED TO CATCH UP BY AGE 2. GROWTH HORMONE DEFICIENCY (CHILDHOOD ONSET, IDIOPATHIC OR ACQUIRED RESULTING FROM HYPOTHALAMIC-PITUITARY DISEASE, CRANIOPHARYNGIOMA, HEAD TRAUMA, RADIATION OR SURGERY): REMOVAL OF PITUITARY GLAND OR FAILED TO RESPOND TO 1 STANDARD GROWTH HORMONE STIMULATION TEST (WITH INSULIN, LEVODOPA, ARGININE, PROPRANOLOL, CLONIDINE OR GLUCAGON). FAILURE IS DEFINED AS A PEAK MEASURED GROWTH HORMONE LEVEL OF LESS THAN 5NG/ML AFTER STIMULATION IN ADULT PATIENTS AND LESS THAN 10NG/ML AFTER STIMULATION IN PEDIATRIC PATIENTS.
Age Restrictions	TURNER SYNDROME, CHRONIC RENAL FAILURE OR PRADER-WILLI SYNDROME: LESS THAN 18 YEARS OF AGE. ALL OTHER INDICATIONS HAVE NO AGE REQUIREMENT.
Prescriber Restrictions	
Coverage Duration	ONE YEAR

PA Criteria	Criteria Details
Other Criteria	

HARVONI

Products Affected

- HARVONI
- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PROVIDER ATTESTESTATION THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). PATIENT IS CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), STRIBILD OR TIPRANAVIR/RITONAVIR.
Required Medical Information	DIAGNOSIS OF CHRONIC HEPATITIS C, GENOTYPE 1A/B, 4, 5, OR 6 AND PRE-TREATMENT HCV RNA LEVEL (WITHIN PAST 3 MONTHS).
Age Restrictions	12 YEARS OF AGE OR OLDER.
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).
Coverage Duration	AUTHORIZED TREATMENT DURATION WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. QUANTITY LIMIT 28 TABLETS PER 28 DAYS.

HETLIOZ

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 30 CAPSULES PER 30 DAYS

HP ACTHAR

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	INFANTILE SPASMS AND MULTIPLE SCLEROSIS: 1 MONTH. OTHER INDICATIONS: 12 MONTHS.
Other Criteria	ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS REQUIRE A TRIAL OR CONTRAINDICATION TO IV CORTICOSTEROIDS.

HRM ANTICHOLINERGICS

Products Affected

- *cyproheptadine*
- *diphenhydramine hcl injection solution 50 mg/ml*
- *diphenhydramine hcl injection syringe*
- *diphenhydramine hcl oral elixir*
- *hydroxyzine hcl intramuscular solution 50 mg/ml*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate*
- *promethazine oral*
- *promethazine rectal*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	N/A
Coverage Duration	6 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

HRM ANTIPARKINSONS AGENTS

Products Affected

- *benztropine oral*
- *trihexyphenidyl*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

HRM BUTALBITAL-CONTAINING MEDICATIONS

Products Affected

- *butalbital compound w/codeine*
- *butalbital compound-codeine*
- *butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg*
- *butalbital-acetaminophen oral tablet*
- *butalbital-acetaminophen-caff oral capsule*
- *butalbital-acetaminophen-caff oral tablet 50-325-40 mg*
- *butalbital-aspirin-caffeine oral capsule*
- *marten-tab*
- *phrenilin forte(with caffeine)*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	N/A
Coverage Duration	6 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. QUANTITY LIMIT OF 180 TABLETS OR CAPSULES PER 30 DAYS.

HRM CARDIOVASCULAR AGENTS

Products Affected

- *guanfacine oral tablet*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OR CONTRAINDICATION TO TWO (2) DRUGS IN THE FOLLOWING CLASSES: ACE INHIBITORS (AND COMBINATIONS), ANGIOTENSIN RECEPTOR BLOCKERS (AND COMBINATIONS), BETA BLOCKERS, CALCIUM CHANNEL BLOCKERS.

HRM ESTROGEN

Products Affected

- *amabelz*
- CLIMARA PRO
- DUAVEE
- ELESTRIN
- *estradiol oral*
- *estradiol transdermal*
- *estradiol-norethindrone acet*
- *estropipate*
- *jinteli*
- *lopreeza*
- *mimvey*
- *mimvey lo*
- PREMARIN ORAL
- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

HRM GLYBURIDE

Products Affected

- *glyburide micronized oral tablet 1.5 mg, 3 mg, 2.5-500 mg, 5-500 mg mg, 6 mg*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OR CONTRAINDICATION TO GLIMEPIRIDE OR GLIPIZIDE. PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. QUANTITY LIMIT APPLIES: GLYBURIDE (SINGLE-AGENT): 1.25MG TABLETS 480 PER 30 DAYS, 1.5MG AND 2.5MG TABLETS 240 PER 30 DAYS, 3MG AND 5MG TABLETS 120 PER 30 DAYS, 6MG TABLETS 60 PER 30 DAYS. GLYBURIDE-METFORMIN COMBINATIONS: 1.25-250MG TABLETS 240 PER 30 DAYS, 2.5-500MG AND 5-500MG TABLETS 120 PER 30 DAYS.

HRM INDOMETHACIN

Products Affected

- *indomethacin oral*
- *indomethacin sodium*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO CELECOXIB OR A TOPICAL NON-STEROIDAL ANTI-INFLAMMATORY DRUG (NSAID) SUCH AS VOLTAREN GEL OR FLECTOR. PRESCRIPTIONS WRITTEN BY A RHEUMATOLOGIST DO NOT REQUIRE TRIAL OF FORMULARY ALTERNATIVES.

HRM MEGESTROL ACETATE

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml*
- *megestrol oral tablet*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

HRM PHENOBARBITAL

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

HRM SKELETAL MUSCLE RELAXANTS

Products Affected

- *carisoprodol*
- *chlorzoxazone*
- *cyclobenzaprine oral tablet*
- *metaxalone*
- *methocarbamol oral*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	N/A
Coverage Duration	6 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

HRM THIORIDAZINE

Products Affected

- *thioridazine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER.

HUMIRA

Products Affected

- HUMIRA
- HUMIRA PEDIATRIC CROHNS START
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	RENEWAL: EVIDENCE OF SYMPTOM IMPROVEMENT WHILE ON HUMIRA TREATMENT
Age Restrictions	N/A
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: RHEUMATOLOGIST. PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS, HYDRADENITIS SUPPURATIVA: DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: GASTROENTEROLOGIST. UVEITIS: OPHTHALMOLOGIST.
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSORIATIC ARTHRITIS (PSA): HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE OF THE FOLLOWING DMARDS: METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE COURSE OF SYSTEMIC THERAPY FOR PSORIASIS (E.G. ACITRETIN, AZATHIOPRINE, METHOTREXATE). CROHN'S DISEASE (CD), ULCERATIVE COLITIS (UC): HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST TWO oF THE FOLLOWING: ORAL CORTICOSTEROIDS, 5-AMINOSALICYLATES, IMMUNOSUPPRESSANTS/IMMUNOMODULATORS (E.G. AZATHIOPRINE, METHOTREXATE). ANKYLOSING SPONDYLITIS: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE PRESCRIPTION NSAID (E.G. DICLOFENAC, IBUPROFEN, MELOXICAM).

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR-2 (HER-2) NEGATIVE ADVANCED OR METASTATIC BREAST CANCER IN COMBINATION WITH AN AROMATASE INHIBITOR AS INITIAL ENDOCRINE BASED THERAPY IN A POSTMENOPAUSAL WOMAN, OR WITH FULVESTRANT IN A WOMAN WITH DISEASE PROGRESSION FOLLOWING ENDOCRINE THERAPY.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ICLUSIG

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF CHRONIC PHASE, ACCELERATED PHASE, OR BLAST PHASE CHRONIC MYELOID LEUKEMIA (CML) OR POSITIVE PHILADELPHIA CHROMOSOME POSITIVE ACUTE LYMPHOBLASTIC LEUKEMIA (PH+ALL) FOR WHICH NO OTHER TYROSINE KINASE INHIBITOR THERAPY IS INDICATED OR T315I-POSITIVE CML (CHRONIC PHASE, ACCELERATED PHASE, OR BLAST PHASE) OR T3151-POSITIVE PH+ALL.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST OR HEMATOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMIT OF 30 TABLETS PER 30 DAYS.

ILARIS

Products Affected

- ILARIS (PF) SUBCUTANEOUS RECON SOLN 150 MG/ML
- ILARIS (PF) SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS): DOCUMENTED DIAGNOSIS OF FAMILIAL COLD AUTOINFLAMMATORY SYNDROME (FCAS) OR MUCKLE-WELLS SYNDROME (MWS). RENEWAL: EVIDENCE OF SYMPTOM IMPROVEMENT WHILE ON ILARIS TREATMENT.
Age Restrictions	FCAS, MWS: 4 YEARS OF AGE OR OLDER. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): 2 YEARS OF AGE OR OLDER.
Prescriber Restrictions	FCAS, MWS: RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST. SJIA: RHEUMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	SJIA: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE CORTICOSTEROID (E.G. PREDNISONE) OR ONE NSAID (E.G. IBUPROFEN, KETOPROFEN).

IMATINIB MESYLATE

Products Affected

- *imatinib*

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	N/A

IMBRUVICA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH AN ONCOLOGIST OR TRANSPLANT SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMITS MAY APPLY.

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PATIENT AGE 2 TO 18 YEARS OF AGE
Prescriber Restrictions	ENDOCRINOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	

INGREZZA

Products Affected

- INGREZZA INITIATION PACK
- INGREZZA ORAL CAPSULE 40 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, MOVEMENT DISORDER SPECIALIST, OR PSYCHIATRIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 60 CAPSULES PER 30 DAYS.

IRESSA

Products Affected

- IRESSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) IN TUMORS THAT HAVE EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 19 DELETIONS OR EXON 21 (L858R) SUBSTITUTION MUTATIONS AS DETECTED BY AN FDA-APPROVED TEST.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF INTERMEDIATE OR HIGH-RISK MYELOFIBROSIS (MF), INCLUDING PRIMARY MF, POST-POLYCYTHEMIA VERA MF AND POST-ESSENTIAL THROMBOCYTHEMIA MF OR A DIAGNOSIS OF POLYCYTHEMIA VERA (PV) WITH AN INADEQUATE RESPONSE OR INTOLERANCE TO HYDROXYUREA.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	SUBSEQUENT AUTHORIZATION REQUIRES DOCUMENTATION OF SPLEEN SIZE REDUCTION OR SYMPTOMATIC IMPROVEMENT.

JUXTAPID

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH) DETERMINED BY SIMON BROOME DIAGNOSTIC (SBD) CRITERIA
Age Restrictions	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF, OR CONTRAINDICATION TO, EVOLOCUMAB (REPATHA). QUANTITY LIMIT OF 30 CAPSULES PER 30 DAYS.

JYNARQUE

Products Affected

- JYNARQUE ORAL TABLET
- JYNARQUE ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS
Age Restrictions	2 YEARS OF AGE OR OLDER
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	N/A

KALYDECO GRANULE PACKETS

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS. PATIENT WEIGHT.
Age Restrictions	6 MONTHS OF AGE AND OLDER
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	N/A

KEVEYIS

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PRIMARY HYPERKALEMIC PERIODIC PARALYSIS, PRIMARY HYPOKALEMIC PERIODIC PARALYSIS, AND RELATED VARIANTS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

KINERET

Products Affected

- KINERET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	RENEWAL: EVIDENCE OF SYMPTOM IMPROVEMENT WHILE ON KINERET TREATMENT
Age Restrictions	RHEUMATOID ARTHRITIS: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	RHEUMATOID ARTHRITIS: RHEUMATOLOGIST. NEONATAL-ONSET MULTISYSTEM INFLAMMATORY DISEASE (NOMID): RHEUMATOLOGIST, DERMATOLOGIST, OR PEDIATRICIAN.
Coverage Duration	12 MONTHS
Other Criteria	RHEUMATOID ARTHRITIS: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE OF THE FOLLOWING DMARDS: METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. QUANTITY LIMIT OF 18.76 PER 28 DAYS.

KISQALI

Products Affected

- KISQALI
- KISQALI FEMARA CO-PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	FOR SINGLE-AGENT KISQALI: MEDICATION WILL BE USED IN COMBINATION WITH AN AROMATASE INHIBITOR (E.G., LETROZOLE, ANASTROZOLE) OR FULVESTRANT. FOR SINGLE AGENT AND COMBINATION PRODUCT: PATIENT IS FEMALE AND PRE/PERI OR POST-MENOPAUSAL, HAS HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR (HER2)-NEGATIVE BREAST CANCER, AND HAS NOT RECEIVED PRIOR ENDOCRINE THERAPY FOR BREAST CANCER (E.G., LETROZOLE, ANASTROZOLE, TAMOXIFEN, FULVESTRANT, EXEMESTANE) OR PATIENT IS FEMALE AND POSTMENOPAUSAL WITH HORMONE RECEPTOR (HR)-POSITIVE, HUMAN EPIDERMAL GROWTH FACTOR RECEPTOR (HER2)-NEGATIVE BREAST CANCER, AGENT BEING USED AS INITIAL ENDOCRINE BASED THERAPY OR FOLLOWING DISEASE PROGRESSION ON ENDOCRINE THERAPY.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	N/A

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF ENDOGENOUS CUSHING'S SYNDROME AND TYPE 2 DIABETES OR GLUCOSE INTOLERANCE, FAILED SURGICAL TREATMENT OR NOT A CANDIDATE FOR SURGERY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE YEAR
Other Criteria	QUANTITY LIMIT OF 112 TABLETS PER 28 DAYS.

KUVAN

Products Affected

- KUVAN

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF HYPERPHENYLALANINEMIA (HPA) DUE TO TETRAHYDROBIOPTERIN (BH4)-RESPONSIVE PHENYLKETONURIA (PKU). RENEWAL: DOCUMENTED DECREASE IN BLOOD PHENYLALANINE (PHE) LEVELS FROM BASELINE.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY A SPECIALIST IN METABOLIC DISORDERS
Coverage Duration	12 MONTHS
Other Criteria	N/A

LENVIMA

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF LOCALLY RECURRENT OR METASTATIC, PROGRESSIVE, RADIOACTIVE IODINE-REFRACTORY DIFFERENTIATED THYROID CANCER (DTC), OR DIAGNOSIS OF ADVANCED RENAL CELL CARCINOMA (RCC) FOLLOWING ONE PRIOR ANTI-ANGIOGENIC THERAPY AND WHEN USED IN COMBINATION WITH EVEROLIMUS .
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

LETAIRIS

Products Affected

- *ambrisentan*
- LETAIRIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PULMONARY ATERIAL HYPERTENSION (PAH) (WHO GROUP 1) CONFIRMED BY RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	RENEWAL: PATIENT HAS HAD A POSITIVE CLINICAL RESPONSE TO THERAPY.

LIDOCAINE OINTMENT

Products Affected

- *lidocaine topical ointment*

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	MEDICATION IS BEING USED FOR ANESTHESIA OF ACCESSIBLE MUCOUS MEMBRANES OF THE OROPHARYNX, ANESTHETIC LUBRICANT FOR INTUBATION, TEMPORARY RELIEF OF PAIN ASSOCIATED WITH MINOR BURNS, ABRASIONS OF THE SKIN OR INSECT BITES, OR LOCAL ANESTHESIA
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	N/A

LIDOCAINE PATCH

Products Affected

- *lidocaine topical adhesive patch,medicated*

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL COVERAGE CONSIDERATION FOR DIABETIC NEUROPATHY, OR BURN PAIN.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE YEAR
Other Criteria	

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	N/A

LORBRENA

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

LYNPARZA

Products Affected

- LYNPARZA ORAL CAPSULE
- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIANGOSIS OF DELETERIOUS OR SUSPECTED DELETERIOUS GERMLINE BRCA-MUTATED ADVANCED OVARIAN CANCER PREVIOUSLY TREATED WITH THREE OR MORE PRIOR LINES OF CHEMOTHERAPY.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	FDA-APPROVED COMPANION DIAGNOSTIC FOR LYNPARZA FOR BRCA MUTATION. QUANTITY LIMITS MAY APPLY.

MAKENA

Products Affected

- MAKENA INTRAMUSCULAR OIL
  250 MG/ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	WOMEN WITH MULTIPLE GESTATIONS OR OTHER RISK FACTORS FOR PRETERM BIRTH.
Required Medical Information	DIAGNOSIS OF PREGNANCY WITH A HISTORY OF SINGLETON SPONTANEOUS PRETERM BIRTH.
Age Restrictions	16 YEARS OF AGE OR OLDER.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

MAVYRET

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PROVIDER ATTESTATION THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION).MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD PUGH B OR C). PATIENT IS CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, RIFAMPIN, ETHINYL ESTRADIOL-CONTAINING MEDICATION, ATAZANAVIR, DARUNAVIR, LOPINAVIR, RITONAVIR, EFAVIRENZ, ST. JOHN'S WORT, ATORVASTATIN, LOVASTATIN, SIMVASTATIN, ROSUVASTATIN AT DOSES GREATER THAN 10MG, OR CYCLOSPORINE AT DOSES GREATER THAN 100MG PER DAY.PRIOR FAILURE OF A DAA REGIMEN WITH NS5A INHIBITOR AND HCV PROTEASE INHIBITOR.
Required Medical Information	DIAGNOSIS OF CHRONIC HEPATITIS C AND PRETREATMENT HCV RNA LEVEL (WITHIN PAST 3 MONTHS).
Age Restrictions	PATIENT 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, OR A PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G., HEPATOLOGIST).
Coverage Duration	AUTHORIZED TREATMENT DURATION WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.QUANTITY LIMIT OF 84 TABLETS IN 28 DAYS.

MEKINIST

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	DIAGNOSIS OF MELANOMA WHICH PROGRESSED ON PRIOR BRAF-INHIBITOR THERAPY.
Required Medical Information	DOCUMENTED DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA WITH A BRAF V600E OR BRAF V600K MUTATION AS DETECTED BY AN FDA-APPROVED TEST OR A DOCUMENTED DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH A BRAF V600E MUTATION AS DETECTED BY AN FDA-APPROVED TEST AND USED IN COMBINATION WITH DABRAFENIB.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

MEKTOVI

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

MULPLETA

Products Affected

- MULPLETA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 MONTHS.
Other Criteria	N/A

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	PRIOR TO STARTING NATPARA, DOCUMENTATION OF SUFFICIENT 25-HYDROXYVITAMIN D LEVEL AND SERUM CALCIUM ABOVE 7.5MG/DL
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 2 PER 28 DAYS.

NERLYNX

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMIT OF 180 TABLETS IN 30 DAYS.

NEXAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 120 TABLETS PER 30 DAYS

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF MULTIPLE MYELOMA USED IN COMBINATION WITH LENALIDOMIDE (REVLIMID) AND DEXAMETHASONE IN PATIENTS WHO HAVE RECEIVED AT LEAST ONE PRIOR THERAPY.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

NORTHERA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	CONCURRENT USE OF XOLAIR
Required Medical Information	BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE LAST 6 WEEKS OR GREATER THAN OR EQUAL TO 300 CELLS/MCL WITHIN THE LAST 12 MONTHS
Age Restrictions	12 YEARS OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE
Coverage Duration	12 MONTHS
Other Criteria	FOR SEVERE ASTHMA: INITIAL THERAPY - PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION WHICH INCLUDES ANY OF THE FOLLOWING: LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, OR ORAL CORTICOSTEROID. RENEWAL REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED SUSTAINED CLINICAL IMPROVEMENT OF ASTHMA (FOR EXAMPLE, REDUCTION IN ORAL CORTICOSTEROID USE, REDUCED ASTHMA EXACERBATIONS, FEWER ASTHMA-RELATED HOSPITALIZATIONS OR URGENT OR EMERGENT CARE VISITS). QUANTITY LIMITS MAY APPLY.

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

NUPLAZID

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (SUCH AS A PSYCHIATRIST)
Coverage Duration	INITIAL 12 MONTHS. RENEWAL 12 MONTHS.
Other Criteria	RENEWAL REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED AN IMPROVEMENT IN PSYCHOSIS SYMPTOMS FORM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT. QUANTITY LIMIT OF 60 TABLETS PER 30 DAYS.

OCALIVA

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PATIENTS WITH COMPLETE BILIARY OBSTRUCTION
Required Medical Information	N/A
Age Restrictions	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 30 TABLETS PER 30 DAYS

OCREVUS

Products Affected

- OCREVUS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	THIS DRUG REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D. QUANTITY LIMIT OF 20 ML PER 180 DAYS.

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF LOCALLY ADVANCED BASAL CELL CARCINOMA THAT HAS RECURRED FOLLOWING SURGERY OR RADIATION THERAPY, OR THOSE WHO ARE NOT CANDIDATES FOR SURGERY OR RADIATION THERAPY.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF IDIOPATHIC PULMONARY FIBROSIS (IPF) AND IS NOT CURRENTLY TAKING PIRFENIDONE (ESBRIET).
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A PULMONOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: PATIENT HAS HAD A POSITIVE CLINICAL RESPONSE TO THERAPY

ORENCIA

Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	RENEWAL: EVIDENCE OF SYMPTOM IMPROVEMENT WITH ONGOING ORENCIA TREATMENT.
Age Restrictions	RHEUMATOID ARTHRITIS (RA): 18 YEARS OF AGE OR OLDER. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): 2 YEARS OF AGE OR OLDER. PSORIATIC ARTHRITIS: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	PRESCRIBED BY A RHEUMATOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	RHEUMATOID ARTHRITIS OR PSORIATIC ARTHRITIS: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST ONE OF THE FOLLOWING DMARDS: METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

ORFADIN

Products Affected

- ORFADIN

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF HEREDITARY TYROSINEMIA TYPE-1.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ORILISSA

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	INITIAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING CONTRACEPTIVE PREPARATION.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PHYSICIAN ATTESTATION OF IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS. QUANTITY LIMITS MAY APPLY.

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	CONCURRENT KALYDECO THERAPY
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS. BASELINE FEV1.
Age Restrictions	2 YEARS OF AGE OR OLDER.
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PLUMONOLOGIST OR PHYSICIAN SPECIALIZING IN THE TREATMENT OF CF
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR BODY MASS INDEX (BMI) OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS. QL OF 120 PER 30 DAYS.

OSPHENA

Products Affected

- OSPHENA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED BY PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

OTEZLA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH: PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: DERMATOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: PSORIATRIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH ONE OF THE FOLLOWING CONVENTIONAL THERAPIES SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. QUANTITY LIMIT OF 1 STARTER PACK PER 365 DAYS AND 60 TABLETS PER 30 DAYS.

OXERVATE

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	8 WEEKS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

PAH DRUGS

Products Affected

- ADCIRCA
- REVATIO ORAL SUSPENSION FOR RECONSTITUTION
- *sildenafil (antihypertensive) oral*
- *tadalafil (antihypertensive)*
- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION (PAH), RAYNAUD'S SYNDROME, OR CURRENTLY RECEIVING TREATMENT WITH REQUESTED MEDICATION. FOR TADALAFIL 2.5MG AND 5MG: DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA (BPH).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE YEAR
Other Criteria	

PIQRAY

Products Affected

- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

POLIVY

Products Affected

- POLIVY

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF MULTIPLE MYELOMA AND HAS RECEIVED AT LEAST TWO (2) PRIOR THERAPIES INCLUDING LENALIDOMIDE AND A PROTEASOME INHIBITOR (KYPROLIS, NINLARO, OR VELCADE) AND HAS DEMONSTRATED DISEASE PROGRESSION ON OR WITHIN 60 DAYS OF COMPLETION OF THE LAST THERAPY.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

PROLIA

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF OSTEOPOROSIS IN MEN AND POSTMENOPAUSAL WOMEN WHO ARE AT HIGH RISK OF FRACTURE DEFINED AS A HISTORY OF OSTEOPOROTIC FRACTURE OR MULTIPLE RISK FACTORS FOR FRACTURE AND A T SCORE LESS THAN OR EQUAL TO -2.0 AS EVIDENCED VIA BONE DENSITY SCAN OR HAS HAD AN INADEQUATE RESPONSE OR INTOLERANCE TO THERAPY WITH AT LEAST ONE OF THE TRADITIONAL OSTEOPOROSIS TREATMENTS (ALENDRONATE, CALCITONIN , IBANDRONATE, RALOXIFENE, RISEDRONATE, ZOLEDRONIC ACID). COVERAGE MAY ALSO BE AUTHORIZED FOR WOMEN AT HIGH RISK FOR FRACTURE RECEIVING ADJUVANT AROMATASE INHIBITOR THERAPY FOR BREAST CANCER OR FOR MEN AT HIGH RISK FOR FRACTURE WHO ARE RECEIVING ANDROGEN DEPRIVATION THERAPY FOR NONMETASTATIC PROSTATE CANCER OR TREATMENT OF GLUCOCORTICOID-INDUCED OSTEOPOROSIS IN PATIENTS AT HIGH RISK OF FRACTURE WHO ARE INITIATING OR CONTINUING SYSTEMIC GLUCOCORTICOIDS AT A DAILY DOSE EQUIVALENT TO OR GREATER THAN 7.5 MG OF PREDNISONE FOR AN ANTICIPATED DURATION OF AT LEAST 6 MONTHS.
Age Restrictions	N/A
Prescriber Restrictions	N/A

PA Criteria	Criteria Details
Coverage Duration	12 MONTHS.
Other Criteria	N/A

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIC PURPURA (ITP) AND HAS HAD AN INSUFFICIENT RESPONSE OR INTOLERANCE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY. COVERAGE MAY ALSO BE AUTHORIZED FOR THE DIAGNOSIS OF THROMBOCYTOPENIA IN PATIENTS WITH CHRONIC HEPATITIS C INFECTION OR FOR THE DIAGNOSIS OF SEVERE APLASTIC ANEMIA WHEN USED IN COMBINATION WITH IMMUNOSUPPRESSIVE THERAPY OR IN PATIENTS WHO HAVE HAD AN INSUFFICIENT RESPONSE TO IMMUNOSUPPRESSIVE THERAPY.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF A UREA CYCLE DISORDER.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

REBIF

Products Affected

- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST OR MULTIPLE SCLEROSIS SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 12 SYRINGES OR PENS PER 28 DAYS

REPATHA

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	HEFH OR ASCVD: 18 YEARS OF AGE AND OLDER. HOFH: 13 YEARS OF AGE AND OLDER.
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	MUST HAVE LDL LEVEL WITHIN THE PAST 6 MONTHS GREATER THAN OR EQUAL TO 70MG/DL ON MAXIMAL DRUG TREATMENT (MDT) FOR AT LEAST 8 WEEKS AND ONE OF THE FOLLOWING: (1) HEFH OR HOFH DETERMINED BY SIMON BROOME DIAGNOSTIC (SBD) CRITERIA OR (2) ASCVD AS SUBSTANTIATED BY DOCUMENTATION SUBMITTED BY REQUESTOR (E.G. ON PROBLEM LIST, ICD-9 OR ICD-10 CODE). NO CONCURRENT USE OF OTHER PCSK9 INHIBITORS. INITIAL THERAPY: FOR STATIN TOLERANT PTS: TAKING ONE OF THE FOLLOWING: (1) HIGH DOSE HIGH INTENSITY STATIN SUCH AS ATORVASTATIN (ATOR) 40 MG OR 80 MG OR ROSUVASTATIN (ROSUV) 20 MG OR 40 MG OR (2) MAX TOLERATED DOSE (MTD) OF ATOR OR ROSUV WITH DOCUMENTATION OF FAILED HIGHEST DOSE OR (3) MTD OF ANY STATIN GIVEN TRIAL AND FAILURE OF ATOR OR ROSUV WITH DOCUMENTATION OF FAILURE. FOR STATIN INTOLERANT PTS: PHYSICIAN MUST ATTEST TO STATIN INTOLERANCE (INCLUDING BUT NOT LIMITED TO MYOPATHY). PTS WITH CONTRAINDICATIONS TO STATINS INCLUDING ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT OR HYPERSENSITIVITY REACTIONS WILL BE APPROVED FOR REPATHA THERAPY WITHOUT DOCUMENTED STATIN INTOLERANCE. IF STATIN TOLERANT, PATIENT MUST INTEND TO CONTINUE ON CURRENT MAXIMAL STATIN THERAPY ONCE REPATHA IS STARTED. RENEWAL CRITERIA: RECEIVING PRIOR REPATHA THERAPY FOR AT LEAST 12 WKS. QL OF 3 SYRINGES/PENS PER 28 DAYS OR 1 PUSHTRONEX SYSTEM PER 28 DAYS.

RETINOIDS

Products Affected

- *adapalene 0.3% gel pump*
- *adapalene topical cream*
- *adapalene topical gel*
- *avita*
- *tazarotene*
- TAZORAC TOPICAL CREAM 0.05 %
- TAZORAC TOPICAL GEL
- *tretinoin (emollient)*
- *tretinoin microspheres topical gel*
- *tretinoin topical cream*

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	ALL COSMETIC USE INDICATIONS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE YEAR
Other Criteria	

REVCOVI

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

REVLIMID

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	DIAGNOSIS OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	N/A

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF RECURRENT EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER WHO ARE IN A COMPLETE OR PARTIAL RESPONSE TO PLATINUM-BASED CHEMOTHERAPY OR DELETERIOUS BRCA MUTATION (GERMLINE AND/OR SOMATIC)-ASSOCIATED EPITHELIAL OVARIAN, FALLOPIAN TUBE, OR PRIMARY PERITONEAL CANCER AS DETECTED BY AN FDA-APPROVED DIAGNOSTIC TEST AND WHO HAVE BEEN TREATED WITH TWO OR MORE PRIOR LINES OF CHEMOTHERAPY.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 240 CAPSULES IN 30 DAYS

SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS
  RECON SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF HIV-ASSOCIATED WASTING OR CACHEXIA WITH EXCESS ABDOMINAL FAT SECONDARY TO HIV-ASSOCIATED LIPODYSTROPHY. CONCOMITANT USE OF ANTIRETROVIRAL THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE YEAR
Other Criteria	

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF CUSHING'S DISEASE AND PITUITARY SURGERY IS NOT AN OPTION OR HAS NOT BEEN CURATIVE.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH AN ONCOLOGIST OR ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS (MDR-TB) AND SIRTURO IS BEING USED IN COMBINATION WITH AT LEAST THREE OTHER DRUGS TO WHICH THE PATIENT'S MDR-TB ISOLATE HAS BEEN SHOWN TO BE SUSCEPTIBLE IN VITRO. IF IN VITRO TESTING RESULTS ARE UNAVAILABLE, TREATMENT MAY BE INITIATED WITH SIRTURO IN COMBINATION WITH AT LEAST FOUR OTHER DRUGS TO WHICH THE PATIENT'S MDR-TB ISOLATE IS LIKELY TO BE SUSCEPTIBLE.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF ACROMEGALY AND HAS HAD A FAILURE OR INTOLERANCE TO A REGIMEN THAT INCLUDES OCTREOTIDE, AND IS NOT A CANDIDATE FOR SURGERY AND/OR RADIATION, OR HAS HAD AN INADEQUATE RESPONSE TO SURGERY AND/OR RADIATION.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

SPRAVATO

Products Affected

- SPRAVATO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

SPRYCEL

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A HEMATOLOGIST OR AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

STELARA

Products Affected

- STELARA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: EVIDENCE OF SYMPTOM IMPROVEMENT WITH ONGOING STELARA TREATMENT.
Age Restrictions	PLAQUE PSORIASIS: 12 YEARS OF AGE OR OLDER. PSORIATIC ARTHRITIS AND CROHN'S DISEASE: 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	PLAQUE PSORAISIS: DERMATOLOGIST. PSORIATIC ARTHRITIS: RHEUMATOLOGIST. CROHN'S DISEASE: GASTROENTEROLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	PLAQUE PSORIASIS: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, ONE COURSE OF SYSTEMIC THERAPY (E.G. METHOTREXATE, AZATHIOPRINE, ACITRETIN). PSORIATIC ARTHRITIS: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, ONE ORAL OR INJECTABLE DMARD, SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. CROHN'S DISEASE: HISTORY OF TREATMENT FAILURE WITH, OR CONTRAINDICATION TO, AT LEAST TWO OF THE FOLLOWING: ORAL CORTICOSTEROIDS, 5-AMINOSALICYLATES, IMMUNOSUPPRESSANTS/IMMUNOMODULATORS (E.G. AZATHIOPRINE, METHOTREXATE).

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

STRENSIQ

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF PERINATAL/INFANTILE-ONSET OR JUVENILE-ONSET HYPOPHOSPHATASIA (HPP)
Age Restrictions	18 YEARS OF AGE OR YOUNGER AT TIME OF DISEASE ONSET
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	N/A

SUTENT

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF ADVANCED RENAL CELL CARCINOMA (ARCC) OR GASTROINTESTINAL STROMAL TUMOR (GIST) WITH DISEASE PROGRESSION OR INTOLERANCE FOLLOWING AN APPROPRIATE TRIAL WITH IMATINIB. COVERAGE MAY ALSO BE AUTHORIZED FOR A DIAGNOSIS OF PROGRESSIVE NEUROENDOCRINE TUMORS (PNET) LOCATED IN THE PANCREAS AND THE TUMOR CANNOT BE REMOVED BY SURGERY OR HAS SPREAD TO OTHER PARTS OF THE BODY.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS. QUANTITY LIMITS MAY APPLY.

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) USED IN COMBINATION WITH TRAMETINIB WITH CONFIRMED BRAF V600E MUTATION AS DETECTED BY AN FDA-APPROVED TEST. COVERAGE MAY ALSO BE AUTHORIZED AS A SINGLE AGENT FOR A DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA WITH BRAF V600E MUTATION AS DETECTED BY AN FDA-APPROVED TEST OR IN COMBINATION WITH TRAMETINIB FOR UNRESECTABLE OR METASTATIC MELANOMA WITH BRAF V600E OR BRAF V600K MUTATIONS AS DETECTED BY AN FDA-APPROVED TEST.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF METASTATIC EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) T790M MUTATION-POSITIVE NON-SMALL CELL LUNG CANCER (NSCLC) AS DETECTED BY AN FDA-APPROVED TEST, AND A DOCUMENTED FAILURE, CONTRAINDICATION, OR INTOLERANCE TO PRIOR TYROSINE KINASE INHIBITOR THERAPY (E.G., AFATINIB, GEFITINIB, ERLOTINIB).
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

TALZENNA

Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

TARCEVA

Products Affected

- *erlotinib*
- TARCEVA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WHOSE TUMORS HAVE EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 19 DELETIONS OR EXON 21 (L858R) SUBSTITUTION MUTATIONS AS DETECTED BY AN FDA-APPROVED TEST RECEIVING FIRST-LINE, MAINTENANCE, OR SECOND OR GREATER LINE TREATMENT AFTER PROGRESSION FOLLOWING AT LEAST ONE PRIOR CHEMOTHERAPY REGIMEN. COVERAGE MAY ALSO BE AUTHORIZED FOR FIRST-LINE TREATMENT FOR LOCALLY ADVANCED, UNRESECTABLE OR METASTATIC PANCREATIC CANCER WHEN USED IN COMBINATION WITH GEMCITABINE.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

TAVALISSE

Products Affected

- TAVALISSE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A HEMATOLOGIST, IMMUNOLOGIST, OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

TECFIDERA

Products Affected

- TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST OR MULTIPLE SCLEROSIS SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 60 CAPSULES PER 30 DAYS, 30 DAY STARTER PACK: 2 PER 365 DAYS.

TEGSEDI

Products Affected

- TEGSEDI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS (HATTR) WITH POLYNEUROPATHY: PHYSICIAN ATTESTATION OF DIAGNOSIS OF HATTR AS CONFIRMED BY EITHER BIOPSY OF TISSUE/ORGAN TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TTR PROTEIN OR DNA GENETIC SEQUENCING TO CONFIRM HATTR MUTATION.
Age Restrictions	N/A
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, CARDIOLOGIST, PHYSICIAN AT AN AMYLOIDOSIS TREATMENT CENTER, OR MEDICAL GENETICIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS STAGE 1 OR 2 POLYNEUROPATHY. RENEWAL: DIAGNOSIS OF HEREDITARY TTR AMYLOIDOSIS (HATTR) AND PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT PROGRESSED TO STAGE 3 POLYNEUROPATHY AS EVIDENCED BY FUNCTIONAL DECLINE (E.G., WHEELCHAIR-BOUND, BEDRIDDEN). QUANTITY LIMITS MAY APPLY.

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF CHOREA ASSOCIATED WITH HUNTINGTON'S DISEASE.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

TIBSOVO

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

TRACLEER

Products Affected

- *bosentan oral tablet 125 mg*
- TRACLEER

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PULMONARY ATERIAL HYPERTENSION (PAH) (WHO GROUP 1) CONFIRMED BY RIGHT HEART CATHETERIZATION, INCLUDING PEDIATRIC PATIENTS WITH IDIOPATHIC OR CONGENTIAL PAH. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	RENEWAL: PATIENT HAS HAD A POSITIVE CLINICAL RESPONSE TO THERAPY.

TRANSMUCOSAL IMMEDIATE RELEASE FENTANYL

Products Affected

- ABSTRAL
- *fentanyl citrate*
- FENTORA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF CANCER AND BREAKTHROUGH CANCER PAIN, OPIOID TOLERANT AND RECEIVING CONCURRENT THERAPY WITH A LONG-ACTING OPIOID
Age Restrictions	
Prescriber Restrictions	ONCOLOGIST, PAIN SPECIALIST
Coverage Duration	ONE YEAR
Other Criteria	QUANTITY LIMIT OF 120 PER 30 DAYS FOR ALL PRODUCTS EXCEPT LAZANDA. NO QUANTITY LIMIT APPLIES FOR LAZANDA.

TYKERB

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	HISTORY OF AT LEAST ONE RECENT OSTEOPORITIC FRACTURE (I.E. FRAGILITY OR LOW TRAUMA), OR MULTIPLE RISK FACTORS FOR FRACTURE (I.E. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.), OR FAILED AT LEAST A 6 MONTH TRIAL OF, OR HAS CONTRAINDICATION TO, OR CANNOT TOLERATE BISPHOSPHONATES, CALCITONIN OR EVISTA.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 MONTHS MAXIMUM.
Other Criteria	N/A

UPTRAVI

Products Affected

- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG PACK
- UPTRAVI ORAL TABLETS,DOSE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED CONFIRMATORY PAH DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS OR CURRENT TREATMENT WITH EITHER A PHOSPHODIESTERASE-5 INHIBITOR (E.G., REVATIO [SILDENAFIL] OR ADCIRCA [TADALAFIL]) AND AN ENDOTHELIN RECEPTOR ANTAGONIST (E.G., TRACLEER [BOSENTAN], LETAIRIS [AMBRISENTAN], OPSUMIT [MACITENTAN]) OR A CONTRAINDICATION TO ALL OF THESE AGENTS, OR A PROSTACYCLIN (E.G., VENTAVIS [ILOPROST], TYVASO [TREPROSTINIL], OR ORENITRAM ER [TREPROSTINIL]). QUANTITY LIMIT APPLIES: 200MCG: 240 TABLETS PER 30 DAYS. 200MCG-800MCG TITRATION PACK: 1 PACK PER 365 DAYS. ALL OTHER STRENGTHS: 60 TABLETS PER 30 DAYS.

VENCLEXTA

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) WITH 17P DELETION AS DETECTED BY AN FDA-APPROVED TEST AND HAS RECEIVED AT LEAST ONE PRIOR THERAPY.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

VENTAVIS

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PULMONARY ATERIAL HYPERTENSION (PAH) (WHO GROUP 1) CONFIRMED BY RIGHT HEART CATHETERIZATION WITH NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

VIMPAT

Products Affected

- VIMPAT ORAL SOLUTION
- VIMPAT ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PARTIAL-ONSET SEIZURES AND HAS HAD AN INSUFFICIENT RESPONSE OR INTOLERANCE TO AT LEAST TWO (2) OTHER MEDICATIONS INDICATED FOR ADJUNCT PARTIAL SEIZURES (E.G. APTIOM, BRIVIACT, FELBAMATE, FYCOMPA, GABAPENTIN, LAMOTRIGINE, LYRICA, LEVETIRACETAM, OXCARBAZEPINE, TIAGABINE, TOPIRAMATE, AND/OR ZONISAMIDE).
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

VITRAKVI

Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

VIZIMPRO

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

VOSEVI

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PROVIDER ATTESTATION THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION).SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS. MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).PATIENT IS CONCURRENTLY TAKING ANY OF THE FOLLOWING: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR OR TIPRANAVIR/RITONAVIR.
Required Medical Information	DIAGNOSIS OF CHRONIC HEPATITIS C AND PRETREATMENT HCV RNA LEVEL (WITHIN PAST 3 MONTHS).
Age Restrictions	PATIENT 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, OR A PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G., HEPATOLOGIST).
Coverage Duration	AUTHORIZED TREATMENT DURATION WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
Other Criteria	TRIAL OF A PREFERRED FORMULARY ALTERNATIVE, MAVYRET, WHEN CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE.CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.QUANTITY LIMIT OF 28 TABLETS IN 28 DAYS.

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	DIAGNOSIS OF ADIPOCYTIC SOFT TISSUE SARCOMA (STS) OR GATROINTESTINAL STROMAL TUMORS
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 120 TABLETS PER 30 DAYS

VYNDAQEL

Products Affected

- VYNDAQEL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT PROGRESSED TO NYHA CLASS IV HEART FAILURE.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST.
Coverage Duration	12 MONTHS.
Other Criteria	INITIAL: PATIENT HAS NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE. DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF 99MTCPYP/DPD, OR 2) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN. QUANTITY LIMITS MAY APPLY.

VYVANSE

Products Affected

- VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 70 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) OR DIAGNOSIS OF MODERATE TO SEVERE BINGE EATING DISORDER (BED).
Age Restrictions	FOR MODERATE TO SEVERE BINGE EATING DISORDER, 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

WAKEFULNESS AGENTS

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	GENERALIZED FATIGUE, TRAVEL-INDUCED SLEEP DISORDER, SLEEP DEPRIVATION (I.E. MILITARY, ACADEMIC).
Required Medical Information	DIAGNOSIS OF SHIFT WORK SLEEP DISORDER (SWSD), OBSTRUCTIVE SLEEP APNEA (OSA)/HYPOPNEA SYNDROME, OR NARCOLEPSY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE YEAR
Other Criteria	

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER (NSCLC) WITH TUMORS THAT ARE ANAPLASTIC LYMPHOMA KINASE (ALK)-POSITIVE OR ROS1-POSITIVE TUMORS AS DETECTED BY A FDA-APPROVED TEST.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

XELJANZ

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, OR ULCERATIVE COLITIS AND INADEQUATE RESPONSE TO OR CONTRAINDICATION/INTOLERANCE TO METHOTREXATE, OR CURRENTLY RECEIVING TREATMENT WITH REQUESTED MEDICATION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONCE YEAR
Other Criteria	

XERMELO

Products Affected

- XERMELO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMIT OF 90 TABLETS PER 30 DAYS.

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PREVENTION OF SKELETAL-RELATED EVENTS IN PATIENTS WITH BONE METASTASES FROM SOLID TUMORS ONLY OR UNRESECTABLE GIANT CELL TUMOR OF BONE (GCTB), OR SURGICAL RESECTION OF GCTB LIKELY TO RESULT IN SEVERE MORBIDITY, OR DIAGNOSIS OF HYPERCALCEMIA OF MALIGNANCY REFRACTORY TO BISPHOSPHONATE THERAPY, OR PREVENTION OF SKELETAL-RELATED EVENTS IN PATIENTS WITH MULTIPLE MYELOMA.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	N/A

XIFAXAN

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF HEPATIC ENCEPHALOPATHY WITH AN INADEQUATE RESPONSE OR A CONTRAINDICATION TO LACTULOSE OR FOR THE DIAGNOSIS OF IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D).
Age Restrictions	FOR HEPATIC ENCEPHALOPATHY, 18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

XOLAIR

Products Affected

- XOLAIR SUBCUTANEOUS RECON SOLN

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF MODERATE TO SEVERE PERSISTENT ASTHMA WITH A POSITIVE SKIN TEST OR IN VITRO REACTIVITY TO A PERENNIAL AEROALLERGEN AND SYMPTOMS ARE INADEQUATELY CONTROLLED WITH A TREATMENT REGIMEN THAT INCLUDED TWO OR MORE OF THE FOLLOWING MEDICATIONS: INHALED CORTICOSTEROIDS, ORAL CORTICOSTEROIDS, LEUKOTRIENE MODIFIERS AND INHALED LONG-ACTING BRONCHODILATORS, OR IS UNABLE TO TOLERATE THESE MEDICATIONS. COVERAGE MAY ALSO BE AUTHORIZED FOR THE DIAGNOSIS OF CHRONIC IDIOPATHIC URTICARIA (CIU) IF THERE IS A DEFINITIVE DIAGNOSIS OF CIU FOR AT LEAST 6 WEEKS AND REMAINS SYMPTOMATIC DESPITE H1 ANTIHISTAMINE TREATMENT.
Age Restrictions	FOR MODERATE-TO-SEVERE PERSISTENT ASTHMA, 6 YEARS OF AGE OR OLDER. FOR CHRONIC IDIOPATHIC URTICARIA (CIU), 12 YEARS OF AGE OR OLDER.
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ALLERGIST, DERMATOLOGIST, IMMUNOLOGIST OR PULMONOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

XOSPATA

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

XPOVIO

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 160 MG/WEEK (20 MG X 8), 60 MG/WEEK (20 MG X 3), 80 MG/WEEK (20 MG X 4)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMITS MAY APPLY.

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF METASTATIC CASTRATION RESISTANT PROSTATE CANCER.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST OR A UROLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

YERVOY

Products Affected

- YERVOY

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	

YONSA

Products Affected

- YONSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST OR UROLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ZAVESCA

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTATION OF TYPE 1 GAUCHER DISEASE AND AT LEAST ONE OF THE FOLLOWING CONDITIONS: ANEMIA, THROMBOCYTOPENIA, BONE DISEASE, HEPATOMEGALY OR SPLENOMEGALY
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	MEMBER IS NOT A CANDIDATE FOR TREATMENT WITH ENZYME REPLACEMENT THERAPY (E.G. CEREZYME, VPRIV) BECAUSE OF AN ALLERGY, HYPERSENSITIVITY OR POOR VENOUS ACCESS. MEMBER HAS TRIED AND FAILED THERAPY WITH CERDELGA. QUANTITY LIMIT OF 90 CAPSULES PER 30 DAYS.

ZEJULA

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 90 TABLETS PER 30 DAYS

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF ERDHEIM-CHESTER DISEASE (ECD) WITH A BRAF V600 MUTATION OR A DOCUMENTED DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA WITH BRAF V600E MUTATION-POSITIVE AS DETECTED BY AN FDA-APPROVED TEST.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ZORBTIVE

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF SHORT BOWEL SYNDROME
Age Restrictions	PATIENT 18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	4 WEEKS
Other Criteria	

ZURAMPIC

Products Affected

- ZURAMPIC

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ESTIMATED CREATININE CLEARANCE OF 45 ML/MIN OF LOWER.
Required Medical Information	PRIOR TRIAL AND FAILURE WITH ALLOPURINOL OR FEBUXOSTAT. ADMINISTERED IN COMBINATION WITH ALLOPURINOL OR FEBUXOSTAT.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS.
Other Criteria	QUANTITY LIMIT OF 30 TABLETS PER 30 DAYS.

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF RELAPSED CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) ADMINISTERED IN COMBINATION WITH RITUXIMAB. COVERAGE MAY ALSO BE AUTHORIZED FOR RELAPSED FOLLICULAR B-CELL NON-HODGKIN LYMPHOMA WITH DOCUMENTED USE OF AT LEAST TWO PRIOR SYSTEMIC THERAPIES OR FOR RELPASED SMALL LYMPHOCYTIC LYMPHOMA (SLL) WITH DOCUMENTED USE OF AT LEAST TWO PRIOR SYSTEMIC THERAPIES.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED DIAGNOSIS OF ANAPLASTIC LYMPHOMA KINASE (ALK)-POSITIVE METASTATIC NONSMALL CELL LUNG CANCER (NSCLC).
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	N/A

ZYTIGA

Products Affected

- ZYTIGA ORAL TABLET 250 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	CONCURRENT USE WITH PREDNISONE
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	QUANTITY LIMIT OF 120 250MG TABLETS PER 30 DAYS OR 60 500MG TABLETS PER 30 DAYS.

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