Plan Year 2017

C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan

Prior Authorization (PA) Criteria

Prior Authorization: C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan requires you (or your physician) to get prior authorization for certain drugs. This means that you will need to get approval from C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan before you fill your prescriptions. If you don't get approval, C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan may not cover the drug.

PLEASE READ:
THIS DOCUMENT CONTAINS INFORMATION ABOUT OUR PRIOR AUTHORIZATION CRITERIA.

The COEHA has a contract with the Federal Government to provide our members with an enhanced Medicare Part D Prescription Drug Plan. Enrollment in C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan depends upon contract renewal.

Formulary ID: 00017457
Last updated 08/01/2017 Version: 12

C and O Employees' Hospital Association Medicare Part D Prescription Drug Plan

Prior Authorization Criteria
Last Updated 8/1/2017

Products Affected

- *adapalene 0.1% cream*
- *adapalene 0.3% gel*
- *avita 0.025% cream*
- AZELEX 20% CREAM
- DIFFERIN 0.1% GEL
- DIFFERIN 0.3% GEL
- EPIDUO 0.1-2.5% GEL
- RETIN-A 0.025% CREAM
- RETIN-A 0.04% GEL
- RETIN-A 0.08% GEL
- RETIN-A 0.1% GEL
- *tretinoin 0.025% cream*
- *tretinoin 0.04% gel*
- *tretinoin 0.05% gel*
- *tretinoin 0.1% gel*
- *adapalene 0.1% gel*
- ATRALIN 0.05% GEL
- *avita 0.025% gel*
- DIFFERIN 0.1% CREAM
- DIFFERIN 0.1% LOTION
- EPIDUO 0.3-2.5% GEL
- RETIN-A 0.01% GEL
- RETIN-A 0.025% GEL
- RETIN-A 0.05% CREAM
- RETIN-A 0.1% CREAM
- *tretinoin 0.01% gel*
- *tretinoin 0.025% gel*
- *tretinoin 0.05% cream*
- *tretinoin 0.1% cream*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ADAGEN 250UNIT/ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ADCIRCA 20MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ADEMPAS 0.5MG TAB
- ADEMPAS 1MG TAB
- ADEMPAS 2MG TAB
- ADEMPAS 1.5MG TAB
- ADEMPAS 2.5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For diagnosis of Pulmonary Arterial Hypertension, trial of one (1) of the following: Letairis, Opsumit or Tracleer. For diagnosis of Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4), trial of prior therapy is not required.

Products Affected

- AFINITOR 10MG TAB (New Starts Only)
- AFINITOR 2.5MG TAB (New Starts Only)
- AFINITOR 2MG SUSP (New Starts Only)
- AFINITOR 3MG SUSP (New Starts Only)
- AFINITOR 5MG SUSP (New Starts Only)
- AFINITOR 5MG TAB (New Starts Only)
- AFINITOR 7.5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ALECENSA 150MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ALUNBRIG 30MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- AMITIZA 24MCG CAP
- AMITIZA 8MCG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed Miralax (glycolax).
Age Restrictions	Age 18 and above.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– AMPYRA 10MG ER TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Neurology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- AXIRON 30MG/ACT TOPICAL SOLN
- METHITEST 10MG TAB
- TESTIM 1% GEL
- TESTOSTERONE 1% (50MG) GEL
- TESTOSTERONE 10MG/ACT GEL
- VOGELXO 1% GEL PUMP
- FORTESTA 10MG/ACT GEL
- *methyltestosterone 10mg cap*
- TESTOSTERONE 1% (25MG) GEL
- TESTOSTERONE 1% GEL PUMP
- VOGELXO 1% (50MG) GEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two morning testosterone levels fall below the normal range for a healthy adult male. Patient must have tried and failed ANDRODERM and ANDROGEL. For Android, Methitest, and Testred, if prescribed for delay in sexual development or metastasis from malignant tumor of breast, inoperable metastatic disease (skeletal) in women 1 to 5 years postmenopausal, testosterone levels and previous trial of ANDRODERM and ANDROGEL not required. For patients on testosterone replacement therapy, documentation of at least one (1) morning testosterone level from the last 12 months is required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ANDRODERM 2MG/24HR PATCH
- ANDRODERM 4MG/24HR PATCH
- ANDROGEL 1% (25MG) GEL
- ANDROGEL 1% (50MG) GEL
- ANDROGEL 1.62% (1.25GM) GEL
- ANDROGEL 1.62% (2.5GM) GEL
- ANDROGEL 1.62% GEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two morning testoterone levels fall below the normal range for a healthy adult male. For patients on testosterone replacement therapy, documentation of at least one (1) morning testosterone level from the last 12 months is required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- APTIOM 200MG TAB (New Starts Only)
- APTIOM 400MG TAB (New Starts Only)
- APTIOM 600MG TAB (New Starts Only)
- APTIOM 800MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ARCALYST 220MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Rheumatology Specialist, Dermatologist, or Immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ARIXTRA 10MG/0.8ML SYRINGE
- ARIXTRA 2.5MG/0.5ML SYRINGE
- ARIXTRA 5MG/0.4ML SYRINGE
- ARIXTRA 7.5MG/0.6ML SYRINGE
- *fondaparinux sodium 12.5mg/ml (0.4ml) syringe*
- *fondaparinux sodium 12.5mg/ml (0.6ml) syringe*
- *fondaparinux sodium 12.5mg/ml (0.8ml) syringe*
- *fondaparinux sodium 5mg/ml syringe*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Body weight less than 50 kg (venous thromboembolism prophylaxis only)
Required Medical Info	Patient has history of Heparin Induced Throbmocytopenia (HIT) or HIT is medically suspected. Or, prescribed for prevention or treatment of DVT in an orthopedic surgery patient.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ABILIFY 300MG MAINTENA INJ (New Starts Only)
- ABILIFY 300MG MAINTENA PF SYRINGE (New Starts Only)
- ABILIFY 400MG MAINTENA PF SYRINGE (New Starts Only)
- *aripiprazole 10mg odt (New Starts Only)*
- *aripiprazole 15mg odt (New Starts Only)*
- ARISTADA 441MG/1.6ML SYRINGE (New Starts Only)
- ARISTADA 662MG/2.4ML SYRINGE (New Starts Only)
- ARISTADA 882MG/3.2ML SYRINGE (New Starts Only)
- FANAPT 10MG TAB (New Starts Only)
- FANAPT 12MG TAB (New Starts Only)
- FANAPT 1MG TAB (New Starts Only)
- FANAPT 2MG TAB (New Starts Only)
- FANAPT 4MG TAB (New Starts Only)
- FANAPT 6MG TAB (New Starts Only)
- FANAPT 8MG TAB (New Starts Only)
- FANAPT TITRATION PACK (New Starts Only)
- INVEGA 1.5MG ER TAB (New Starts Only)
- INVEGA 117MG/0.75ML SYRINGE (New Starts Only)
- INVEGA 156MG/ML SYRINGE (New Starts Only)
- INVEGA 234MG/1.5ML SYRINGE (New Starts Only)
- INVEGA 273MG/0.875ML SYRINGE (New Starts Only)
- INVEGA 39MG/0.25ML SYRINGE (New Starts Only)
- INVEGA 3MG ER TAB (New Starts Only)
- INVEGA 410MG/1.315ML SYRINGE (New Starts Only)
- INVEGA 546MG/1.75ML SYRINGE (New Starts Only)
- INVEGA 6MG ER TAB (New Starts Only)
- INVEGA 78MG/0.5ML SYRINGE (New Starts Only)
- INVEGA 819MG/2.625ML SYRINGE (New Starts Only)
- INVEGA 9MG ER TAB (New Starts Only)
- LATUDA 120MG TAB (New Starts Only)
- LATUDA 20MG TAB (New Starts Only)
- LATUDA 40MG TAB (New Starts Only)
- LATUDA 60MG TAB (New Starts Only)
- LATUDA 80MG TAB (New Starts Only)
- *paliperidone 1.5mg er tab (New Starts Only)*
- *paliperidone 3mg er tab (New Starts Only)*
- *paliperidone 6mg er tab (New Starts Only)*
- *paliperidone 9mg er tab (New Starts Only)*
- REXULTI 0.25MG TAB (New Starts Only)
- REXULTI 0.5MG TAB (New Starts Only)
- REXULTI 1MG TAB (New Starts Only)
- REXULTI 2MG TAB (New Starts Only)
- REXULTI 3MG TAB (New Starts Only)
- REXULTI 4MG TAB (New Starts Only)
- RISPERDAL 12.5MG INJ (New Starts Only)
- RISPERDAL 25MG INJ (New Starts Only)
- RISPERDAL 37.5MG INJ (New Starts Only)
- RISPERDAL 50MG INJ (New Starts Only)
- SAPHRIS 10MG SL TAB (New Starts Only)
- SAPHRIS 2.5MG SL TAB (New Starts Only)
- SAPHRIS 5MG SL TAB (New Starts Only)
- VRAYLAR 1.5/3MG MIXED PACK (New Starts Only)
- VRAYLAR 1.5MG CAP (New Starts Only)
- VRAYLAR 3MG CAP (New Starts Only)
- VRAYLAR 4.5MG CAP (New Starts Only)
- VRAYLAR 6MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed or was intolerant to 2 of the following for each indication: Bipolar Disorder: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. Schizophrenia: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. Irritability with Autistic Disorder: aripiprazole, risperidone. Patient has tried and failed or was intolerant to 1 of the following for each indication: Bipolar Depression: olanzapine. Major Depressive Disorder: aripiprazole. Tourette Syndrome: aripiprazole. Acute Manic/Mixed Episodes with Bipolar Disorder: aripiprazole. No trials required for the following indications: Schizoaffective Disorder.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- AUBAGIO 14MG TAB
- AUBAGIO 7MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For use in Multiple Sclerosis (MS), patient has a relapsing form of Multiple Sclerosis (MS).
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist or a Multiple Sclerosis (MS) specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For use in MS, patient has a relapsing form of MS and patient has tried dimethyl fumarate (Tecfidera) AND one of the following: beta-1a (Avonex), peginterferon beta-1a (Plegridy), or glatiramer (Copaxone). Exceptions to having tried an interferon product or glatiramer acetate (Copaxone) can be made if the patient is unable to administer injections due to dexterity issues or visual impairment.

Products Affected

– BELEODAQ 500MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BOSULIF 100MG TAB (New Starts Only)
- BOSULIF 500MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BRIVIACT 100MG TAB (New Starts Only)
- BRIVIACT 10MG/ML INJ (New Starts Only)
- BRIVIACT 25MG TAB (New Starts Only)
- BRIVIACT 75MG TAB (New Starts Only)
- BRIVIACT 10MG TAB (New Starts Only)
- BRIVIACT 10MG/ML ORAL SOLN (New Starts Only)
- BRIVIACT 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CABOMETYX 20MG TAB (New Starts Only)
- CABOMETYX 40MG TAB (New Starts Only)
- CABOMETYX 60MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CAPRELSA 100MG TAB (New Starts Only)
- CAPRELSA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncologist or Endocrinologist or under the direct consultation of an Oncologist or Endocrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CARBAGLU 200MG SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CAYSTON 75MG INH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Infectious Disease or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CESAMET 1MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
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.

Products Affected

- CHOLBAM 250MG CAP
- CHOLBAM 50MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a hepatologist or pediatric gastroenterologist.
Coverage Duration	Initial will be 3 months, then if criteria is met approved for the rest of the plan year.
Other Criteria	Renewal requires documentation of stable or improved liver function.

Products Affected

- CIMZIA 200MG INJ
- CIMZIA 200MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For RA, psoriatic arthritis, and ankylosing spondylitis requires intolerance to or failure of therapy etanercept (Enbrel) AND adalimumab (Humira). For Crohn's disease requires a trial of adalimumab (Humira).
Age Restrictions	
Prescriber Restriction	For RA, psoriatic arthritis, and ankylosing spondylitis, must be prescribed by Rheumatology Specialist. For Crohn's Disease, must be prescribed by Gastroenterology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- BERINERT 500UNIT INJ
- CINRYZE 500UNIT INJ
- FIRAZYR 30MG/3ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– COLCHICINE 0.6MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	If for gout, trial of Mitigare required. If for Familial Mediterranean fever, trial of Mitigare is not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- COMETRIQ 100MG DAILY DOSE CARTON PACK (New Starts Only)
- COMETRIQ 140MG DAILY DOSE CARTON PACK (New Starts Only)
- COMETRIQ 60MG DAILY DOSE CARTON PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CORLANOR 5MG TAB
- CORLANOR 7.5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The patient is on a maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- COSENTYX 150MG/ML AUTO-INJECTOR
- COSENTYX 150MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance to or failure of therapy with Humira
Age Restrictions	
Prescriber Restriction	Psoriatic Arthritis and Ankylosing Spondylitis: Prescriber must be a Rheumatologist. Plaque Psoriasis: Prescriber must be a Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– COTELLIC 20MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CYRAMZA 100MG/10ML INJ (New Starts Only)
- CYRAMZA 500MG/50ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CYSTAGON 150MG CAP
- CYSTAGON 50MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Endocrinologist, Geneticist, or Metabolic Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– CYSTARAN 0.44% OPHTH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of corneal cystine crystal accumulation in patients with cystinosis
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Ophthalmologist or Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– DARZALEX 100MG/5ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- DESOXYN 5MG TAB
- *methamphetamine 5mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *dronabinol 10mg cap*
- *dronabinol 2.5mg cap*
- *dronabinol 5mg cap*
- MARINOL 10MG CAP
- MARINOL 2.5MG CAP
- MARINOL 5MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of loss of appetite due to AIDS OR chemotherapy induced nausea and vomiting
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
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.

Products Affected

– DYMISTA 137-50MCG NASAL INHALER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Info	Requires trial of one (1) formulary steroid nasal spray and one (1) formulary antihistamine nasal spray
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- EMPLICITI 300MG INJ (New Starts Only)
- EMPLICITI 400MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or Hematology Specialist, or in consultation with an Oncology Specialist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ENBREL 25MG INJ
- ENBREL 25MG/0.5ML SYRINGE
- ENBREL 50MG/ML SURECLICK INJ
- ENBREL 50MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA or Psoriatic Arthritis requires Trial of or failure of therapy with methotrexate (at least 20mg/wk). Plaque Psoriasis: Trial of, or intolerance to, methotrexate at a dose of 15mg/week or trial of, or intolerance to, soriatane.
Age Restrictions	
Prescriber Restriction	Rheumatoid Arthritis, Psoriatic Arthritis and Ankylosing Spondylitis: Prescriber must be a Rheumatologist. All Plaque Psoriasis: Prescriber must be a Dermatologist.
Coverage Duration	Approved for the duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ENTRESTO 24-26MG TAB
- ENTRESTO 49-51MG TAB
- ENTRESTO 97-103MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- EPCLUSA 400-100MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments
Age Restrictions	Member must be 18 years of age or older
Prescriber Restriction	Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist
Coverage Duration	Coverage duration of 12 weeks.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. For genotypes 1 and 4 only, failure or intolerance to Harvoni and Zepatier are required. For genotypes 5 and 6 only, failure or intolerance to Harvoni is required.

Products Affected

– ERIVEDGE 150MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or inconsultation with Oncology Specialist or Dermatologist.
Coverage Duration	Covered for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ERWINAZE 10000UNIT INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to Oncology Specialists or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- EXONDYS 100MG/2ML INJ
- EXONDYS 500MG/10ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FARYDAK 10MG CAP (New Starts Only)
- FARYDAK 15MG CAP (New Starts Only)
- FARYDAK 20MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology or Hematology Specialist or in consultation with an Oncology or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FERRIPROX 100MG/ML ORAL SOLN
- FERRIPROX 500MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to Hematology Specialists or in consult with Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FIRMAGON 120MG INJ (New Starts Only)
- FIRMAGON 80MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with Oncologist or Urologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination

Products Affected

– FLECTOR 1.3% PATCH

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility
Other Criteria	

Products Affected

- FOLOTYN 40MG/2ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or on consultation with Hematologist or Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination.

Products Affected

– FORTEO 600MCG/2.4ML PEN INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has had at least 1 fracture, OR member has BMD screening results of -2.5 or below, OR member has previously used and failed a bisphosphonate.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- FYCOMPA 0.5MG/ML SUSP (New Starts Only)
- FYCOMPA 10MG TAB (New Starts Only)
- FYCOMPA 12MG TAB (New Starts Only)
- FYCOMPA 2MG TAB (New Starts Only)
- FYCOMPA 4MG TAB (New Starts Only)
- FYCOMPA 6MG TAB (New Starts Only)
- FYCOMPA 8MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- GARDASIL 9 INJ
- GARDASIL 9 SYRINGE
- GARDASIL INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	PA not required for members age 9-26.
Prescriber Restriction	
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– GATTEX 5MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of short bowel syndrome with less than 200cm of remnant functional intestine. Dependent on parenteral support for at least 12 months and at least 3 days per week.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– GILENYA 0.5MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For use in Multiple Sclerosis (MS), patient has a relapsing form of MS.
Age Restrictions	
Prescriber Restriction	Prescribed by a neurologist or a Multiple Sclerosis (MS) specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For use in MS, patient has a relapsing form of MS and patient has tried dimethyl fumarate (Tecfidera) AND one of the following: beta-1a (Avonex), peginterferon beta-1a (Plegridy), or glatiramer (Copaxone). Exceptions to having tried an interferon product or glatiramer acetate (Copaxone) can be made if the patient is unable to administer injections due to dexterity issues or visual impairment.

Products Affected

- GILOTRIF 20MG TAB (New Starts Only)
- GILOTRIF 30MG TAB (New Starts Only)
- GILOTRIF 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- GLEEVEC 100MG TAB (New Starts Only)
- *imatinib 100mg tab (New Starts Only)*
- GLEEVEC 400MG TAB (New Starts Only)
- *imatinib 400mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by Oncologist or Hematologist, or under the direct consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NORDITROPIN 10MG/1.5ML PEN INJ
- NORDITROPIN 15MG/1.5ML PEN INJ
- NORDITROPIN 30MG/3ML PEN INJ
- NORDITROPIN 5MG/1.5ML PEN INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The criteria for approval of growth hormones in adults require the diagnosis of Somatropin Deficiency Syndrome (defined by failure to stimulate Growth Hormone secretion (peak GH level of 10mcg/L or less) by one of the acceptable provocative tests). This may include adults who as children had Growth Hormone deficiency or adults with known pituitary disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– HARVONI 90-400MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments
Age Restrictions	Member must be 18 years of age or older
Prescriber Restriction	Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist
Coverage Duration	Coverage duration of 12 to 24 weeks based on cirrhosis status and previous treatment.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

– HETLIOZ 20MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient is totally blind.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- JUXTAPID 10MG CAP
- JUXTAPID 20MG CAP
- JUXTAPID 30MG CAP
- JUXTAPID 40MG CAP
- JUXTAPID 5MG CAP
- JUXTAPID 60MG CAP
- KYNAMRO 200MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Untreated LDL greater than 500 mg/dL OR treated LDL greater than or equal to 300 mg/dL. Concurrent use of maximum statin dose (atorvastatin or rosuvastatin) and one other lipid lowering agent (include dates and reasons for discontinuation). For patients with statin intolerance, concurrent use of maximum statin dose not required. Chart documentation showing the most recent full lipid panel, including Apo-B within the past 12 months.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Lipidologist, Cardiologist, or an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- HUMIRA 10MG/0.2ML SYRINGE
- HUMIRA 20MG/0.4ML SYRINGE
- HUMIRA 40MG/0.8ML AUTO-INJECTOR
- HUMIRA 40MG/0.8ML SYRINGE
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (3) 40MG/0.8ML IN
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (6) 40MG/0.8ML IN
- HUMIRA PEN - CROHN'S STARTER PACK 40MG/0.8ML INJ
- HUMIRA PEN - PSORIASIS STARTER PACK 40MG/0.8ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA or Psoriatic Arthritis requires intolerance to or failure of therapy with methotrexate (at least 20mg/wk). Plaque Psoriasis: Failure of, or intolerance to, methotrexate at a dose of 15mg/week or failure of, or intolerance to, soriatane. If for Hidradenitis Suppurativa (HS), patient must have at least 3 cysts.
Age Restrictions	
Prescriber Restriction	Rheumatoid Arthritis, Psoriatic Arthritis and Ankylosing Spondylitis: Prescriber must be a Rheumatologist. All Plaque Psoriasis and Hidradenitis Suppurativa (HS): Prescriber must be a Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– HYDROXYPROGESTERONE CAPROATE 250MG/ML INJ (New Start

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- IBRANCE 100MG CAP (New Starts Only)
- IBRANCE 125MG CAP (New Starts Only)
- IBRANCE 75MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility
Other Criteria	

Products Affected

- ICLUSIG 15MG TAB (New Starts Only)
- ICLUSIG 45MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ILARIS 180MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– IMBRUVICA 140MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncologist or Hemotologist or under the direct consultation of an Oncologist or Hemotologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- IMFINZI 120MG/2.4ML INJ (New Starts Only)
- IMFINZI 500MG/10ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– INCRELEX 40MG/4ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the long-term treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- INLYTA 1MG TAB (New Starts Only)
- INLYTA 5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncology Specialist.
Coverage Duration	Covered for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ESBRIET 267MG CAP
- ESBRIET 267MG TAB
- ESBRIET 801MG TAB
- OFEV 100MG CAP
- OFEV 150MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Definitive diagnosis of idiopathic pulmonary fibrosis defined by the following: No known cause of lung fibrosis AND one of the following: A. Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) B. High-resolution computed tomography indicates definite UIP pattern C. High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP
Age Restrictions	
Prescriber Restriction	Prescribed by a Pulmonology Specialist or in consultation with a Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Will not be used in combination with other medications used to treat IPF.

Products Affected

– IRESSA 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ISTODAX 10MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or consultation with Hematologist or Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination

Products Affected

- *itraconazole 100mg cap*
- SPORANOX 10MG/ML ORAL SOLN
- SPORANOX 100MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For onychomycosis or diffuse dermatologic fungal infections: 1. If not prescribed by a Dermatologist or Podiatrist OR fungal infection is confirmed by a positive KOH test. 2. For onychomycosis, must fail terbinafine. For dermatologic infections, must fail one topical antifungal medication.
Age Restrictions	
Prescriber Restriction	Infectious Disease Specialists, Pulmonologist or Dermatologist or have consulted with an Infectious Disease Specialist, Pulmonologist or Dermatologist concerning the patient.
Coverage Duration	Approved for 6 months.
Other Criteria	

Products Affected

- BIVIGAM 10% INJ
- FLEBOGAMMA 10% INJ
- GAMASTAN 180UNIT/ML INJ
- GAMMAGARD 10GM INJ
- GAMMAGARD 5GM INJ
- GAMMAPLEX 10GM/100ML INJ
- GAMMAPLEX 20GM/200ML INJ
- GAMUNEX 1GM/10ML INJ
- OCTAGAM 2GM/20ML INJ
- CARIMUNE 6GM INJ
- GAMASTAN 1800UNIT/10ML INJ
- GAMASTAN 360UNIT/2ML INJ
- GAMMAGARD 2.5GM/25ML INJ
- GAMMAKED 1GM/10ML INJ
- GAMMAPLEX 10GM/200ML INJ
- GAMMAPLEX 5GM/50ML INJ
- OCTAGAM 25GM/500ML INJ
- PRIVIGEN 20GM/200ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- JAKAFI 10MG TAB (New Starts Only)
- JAKAFI 15MG TAB (New Starts Only)
- JAKAFI 20MG TAB (New Starts Only)
- JAKAFI 25MG TAB (New Starts Only)
- JAKAFI 5MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncology or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KADCYLA 100MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- KALYDECO 150MG TAB
- KALYDECO 50MG GRANULES PACKET
- KALYDECO 75MG GRANULES PACKET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Pulmonology Specialist.
Coverage Duration	Covered for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KEYTRUDA 100MG/4ML INJ (New Starts Only)
- KEYTRUDA 50MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– KINERET 100MG/0.67ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	If for the treatment of RA, trial or contraindication to Enbrel and Humira.
Age Restrictions	
Prescriber Restriction	Prescribed by a Rheumatologist (All Indications). If for Cryopyrin-Associated Periodic Syndromes (CAPS), Prescribed by a Rheumatologist or Pediatrician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– KORLYM 300MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KUVAN 100MG POWDER FOR ORAL SOLN
- KUVAN 100MG TAB
- KUVAN 500MG POWDER FOR ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuing therapy the patient must have shown a 20% drop in Phenylalanine levels after 2 months of Kuvan treatment.
Age Restrictions	
Prescriber Restriction	Prescribed by a Medical Geneticist or Metabolic Specialist.
Coverage Duration	Initial = 3 months, then if critieria is met approved for the rest of the plan year.
Other Criteria	

Products Affected

- KYPROLIS 30MG INJ (New Starts Only)
- KYPROLIS 60MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– LARTRUVO 10MG/ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LENVIMA (8) 4MG PACK (New Starts Only)
- LENVIMA 10 10MG PACK (New Starts Only)
- LENVIMA 14 PACK (New Starts Only)
- LENVIMA 18 PACK (New Starts Only)
- LENVIMA 20 10MG PACK (New Starts Only)
- LENVIMA 24 PACK (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LETAIRIS 10MG TAB
- LETAIRIS 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *lidocaine 5% patch*
- LIDODERM 5% PATCH

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Management of neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia.
Exclusion Criteria	
Required Medical Info	Trial and failure of gabapentin of four weeks or more
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LINZESS 145MCG CAP
- LINZESS 290MCG CAP
- LINZESS 72MCG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- LONSURF 15-6.14MG TAB (New Starts Only)
- LONSURF 20-8.19MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– LYNPARZA 50MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to Oncology Specialist or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- MEGACE 40MG/ML SUSP
- *megestrol acetate 125mg/ml susp*
- MEGACE 625MG/5ML SUSP
- *megestrol acetate 40mg/ml susp*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *megestrol acetate 20mg tab (New Starts Only)*
- *megestrol acetate 40mg tab (New Starts Only)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- MEKINIST 0.5MG TAB (New Starts Only)
- MEKINIST 2MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- DEMEROL 50MG/ML INJ
- *meperidine 25mg/ml inj*
- *meperidine 100mg/ml inj*
- *meperidine 50mg/ml inj*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- MOVANTIK 12.5MG TAB
- MOVANTIK 25MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Initial Therapy: Member must meet all criteria. 1. Opioid-induced constipation. 2. Failed two laxative/bowel therapies -- polyethylene glycol and lactulose.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	4 Months
Other Criteria	

Products Affected

- ABELCET 5MG/ML INJ
- *acetylcysteine 20% inh soln*
- *adriamycin 2mg/ml inj*
- AKYNZEO 300-0.5MG CAP
- *albuterol 0.417mg/ml (1.25mg/3ml) inh soln*
- *albuterol 1mg/ml (0.5%) inh soln*
- AMINOSYN 7% WITH ELECTROLYTES, SULFITE-FREE INJ
- AMINOSYN II 10% INJ
- *aminosyn ii 8.5% with electrolytes, sulfite-free inj*
- AMINOSYN-HBC 7%, SULFITE-FREE INJ
- AMINOSYN-PF 7% INJ
- AMPHOTERICIN B 50MG INJ
- ANZEMET 50MG TAB
- *aprepitant 125mg/80mg pack*
- *aprepitant 80mg cap*
- ARANESP 100MCG/ML INJ
- ARANESP 150MCG/0.3ML SYRINGE
- ARANESP 200MCG/ML INJ
- ARANESP 25MCG/ML INJ
- ARANESP 300MCG/ML INJ
- ARANESP 40MCG/ML INJ
- ARANESP 60MCG/0.3ML SYRINGE
- ASTAGRAF 0.5MG XL CAP
- ASTAGRAF 5MG XL CAP
- AZASAN 100MG TAB
- AZATHIOPRINE 10MG/ML INJ
- BCG, LIVE, TICE STRAIN 50MG/ML INJ
- BONIVA 3MG/3ML SYRINGE
- BROVANA 15MCG/2ML INH SOLN
- *acetylcysteine 10% inh soln*
- *acyclovir 50mg/ml inj*
- *adrucil 500mg/10ml inj*
- *albuterol 0.21mg/ml (0.63mg/3ml) inh soln*
- *albuterol 0.83mg/ml (0.083%) inh soln*
- AMBISOME 50MG INJ
- *aminosyn 8.5% with electrolytes, sulfite-free inj*
- AMINOSYN II 15% INJ
- AMINOSYN II 8.5%, SULFITE-FREE INJ
- AMINOSYN-PF 10%, SULFITE-FREE INJ
- AMINOSYN-RF 5.2%, SULFITE-FREE INJ
- ANZEMET 100MG TAB
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- ARANESP 100MCG/0.5ML SYRINGE
- ARANESP 10MCG/0.4ML SYRINGE
- ARANESP 200MCG/0.4ML SYRINGE
- ARANESP 25MCG/0.42ML SYRINGE
- ARANESP 300MCG/0.6ML SYRINGE
- ARANESP 40MCG/0.4ML SYRINGE
- ARANESP 500MCG/ML SYRINGE
- ARANESP 60MCG/ML INJ
- ASTAGRAF 1MG XL CAP
- ATGAM 50MG/ML INJ
- AZASAN 75MG TAB
- *azathioprine 50mg tab*
- *bleomycin 15unit/ml inj*
- BOOSTRIX INJ
- *budesonide 0.125mg/ml inh soln*

- *budesonide 0.25mg/ml inh soln*
- *calcitriol 0.00025mg cap*
- *calcitriol 0.001mg/ml inj*
- CARNITOR 1GM/10ML ORAL SOLN
- CARNITOR 330MG TAB
- CELLCEPT 250MG CAP
- CELLCEPT 500MG TAB
- CLINIMIX 2.75/5 INJ
- CLINIMIX 4.25/20 INJ
- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/20 INJ
- CLINIMIX E 2.75/10 INJ
- CLINIMIX E 4.25/10 INJ
- CLINIMIX E 4.25/5 INJ
- CLINIMIX E 5/20 INJ
- *clinisol 15% inj*
- CYCLOPHOSPHAMIDE 25MG CAP
- *cyclosporine 100mg cap*
- *cyclosporine 50mg/ml inj*
- *cyclosporine, modified 100mg/ml oral soln*
- CYCLOSPORINE, MODIFIED 50MG CAP
- CYTARABINE INJ 20MG/ML
- DIPHTHERIA/TETANUS TOXOID INJ
- *doxercalciferol 0.001mg cap*
- *doxercalciferol 0.002mg/ml inj*
- *duramorph 0.5mg/ml inj*
- EMEND 125MG CAP
- EMEND 80MG CAP
- ENGERIX-B 10MCG/0.5ML INJ
- ENGERIX-B 20MCG/ML SYRINGE
- *budesonide 0.5mg/ml inh soln*
- *calcitriol 0.0005mg cap*
- *calcitriol 0.001mg/ml oral soln*
- CARNITOR 200MG/ML INJ
- CELLCEPT 200MG/ML SUSP
- CELLCEPT 500MG INJ
- *cladribine 1mg/ml inj*
- CLINIMIX 4.25/10 INJ
- CLINIMIX 4.25/25 INJ
- CLINIMIX 5/15 INJ
- CLINIMIX 5/25 INJ
- CLINIMIX E 2.75/5 INJ
- CLINIMIX E 4.25/25 INJ
- CLINIMIX E 5/15 INJ
- CLINIMIX E 5/25 INJ
- CROMOLYN SODIUM 10MG/ML INH SOLN
- CYCLOPHOSPHAMIDE 50MG CAP
- *cyclosporine 25mg cap*
- *cyclosporine, modified 100mg cap*
- *cyclosporine, modified 25mg cap*
- *cytarabine 100mg/ml inj*
- CYTOVENE 500MG INJ
- *doxercalciferol 0.0005mg cap*
- *doxercalciferol 0.0025mg cap*
- *doxorubicin 2mg/ml inj*
- *duramorph 1mg/ml inj*
- EMEND 40MG CAP
- EMEND TRI-FOLD PACK
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENVARSUS 0.75MG ER TAB

- ENVARSUS 1MG ER TAB
- EPOGEN 10000UNIT/ML INJ
- EPOGEN 2000UNIT/ML INJ
- EPOGEN 4000UNIT/ML INJ
- FREAMINE 6.9% INJ
- *gengraf 100mg cap*
- *gengraf 25mg cap*
- *glucose 10% inj*
- *glycopyrrolate 0.2mg/ml inj*
- HECTOROL 0.5MCG CAP
- HECTOROL 2.5MCG CAP
- *heparin sodium, porcine 10000unit/ml inj*
- HEPARIN SODIUM, PORCINE 100UNIT/ML INJ
- *heparin sodium, porcine 40unit/ml inj*
- *heparin sodium, porcine 50unit/ml inj*
- HYPERRAB 150UNIT/ML (10ML) INJ
- *ibandronate 1mg/ml inj*
- IMOVAX 2.5UNIT/ML INJ
- *intralipid 20% inj*
- *ipratropium bromide 0.02% inh soln*
- *levalbuterol 0.31mg inh soln*
- *levalbuterol 1.25mg inh soln*
- *levocarnitine 100mg/ml oral soln*
- *methylprednisolone 40mg/ml inj*
- MIACALCIN 200UNIT/ML INJ
- MORPHINE SULFATE 2MG/ML SYRINGE
- MORPHINE SULFATE 8MG/ML SYRINGE
- *mycophenolate mofetil 250mg cap*
- *mycophenolate mofetil 500mg tab*
- *mycophenolic acid 360mg dr tab*
- ENVARSUS 4MG ER TAB
- EPOGEN 20000UNIT/ML INJ
- EPOGEN 3000UNIT/ML INJ
- *fluorouracil 50mg/ml inj*
- *ganciclovir 500mg inj*
- *gengraf 100mg/ml oral soln*
- *gengraf 50mg cap*
- *glucose 5% inj*
- *granisetron 1mg tab*
- HECTOROL 1MCG CAP
- HECTOROL 4MCG/2ML INJ
- *heparin sodium, porcine 1000unit/ml inj*
- *heparin sodium, porcine 20000unit/ml inj*
- *heparin sodium, porcine 5000unit/ml inj*
- HEPATAMINE 8% INJ
- HYPERRAB 150UNIT/ML (2ML) INJ
- IMOGAM 150UNIT/ML (2ML) INJ
- IMURAN 50MG TAB
- INTRALIPID 30% INJ
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- *levalbuterol 0.63mg inh soln*
- *levalbuterol 2.5mg inh soln*
- *levocarnitine 330mg tab*
- *methylprednisolone 62.5mg/ml inj*
- MORPHINE SULFATE 10MG/ML SYRINGE
- MORPHINE SULFATE 4MG/ML SYRINGE
- *mycophenolate mofetil 200mg/ml susp*
- *mycophenolate mofetil 500mg inj*
- *mycophenolic acid 180mg dr tab*
- MYFORTIC 180MG DR TAB

- MYFORTIC 360MG DR TAB
- NEORAL 100MG CAP
- NEORAL 25MG CAP
- NULOJIX 250MG INJ
- *ondansetron 0.8mg/ml oral soln*
- *ondansetron 4mg odt*
- *ondansetron 8mg odt*
- *pamidronate disodium 3mg/ml inj*
- *pamidronate disodium 9mg/ml inj*
- *paricalcitol 0.002mg cap*
- *paricalcitol 0.004mg cap*
- PENTAM 300MG INJ
- *plenamine 15% inj*
- *premasol 6% inj*
- PROCRIT 10000UNIT/ML INJ
- PROCRIT 2000UNIT/ML INJ
- PROCRIT 40000UNIT/ML INJ
- PROGRAF 0.5MG CAP
- PROGRAF 5MG CAP
- PROSOL 20% INJ
- PULMICORT 0.5MG/2ML INH SOLN
- PULMOZYME 1MG/ML INH SOLN
- RAPAMUNE 0.5MG TAB
- RAPAMUNE 1MG/ML ORAL SOLN
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 5MCG/0.5ML SYRINGE
- REMODULIN 10MG/ML INJ
- REMODULIN 2.5MG/ML INJ
- ROBINUL 0.4MG/2ML INJ
- ROCALTROL 0.5MCG CAP
- NEBUPENT 300MG INH SOLN
- NEORAL 100MG/ML ORAL SOLN
- NEPHRAMINE 5.4% INJ
- *nutrilipid 20% iv soln*
- *ondansetron 24mg tab*
- *ondansetron 4mg tab*
- *ondansetron 8mg tab*
- PAMIDRONATE DISODIUM 6MG/ML INJ
- *paricalcitol 0.001mg cap*
- *paricalcitol 0.002mg/ml inj*
- *paricalcitol 0.005mg/ml inj*
- PERFOROMIST 20MCG/2ML INH SOLN
- PREMASOL 10% INJ
- PROCALAMINE 3% INJ
- PROCRIT 20000UNIT/ML INJ
- PROCRIT 3000UNIT/ML INJ
- PROCRIT 4000UNIT/ML INJ
- PROGRAF 1MG CAP
- PROGRAF 5MG/ML INJ
- PULMICORT 0.25MG/2ML INH SOLN
- PULMICORT 1MG/2ML INH SOLN
- RABAVERT 2.5UNIT/ML INJ
- RAPAMUNE 1MG TAB
- RAPAMUNE 2MG TAB
- RECOMBIVAX 40MCG/ML INJ
- RECOMBIVAX HB 10MCG/ML INJ
- REMODULIN 1MG/ML INJ
- REMODULIN 5MG/ML INJ
- ROCALTROL 0.25MCG CAP
- ROCALTROL 1MCG/ML ORAL SOLN

- SANDIMMUNE 100MG CAP
- SANDIMMUNE 25MG CAP
- *sirolimus 0.5mg tab*
- *sirolimus 2mg tab*
- SOLU-MEDROL 2GM INJ
- SOLU-MEDROL 500MG INJ
- *tacrolimus 1mg cap*
- TENIVAC SYRINGE
- THYMOGLOBULIN 25MG INJ
- TROPHAMINE 10% INJ
- TWINRIX INJ
- VINBLASTINE 1MG/ML INJ
- *vincristine sulfate 1mg/ml inj*
- XOPENEX 0.63MG INH SOLN
- XOPENEX 2.5MG INH SOLN
- ZEMPLAR 2MCG CAP
- ZEMPLAR 5MCG/ML INJ
- ZOFRAN 4MG TAB
- ZOFRAN 8MG ODT
- SANDIMMUNE 100MG/ML ORAL SOLN
- SANDIMMUNE 50MG/ML INJ
- *sirolimus 1mg tab*
- SOLU-MEDROL 125MG INJ
- SOLU-MEDROL 40MG INJ
- *tacrolimus 0.5mg cap*
- *tacrolimus 5mg cap*
- TETANUS/DIPHTHERIA TOXOID INJ
- TRAVASOL 10% INJ
- TROPHAMINE 6% INJ
- VARUBI 90MG TAB
- *vincasar 1mg/ml inj*
- XOPENEX 0.31MG INH SOLN
- XOPENEX 1.25MG INH SOLN
- ZEMPLAR 1MCG CAP
- ZEMPLAR 2MCG/ML INJ
- ZOFRAN 4MG ODT
- ZOFRAN 4MG/5ML ORAL SOLN
- ZOFRAN 8MG TAB

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

Products Affected

- NATPARA 100MCG CARTRIDGE
- NATPARA 25MCG CARTRIDGE
- NATPARA 50MCG CARTRIDGE
- NATPARA 75MCG CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NEXAVAR 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Require patient to be at least 18 years old.
Prescriber Restriction	Prescribed by a Oncologist or under the direct consultation of an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NINLARO 2.3MG CAP (New Starts Only)
- NINLARO 3MG CAP (New Starts Only)
- NINLARO 4MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or Hematology Specialist, or in consultation with an Oncology Specialist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NORTHERA 100MG CAP
- NORTHERA 200MG CAP
- NORTHERA 300MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Neurology Specialist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- NOXAFIL 100MG DR TAB
- NOXAFIL 40MG/ML SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NUCALA 100MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of 2 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s).
Age Restrictions	Member must be at least 12 years old.
Prescriber Restriction	Prescribed by, or in consultation with, an Allergy Specialist, Immunologist, or Pulmonary Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– NUPLAZID 17MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *armodafinil 150mg tab*
- *armodafinil 200mg tab*
- *armodafinil 250mg tab*
- *armodafinil 50mg tab*
- *modafinil 100mg tab*
- *modafinil 200mg tab*
- NUVIGIL 200MG TAB
- PROVIGIL 100MG TAB
- PROVIGIL 200MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of narcolepsy, OR obstructive sleep apnea/hypopnea syndrome, OR shift work sleep disorder
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- OCALIVA 10MG TAB
- OCALIVA 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hepatologist or Gastroenterologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For use in treatment of primary biliary cholangitis, patient has had an inadequate response to a year of therapy with ursodiol or experienced intolerance to ursodiol.

Products Affected

– ODOMZO 200MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or inconsultation with Oncology Specialist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ONFI 10MG TAB (New Starts Only)
- ONFI 20MG TAB (New Starts Only)
- ONFI 2.5MG/ML SUSP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA Approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– OPDIVO 40MG/4ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to Oncology Specialist or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– OPSUMIT 10MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ABSTRAL 100MCG SL TAB
- ABSTRAL 200MCG SL TAB
- ABSTRAL 300MCG SL TAB
- ABSTRAL 400MCG SL TAB
- ABSTRAL 600MCG SL TAB
- ABSTRAL 800MCG SL TAB
- ACTIQ 1200MCG LOZENGE
- ACTIQ 1600MCG LOZENGE
- ACTIQ 200MCG LOZENGE
- ACTIQ 400MCG LOZENGE
- ACTIQ 600MCG LOZENGE
- ACTIQ 800MCG LOZENGE
- *fentanyl 0.2mg lozenge*
- *fentanyl 0.4mg lozenge*
- *fentanyl 0.6mg lozenge*
- *fentanyl 0.8mg lozenge*
- *fentanyl 1.2mg lozenge*
- *fentanyl 1.6mg lozenge*
- FENTORA 100MCG BUCCAL TAB
- FENTORA 200MCG BUCCAL TAB
- FENTORA 400MCG BUCCAL TAB
- FENTORA 600MCG BUCCAL TAB
- FENTORA 800MCG BUCCAL TAB
- LAZANDA 100MCG/ACT NASAL SPRAY
- LAZANDA 300MCG/ACT NASAL SPRAY
- LAZANDA 400MCG/ACT NASAL SPRAY

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Breakthrough cancer pain and opioid tolerence. Documented tolerance to opioids defined as patients taking around the clock medicine consisting of at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl per hour, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Trial of Fentora before another branded oral fentanyl product

Products Affected

- ORENCIA 125MG/ML AUTO-INJECTOR
- ORENCIA 125MG/ML SYRINGE
- ORENCIA 250MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA intolerance to or failure of therapy with Enbrel OR Humira. For Polyarticular Juvenile Idiopathic Arthritis intolerance to or failure of therapy with Enbrel.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ORFADIN 10MG CAP
- ORFADIN 2MG CAP
- ORFADIN 5MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ORKAMBI 100-125MG TAB
- ORKAMBI 200-125MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Lung function (FEV1, ppFEV1), 2) BMI, 3) Pulmonary exacerbation history to be collected initially and at continuation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, pulmonologist.
Coverage Duration	Initial and continuation approval of 6 months to assess required medical info
Other Criteria	

Products Affected

- PRALUENT 150MG/ML AUTO-INJECTOR
- PRALUENT 75MG/ML AUTO-INJECTOR
- REPATHA 120MG/ML CARTRIDGE
- REPATHA 140MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initiation of therapy patient must: A) have one of the following conditions: 1) prior clinical atherosclerotic cardiovascular disease (ASCVD) (see Other Criteria), 2) heterozygous familial hypercholesterolemia (HeFH) (see Other Criteria), or 3) homozygous familial hypercholesterolemia (HoFH) (see Other Criteria), AND B) for patients with prior clinical ASCVD or HeFH, current LDL-C level is over 100 mg/dL or over 70 mg/dL with diabetes, AND one of the following requirements is met: 1) patient has been treated for 8 weeks or more with a high intensity statin (atorvastatin 40mg or greater OR rosuvastatin 20mg or greater) in combination with ezetimibe, OR 2) patient is intolerant to statins demonstrated by the failure of 2 statins in combination with ezetimibe, including an attempt with a low- or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin). For continuation of therapy, patient must: A) have one of the following conditions: 1) prior clinical ASCVD (see Other Criteria), 2) HeFH (see Other Criteria), or 3) HoFH (see Other Criteria), AND B) demonstrate a reduction of LDL-C on PCSK9 inhibitor therapy.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a Cardiologist, Lipidologist, or Endcrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Clinical ASCVD defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure, prior stroke or transient ischemic attack, or peripheral arterial disease of presumed atherosclerotic origin. Diagnosis of HeFH must be confirmed by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo B, OR PCSK9 gain of function mutation, 2) Untreated LDL-C greater than 190 mg/dl AND tendon xanthomas in patient or first/second degree relative, 3) Untreated LDL-C greater than 190 mg/dl AND either first degree relative less than 60 years of age or second degree relative less than 50 years of age with premature heart disease, OR 4) untreated LDL-C greater than 190 mg/dl AND first or second degree relative with total cholesterol greater than 290 mg/dL. Diagnosis of HoFH confirmed by the following: 1) two parents diagnosed with HeFH OR genetic confirmation of LDL

	receptor mutation, AND 2) untreated total cholesterol greater 290 mg/dL or LDL-C greater 190 mg/dL, AND 3) either xanthomas present at 10 years of age or younger OR atherosclerotic disease at 20 years of age or younger.

Products Affected

– PERJETA 420MG/14ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Oncologist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- POMALYST 1MG CAP (New Starts Only)
- POMALYST 2MG CAP (New Starts Only)
- POMALYST 3MG CAP (New Starts Only)
- POMALYST 4MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Oncologist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- POTIGA 200MG TAB (New Starts Only)
- POTIGA 300MG TAB (New Starts Only)
- POTIGA 400MG TAB (New Starts Only)
- POTIGA 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- CRINONE 4% VAGINAL GEL
- CRINONE 8% VAGINAL GEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- PROMACTA 12.5MG TAB
- PROMACTA 25MG TAB
- PROMACTA 50MG TAB
- PROMACTA 75MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– RAVICTI 1.1GM/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial of sodium phenylbutyrate powder.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Metabolic Specialist or Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- RELISTOR 12MG/0.6ML INJ
- RELISTOR 12MG/0.6ML SYRINGE
- RELISTOR 8MG/0.4ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Initial Therapy: Member must meet both of the following: 1.Opioid-induced constipation. 2. Trial, or intolerance to, 2 laxative/bowel therapies -- polyethylene glycol + Lactulose.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	4 Months
Other Criteria	

Products Affected

- INFLECTRA 100MG INJ
- REMICADE 100MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of RA member must have tried and failed Enbrel and Humira. For the treatment of Plaque Psoriasis, Psoriatic Arthritis or ankylosing spondylitis must have tried and failed Enbrel and Humira. For the treatment of Crohn's Disease must have tried and failed Humira.
Age Restrictions	Rheumatoid Arthritis require the patient to be at least 18 years of age.
Prescriber Restriction	Rheumatoid Arthritis, Psoriatic Arthritis, Reactive Arthritis and Ankylosing Spondylitis= prescriber must be a Rheumatologist. Crohn's Disease or Ulcerative Colitis= prescriber must be a Gastroenterologist. Plaque Psoriasis= prescriber must be a Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For members with Ulcerative Colitis additional required medical information is not required.

Products Affected

- REVATIO 10MG/12.5ML INJ
- *sildenafil 0.8mg/ml inj*
- REVATIO 20MG TAB
- *sildenafil 20mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- REVLIMID 10MG CAP (New Starts Only)
- REVLIMID 15MG CAP (New Starts Only)
- REVLIMID 2.5MG CAP (New Starts Only)
- REVLIMID 20MG CAP (New Starts Only)
- REVLIMID 25MG CAP (New Starts Only)
- REVLIMID 5MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- KISQALI 200MG DAILY DOSE PACK (New Starts Only)
- KISQALI 400MG DAILY DOSE PACK (New Starts Only)
- KISQALI 600MG DAILY DOSE PACK (New Starts Only)
- KISQALI/FEMARA TAB CO-PACK 200MG (New Starts Only)
- KISQALI/FEMARA TAB CO-PACK 400MG (New Starts Only)
- KISQALI/FEMARA TAB CO-PACK 600MG (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility
Other Criteria	

Products Affected

– ROZEREM 8MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For approval, a prior use of zolpidem is required OR patient has had history of scheduled drug dependence
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of the contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- RUBRACA 200MG TAB (New Starts Only)
- RUBRACA 300MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– RUCONEST 2100UNIT INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– RYDAPT 25MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SABRIL 500MG ORAL SOLN (New Starts Only)
- SABRIL 500MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Neurologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIGNIFOR 0.3MG/ML INJ
- SIGNIFOR 0.6MG/ML INJ
- SIGNIFOR 0.9MG/ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Info	Prescribed for the treatment of an adult patient with Cushing disease AND Pituitary surgery is not an option OR Pituitary surgery was not curative
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with an endocrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIMPONI 100MG/ML AUTO-INJECTOR
- SIMPONI 50MG/0.5ML AUTO-INJECTOR
- SIMPONI ARIA 50MG/4ML INJ
- SIMPONI 100MG/ML SYRINGE
- SIMPONI 50MG/0.5ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA, Psoriatic Arthritis, and ankylosing arthritis intolerance to or failure of therapy with Enbrel AND Humira.
Age Restrictions	
Prescriber Restriction	Prescribed by a Rheumatology Specialist, Gasteroenterologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SIVEXTRO 200MG INJ
- SIVEXTRO 200MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to Infectious Disease Specialist or in consult with Infectious Disease Specialist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *diclofenac sodium 3% gel (New Starts Only)*
- SOLARAZE 3% GEL (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SOLTAMOX 10MG/5ML ORAL SOLN (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded by Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SOMAVERT 10MG INJ
- SOMAVERT 15MG INJ
- SOMAVERT 20MG INJ
- SOMAVERT 25MG INJ
- SOMAVERT 30MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Endocrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SOVALDI 400MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer
Age Restrictions	member must be 18 years of age or older
Prescriber Restriction	Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist
Coverage Duration	Coverage of 12 to 48 weeks based on genotype and treatment as defined by current AASLD guidelines.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

- SPRITAM 1000MG ODT (New Starts Only)
- SPRITAM 250MG ODT (New Starts Only)
- SPRITAM 500MG ODT (New Starts Only)
- SPRITAM 750MG ODT (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member must have a trial or contraindication to generic levetiracetam.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SPRYCEL 100MG TAB (New Starts Only)
- SPRYCEL 140MG TAB (New Starts Only)
- SPRYCEL 20MG TAB (New Starts Only)
- SPRYCEL 50MG TAB (New Starts Only)
- SPRYCEL 70MG TAB (New Starts Only)
- SPRYCEL 80MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– STIVARGA 40MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- STRENSIQ 40MG/ML INJ
- STRENSIQ 80MG/0.8ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Pediatric Endocrinologist, Metabolic Specialist, or Genetic Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SUCRAID 8500UNIT/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SUTENT 12.5MG CAP (New Starts Only)
- SUTENT 25MG CAP (New Starts Only)
- SUTENT 37.5MG CAP (New Starts Only)
- SUTENT 50MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- SYLATRON 200MCG INJ (New Starts Only)
- SYLATRON 300MCG INJ (New Starts Only)
- SYLATRON 600MCG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SYNAGIS 50MG/0.5ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Approve up to five (MAXIMUM) monthly doses of Synagis when an infant or child meets the criteria for one of the following conditions: Infants and children younger than 24 months with chronic lung disease of prematurity (CLD previously known as bronchopulmonary dysplasia) receiving medical therapy within 6 months before the start of the RSV season OR Infants born before 32 weeks of gestation even if they do not have CLD OR Infants born at 32 to less than 35 weeks of gestation, particularly when at least 1 of the following 2 risk factors is present: the infant attends child care, or 1 or more siblings or other children younger than 5 years live permanently in the same household OR Infants with congenital abnormalities of the airway or neuromuscular disease OR Infants and children 24 months or younger with hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an ICU physician, Neonatologist, Pediatric Specialist, Pulmonologist, Cardiologist, Infectious Disease Specialist, or Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– SYPRINE 250MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TAFINLAR 50MG CAP (New Starts Only)
- TAFINLAR 75MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TAGRISSO 40MG TAB (New Starts Only)
- TAGRISSO 80MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TARCEVA 100MG TAB (New Starts Only)
- TARCEVA 150MG TAB (New Starts Only)
- TARCEVA 25MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *bexarotene 75mg cap (New Starts Only)*
- TARGRETIN 75MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncology or Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TASIGNA 150MG CAP (New Starts Only)
- TASIGNA 200MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Requires trial of Sprycel for FDA indications that are shared.

Products Affected

– TECENTRIQ 60MG/ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- THALOMID 100MG CAP (New Starts Only)
- THALOMID 150MG CAP (New Starts Only)
- THALOMID 200MG CAP (New Starts Only)
- THALOMID 50MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TIGAN 300MG CAP
- *trimethobenzamide 300mg cap*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TOBI 300MG/5ML INH SOLN
- TOBI PODHALER KIT 28MG PACK
- *tobramycin 60mg/ml inh soln*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Infectious Disease or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

Products Affected

- AMCINONIDE 0.1% CREAM
- APEXICON 0.05% CREAM
- *clobetasol propionate 0.05% cream*
- *clobetasol propionate 0.05% gel*
- *clobetasol propionate 0.05% ointment*
- *clobetasol propionate 0.05% spray*
- CLOBEX 0.05% LOTION
- CLOBEX 0.05% SPRAY
- CLODERM 0.1% CREAM
- CUTIVATE 0.05% LOTION
- *desonide 0.05% cream*
- DESOWEN 0.05% CREAM
- DIFLORASONE DIACETATE 0.05% CREAM
- *fluticasone propionate 0.05% lotion*
- HALOG 0.1% OINTMENT
- LOCOID 0.1% CREAM
- LOCOID 0.1% OINTMENT
- *lokara 0.05% lotion*
- PANDEL 0.1% CREAM
- TEMOVATE 0.05% OINTMENT
- TOPICORT 0.05% OINTMENT
- TRIDESILON 0.05% CREAM
- AMCINONIDE 0.1% OINTMENT
- *betamethasone valerate 0.12% foam*
- *clobetasol propionate 0.05% foam*
- *clobetasol propionate 0.05% lotion*
- *clobetasol propionate 0.05% shampoo*
- *clobetasol propionate 0.05% topical soln*
- CLOBEX 0.05% SHAMPOO
- *clodan 0.05% shampoo*
- *cormax 0.05% topical soln*
- DESONATE 0.05% GEL
- *desonide 0.05% lotion*
- DESOWEN 0.05% LOTION
- DIFLORASONE DIACETATE 0.05% OINTMENT
- HALOG 0.1% CREAM
- *hydrocortisone butyrate 0.1% cream*
- LOCOID 0.1% LOTION
- LOCOID 0.1% TOPICAL SOLN
- OLUX 0.05% FOAM
- PSORCON 0.05% CREAM
- TOPICORT 0.05% GEL
- TOPICORT 0.25% OINTMENT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial of two formulary topical steroids
Age Restrictions	

Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- TRACLEER 125MG TAB
- TRACLEER 62.5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Pulmonology or Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TREANDA 100MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- QUDEXY 100MG XR CAP (New Starts Only)
- QUDEXY 150MG XR CAP (New Starts Only)
- QUDEXY 200MG XR CAP (New Starts Only)
- QUDEXY 25MG XR CAP (New Starts Only)
- QUDEXY 50MG XR CAP (New Starts Only)
- TOPIRAMATE 100MG ER CAP (New Starts Only)
- TOPIRAMATE 150MG ER CAP (New Starts Only)
- TOPIRAMATE 200MG ER CAP (New Starts Only)
- TOPIRAMATE 25MG ER CAP (New Starts Only)
- TOPIRAMATE 50MG ER CAP (New Starts Only)
- TROKENDI 100MG XR CAP (New Starts Only)
- TROKENDI 200MG XR CAP (New Starts Only)
- TROKENDI 25MG XR CAP (New Starts Only)
- TROKENDI 50MG XR CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed topiramate (TOPAMAX) AND Patient has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TYKERB 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Tykerb is prescribed in combination with capecitabine (Xeloda) AND The patient has advanced or metastatic breast cancer with tumor over-expression of HER2 AND The patient has recieved prior therapy including an anthracycline and a taxane and trastumab. Tykerb is prescribed in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.
Age Restrictions	
Prescriber Restriction	Approval requires the prescriber to be an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– TYSABRI 300MG/15ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For use in Multiple Sclerosis (MS), patient has a relapsing form of MS.
Age Restrictions	
Prescriber Restriction	If prescribed for MS, prescribed by a neurologist or a Multiple Sclerosis (MS) specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For use in MS, patient has a relapsing form of MS and patient has tried dimethyl fumarate (Tecfidera) AND one of the following: beta-1a (Avonex), peginterferon beta-1a (Plegridy), or glatiramer (Copaxone). Exceptions to having tried an interferon product or glatiramer acetate (Copaxone) can be made if the patient is unable to administer injections due to dexterity issues or visual impairment.

Products Affected

- UCERIS 2MG/ACT FOAM
- UCERIS 9MG ER TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has active mild to moderate ulcerative colitis and has tried and failed or was intolerant to mesalamine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- UPTRAVI 1000MCG TAB
- UPTRAVI 1200MCG TAB
- UPTRAVI 1400MCG TAB
- UPTRAVI 1600MCG TAB
- UPTRAVI 200MCG TAB
- UPTRAVI 400MCG TAB
- UPTRAVI 600MCG TAB
- UPTRAVI 800MCG TAB
- UPTRAVI TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– VALCHLOR 0.016% GEL (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has received prior skin-directed therapy such as topical steroids.
Age Restrictions	
Prescriber Restriction	Prescribed by Oncology Specialist or Dermatology Specialist or in consultation with an Oncology or Dermatology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VASCEPA 1GM CAP
- VASCEPA 500MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has triglyceride level greater than or equal to 500 mg/dl.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VELTASSA 16.8GM POWDER FOR ORAL SUSP
- VELTASSA 25.2GM POWDER FOR ORAL SUSP
- VELTASSA 8.4GM POWDER FOR ORAL SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VENCLEXTA 10/100/50MG STARTING PACK (New Starts Only)
- VENCLEXTA 10MG TAB (New Starts Only)
- VENCLEXTA 100MG TAB (New Starts Only)
- VENCLEXTA 50MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VENTAVIS 10MCG/ML INH SOLN
- VENTAVIS 20MCG/ML INH SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Restricted to or on consult with Pulmonology or Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- VFEND 200MG INJ
- VFEND 40MG/ML SUSP
- *voriconazole 200mg inj*
- *voriconazole 40mg/ml susp*
- VFEND 200MG TAB
- VFEND 50MG TAB
- *voriconazole 200mg tab*
- *voriconazole 50mg tab*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Infectious Disease Specialist or Oncologist or in consultation with an Infectious Disease Specialist or Oncologist concerning the patient.
Coverage Duration	Approved for six months subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– VOTRIENT 200MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Require the prescriber to be an Oncologist or be in under the direct consultation with an Oncologist.
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- XALKORI 200MG CAP (New Starts Only)
- XALKORI 250MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XATMEP 2.5MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient must have trial of or inability to use oral methotrexate tablet AND methotrexate injection.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- XELJANZ 11MG ER TAB
- XELJANZ 5MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has had an inadequate response to, or is intolerant of: etanercept (ENBREL) AND adalimumab (HUMIRA)
Age Restrictions	
Prescriber Restriction	Prescribed by Rheumatology Specialist or in consultation with a Rheumatology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *tetrabenazine 12.5mg tab*
- XENAZINE 12.5MG TAB
- *tetrabenazine 25mg tab*
- XENAZINE 25MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has chorea due to Huntington's Disease.
Age Restrictions	
Prescriber Restriction	Prescribed by a Neurologist or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XGEVA 120MG/1.7ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XIFAXAN 550MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Prior Authorization required for quantities greater than 2 tablets per day. For quantities of 3 tablets per day, a diagnosis of IBS-D is required.

Products Affected

– XOLAIR 150MG INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1. If for moderate to severe persistent asthma: There must be objective evidence of reversible airway obstruction AND the patient's lgE level must be between 30 IU/ml and 700 IU/ml, AND the patient must have a positive skin test or RAST test for specific allergic sensitivity and one of the following: Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists OR a leukotriene modifier and systemic steroids OR high dose inhaled corticosteroids are required to maintain adequate asthma control OR intolerance or contradindication to the previously listed drugs. 2. If for chronic idiopathic urticaria, patient remains symptomatic despite H1 antihistamine treatment or has intolerance or contraindication to H1 antihistamine treatment.
Age Restrictions	If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old.
Prescriber Restriction	Prescribed by, or in consultation with, an Allergy Specialist, Pulmonary Specialist, Dermatologist, or Immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– XTANDI 40MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist
Coverage Duration	Covered for duration of plan year subject to member eligibility and formulary change.
Other Criteria	

Products Affected

– XYREM 500MG/ML ORAL SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– YERVOY 50MG/10ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with Oncologist or Dermatologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval based on BvD determination

Products Affected

– YONDELIS 1MG INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZALTRAP 100MG/4ML INJ (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZAVESCA 100MG CAP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, a Clinical Geneticist, Medical Biochemical Geneticist, Hematologist, or Metabolic Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZEJULA 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZELBORAF 240MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with, an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZEPATIER 50-100MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments
Age Restrictions	Member must be 18 years of age or older
Prescriber Restriction	Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist
Coverage Duration	Coverage duration of 12 to 16 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

Products Affected

– ZINBRYTA 150MG/ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist or an MS Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For use in MS, patient has a relapsing form of MS and patient has tried dimethyl fumarate (Tecfidera) AND one of the following: beta-1a (Avonex), peginterferon beta-1a (Plegridy), or glatiramer (Copaxone). Exceptions to having tried an interferon product or glatiramer acetate (Copaxone) can be made if the patient is unable to administer injections due to dexterity issues or visual impairment. Patients who have tried natalizumab (Tysabri) for MS and have a relapsing form of MS will receive authorization, they are not required to try an interferon beta product or glatiramer acetate.

Products Affected

– ZOLINZA 100MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Restricted to or in consult with Oncology or Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZONTIVITY 2.08MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by a Cardiology Specialist or in consultation with an Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- ZORTRESS 0.25MG TAB (New Starts Only)
- ZORTRESS 0.5MG TAB (New Starts Only)
- ZORTRESS 0.75MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Coverage determination based on Med-B vs. Med-D review.

Products Affected

– ZOSTAVAX 19400UNIT/0.65ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	PA not required for members 50 and older.
Prescriber Restriction	
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility
Other Criteria	

Products Affected

- ZYDELIG 100MG TAB (New Starts Only)
- ZYDELIG 150MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	DIAGNOSIS A: Patient has relapsed CLL, defined as CLL progression less than 24 months since the completion of the last prior therapy AND Idelalisib (ZYDELIG) will be used in combination with rituximab (RITUXAN). DIAGNOSIS B and C: Patient has relapsed follicular B-cell non-Hodgkin lymphoma (FL) OR Patient has relapsed small lymphocytic lymphoma (SLL) AND Patient has received at least two (2) prior systemic therapies.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with an Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZYKADIA 150MG CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Zykadia requires the prescriber to be an Oncologist or under the direct consultation of an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

– ZYTIGA 250MG TAB (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by or in consult with Oncology Specialist or Urology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

Products Affected

- *linezolid 20mg/ml susp*
- *linezolid 600mg tab*
- ZYVOX 2MG/ML INJ
- *linezolid 2mg/ml inj*
- ZYVOX 100MG/5ML SUSP
- ZYVOX 600MG TAB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Infectious Disease Specialist or in consultation with an Infectious Disease Specialist concerning the patient.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	