American Health Advantage of Oklahoma (HMO SNP)
2019 Formulary
Prior Authorization Criteria

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Severely impaired liver or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracyclines. Pregnancy. Females of child-bearing potential who intend to become pregnant during therapy or at any time for at least 3 years after discontinuing therapy. Females of child-bearing potential who will not use reliable contraception while undergoing treatment and for at least 3 years following discontinuation. Females of child-bearing potential who drink alcohol during treatment or for two months after cessation of therapy.
Required Medical Information	Diagnosis of plaque psoriasis and documented treatment failure, intolerance, or contraindication to any one of the following: high potency steroids, (i.e. betamethasone, fluocinonide, desoximetasone), calcipotriene, or tazarotene.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist
Coverage Duration	12 months
Other Criteria	None

American Health Advantage of Oklahoma (HMO SNP)
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Prior Authorization Criteria

ACTEMRA

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with an ANC less than 2000/mm3, a platelet count less than 100,000/mm3, or an ALT or AST greater than 1.5 times the upper limit of normal. Patient is not receiving Actemra in combination with a biologic DMARD (Enbrel , Humira , Cimzia , Simponi) . Patient is not receiving Actemra in combination with a Janus kinase inhibitor (eg, Xeljanz).
Required Medical Information	Diagnosis of Polyarticular juvenile idiopathic arthritis, rheumatoid arthritis, systemic juvenile idiopathic arthritis, or giant cell arteritis. For PAJIA, member needs trial or intolerance/contraindication to Humira. For RA, member needs trial or intolerance/contraindication to Humira and Enbrel. For systemic juvenile idiopathic arthritis or giant cell arteritis, Actemra will be approved.
Age Restrictions	2 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Prior history of E. coli protein hypersensitivity or known hypersensitivity to interferon gamma or any product component.
Required Medical Information	Diagnosis of chronic granulomatous disease and used to reduce the frequency and severity of serious infections OR severe, malignant osteopetrosis and used to delay the time to disease progression.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	B vs D coverage determination per CMS guidelines

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form. Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline). Pregnancy.
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO group I) AND diagnosis was confirmed by right heart catheterization OR Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) AND patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable AND female patients are enrolled in the ADEMPAS REMS program.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.)

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with sunitinib or sorafenib OR in combination with lenvatinib, following one prior anti-angiogenic therapy. Diagnosis of pancreatic neuroendocrine tumors (pNET) that are unresectable, locally advanced or metastatic OR Diagnosis of renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery OR Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin OR Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection OR progressive, well-differentiated, non-functional, neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin with unresectable, locally advanced or metastatic disease OR renal angiomyolipoma and tuberous sclerosis complex not requiring immediate surgery OR Diagnosis of tuberous sclerosis complex (TSC)-associated partial-onset seizures.
Age Restrictions	18 years of age or older for RCC, pNET, NET of GI or lung origin, advanced HER2-negative breast cancer, and renal angiomyolipoma with TSC. 1 year of age or older for SEGA. 2 years of age or older for TSC-associated partial-onset seizures.
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or neurologist
Coverage Duration	12 months

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Prior Authorization Criteria

PA Criteria	Criteria Details
Other Criteria	None

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic, ALK-positive non-small cell lung cancer (NSCLC).
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	12 months
Other Criteria	None

ALINIA

Products Affected

- ALINIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of diarrhea caused by Cryptosporidium parvum, OR diarrhea caused by Giarda lamblia. For Giarda lamblia, patient has an inadequate response, intolerable side effect, or contraindication to metronidazole or other documented medical justification why metronidazole cannot be used.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	1 month
Other Criteria	None

ALOSETRON

Products Affected

- *alosetron hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with a history of ischemic colitis, severe constipation, GI obstruction, GI perforation, GI stricture, toxic megacolon, and or GI adhesions. Patients with a history of or currently active diverticulitis, Crohn's disease, or ulcerative colitis, impaired intestinal circulation, thrombophlebitis or a hypercoagulable state. Patients with a history of or currently active severe hepatic disease.
Required Medical Information	1) Prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) Chronic IBS symptoms lasting at least 6 months AND 3) Gastrointestinal tract abnormalities have been ruled out AND 4) Inadequate response to conventional therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ALPHA1-PROTEINASE INHIBITOR

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Not covered for patients with IgA deficiency
Required Medical Information	All of the following: A) Patient has an alpha-1 proteinase inhibitor (alpha-1 antitrypsin) deficiency AND B) Diagnosis of emphysema AND C) One of the following: 1) Patient has a high risk phenotype: PiZZ, PiZ(null), Pi(null)(null) OR 2) Patient has serum alpha-1 antitrypsin concentrations of less than 11 mmols/L (80 mg/dL) AND D) One of the following: FEV1 level is between 30% and 65% of predicted OR the patient has experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Pulmonologist
Coverage Duration	12 months
Other Criteria	None

ALUNBRIG

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic, ALK positive non-small cell lung cancer and have progressed or are intolerant to crizotinib.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	12 months
Other Criteria	None

AMBRISENTAN

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH AND pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with two forms of reliable contraception in female patients of reproductive potential.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	None

AMPYRA

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute).
Required Medical Information	Diagnosis of multiple sclerosis. Patient must demonstrate sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting Ampyra (dalfampridine) and patient is currently on a disease modifying drug (interferon beta 1a, peginterferon beta 1a, intereron beta 1b, or glatiramer) to control disease progression, or has documented treatment failure, intolerance, or contraindication to any one of the following: interferon beta 1a, peginterferon beta 1a, intereron beta 1b, or glatiramer.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consulation with a neurologist
Coverage Duration	Initial - 3 months. Renewal - 12 months
Other Criteria	Multiple Sclerosis (MS) (initial): Diagnosis of MS. Physician confirmation that patient has difficulty walking (eg, timed 25 foot walk test). One of the following: expanded disability status scale (EDSS) score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).

ANTIFUNGAL

Products Affected

- *caspofungin acetate*
- ERAXIS
- MYCAMINE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of systemic fungal infection (e.g., aspergillosis, histoplasmosois, blastomycosis)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	12 weeks
Other Criteria	None

APOKYN

Products Affected

- APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	PD (Initial, reauth): Patient is using Apokyn with any 5-HT3 antagonist (eg, ondansetron, granisetron, dolasetron, palonosetron, alosetron)
Required Medical Information	Parkinson's disease (PD) (Initial): Diagnosis of advanced PD. Patient is experiencing acute intermittent hypomobility (defined as off episodes characterized by muscle stiffness, slow movements, or difficulty starting movements). Patient is receiving Apokyn in combination with other medications for the treatment of PD (e.g., carbidopa/levodopa, pramipexole, ropinirole, benztropine, etc.).
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

APTIOM

Products Affected

- APTIOM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of eslicarbazepine hypersensitivity or oxcarbazepine hypersensitivity.
Required Medical Information	Diagnosis of partial seizure disorder and documented treatment failure, intolerance, or contraindication to any one of the following: Carbamazepine, Diazepam, Gabapentin, Lamotrigine, Levetiracetam, Oxcarbazepine, Phenobarbital, Phenytoin, Topiramate, or Valproic Acid, Divalproex Sodium.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ARIKAYCE

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Pulmonary Mycobacterium avium complex infection and used as part of a combination antibacterial drug regimen in patients who do not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with infectious disease specialist or pulmonologist
Coverage Duration	12 months
Other Criteria	None

ARMODAFINIL

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome confirmed by sleep lab evaluation, e.g., multiple sleep latency test, polysomnography), B) excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine), OR C) excessive sleepiness associated with shift work disorder with a primary complaint of excessive sleepiness or insomnia which is temporally associated with a work period (usually night work) that occurs during the habitual sleep phase or polysomnography and the MSLT demonstrate loss of a normal sleep-wake pattern.
Age Restrictions	17 years of age and older
Prescriber Restrictions	None
Coverage Duration	OSA/hypopnea syndrome: 6 months (initial), 12 months (renewal). Other diagnoses: 12 months.
Other Criteria	None

ATYPICALS

Products Affected

- ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER
- FANAPT
- FANAPT TITRATION PACK
- GEODON INTRAMUSCULAR
- INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE
- INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE
- LATUDA
- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG
- *paliperidone er*
- PERSERIS
- REXULTI
- RISPERDAL CONSTA
- SAPHRIS
- VERSACLOZ
- VRAYLAR
- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Select atypical antipsychotics will be covered when the following criteria are met: A) Patient is using the requested drug for an FDA-Approved or compendia supported indication AND 1B) The patient unable to take at least one generic oral atypical antipsychotic due to inadequate treatment response, intolerance, or contraindication, OR 2B) Patient has a clinical condition for which there is no generic alternative or the generic alternatives are not recommended based on published guidelines or clinical literature OR 3B) The patient medically requires use of a specific dosage form that is not available in the generic alternatives (examples: suspension, solution, injection).
Age Restrictions	None
Prescriber Restrictions	None

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PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	None

AUBAGIO

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Severe hepatic impairment. Current treatment with leflunomide. Patients who are pregnant or women of childbearing potential not using reliable contraception.
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease)

AURYXIA

Products Affected

- AURYXIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Ferric citrate is contraindicated in patients with iron overload syndromes.
Required Medical Information	For the management of hyperphosphatemia in patients with chronic kidney disease on dialysis
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or nephrologist
Coverage Duration	12 months
Other Criteria	None

AUSTEDO

Products Affected

- AUSTEDO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Suicidal ideation and/or untreated or inadequately treated depression, hepatic impairment, or taking MAOIs, reserpine, or tetrabenazine.
Required Medical Information	Diagnosis of chorea associated with Huntington's Disease (Huntington's Chorea) OR tardive dyskinesia.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in collaboration with a neurologist or psychiatrist
Coverage Duration	12 months
Other Criteria	Dosing will be approved per the FDA labeling based on CYP2D6 testing. For renewal, patient had an objective response to therapy.

BALVERSA

Products Affected

- BALVERSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic urothelial carcinoma with susceptible FGFR3 or FGFR2 genetic alterations and patient has progressed during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None

BANZEL

Products Affected

- BANZEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Familial Short QT syndrome
Required Medical Information	Diagnosis of seizures associated with Lennox-Gastaut syndrome and documented treatment failure, intolerance, or contraindication to any one of the following: Clonazepam, Lamotrigine, or Topiramate.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Systemic lupus erythematosus (SLE) (init): Diagnosis of active SLE. Autoantibody positive (ie, anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL). Currently receiving at least one standard of care treatment for active SLE (eg, antimalarials [eg, Plaquenil (hydroxychloroquine)], corticosteroids [eg, prednisone], or immunosuppressants [eg, methotrexate, Imuran (azathioprine), CellCept (mycophenolate mofetil)]).
Age Restrictions	None
Prescriber Restrictions	SLE (init): Prescribed by or in consultation with a rheumatologist
Coverage Duration	SLE (init, reauth): 6 months
Other Criteria	SLE (reauth): Documentation of positive clinical response to Benlysta therapy

BEXAROTENE

Products Affected

- *bexarotene*
- TARGRETIN EXTERNAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy or retinoid hypersensitivity.
Required Medical Information	Diagnosis of cutaneous T-cell lymphoma (CTCL), including mycosis fungoides for the treatment of cutaneous manifestations in patients who are refractory to at least 1 prior systemic therapy (i.e. corticosteroids) OR for the treatment of cutaneous lesions of stage IA or IB CTCL in patients who have refractory or persistent disease after other therapies or who have not tolerated other therapies.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Female patients of child-bearing potential have a documented negative pregnancy test one week prior to the initiation of therapy. For renewal, patient has not had disease progression while on therapy and female patients of child-bearing potential are not pregnant and are continuing to use adequate birth-control measures during therapy.

BOSENTAN

Products Affected

- *bosentan*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Receiving concomitant cyclosporine A or glyburide therapy. Aminotransferase elevations are accompanied by signs or symptoms of liver dysfunction or injury or increases in bilirubin at least 2 times the upper limit of normal.
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH AND Patient has New York Heart Association (NYHA) Functional Class II-IV AND pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with two forms of reliable contraception in female patients of reproductive potential.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	Liver aminotransferases will be measured prior to initiation of treatment and then monthly.

BOSULIF

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of newly diagnosed chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia (Ph + CML) OR chronic, accelerated, or blast phase Philadelphia chromosome-positive CML with resistance, relapse, or inadequate response to prior therapy with either one of imatinib, nilotinib, or dasatinib.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

BRAFTOVI

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable or metastic malignant melanoma with documented BRAF V600E or V600K mutation as detected by an FDA-approved test used in combination with binimetinib
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

BRIVIACT

Products Affected

- BRIVIACT ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of partial-onset seizures, member must have history of inadequate response, contraindication, or intolerance to levetiracetam prior to approval.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

BUPRENORPHINE SL

Products Affected

- *buprenorphine hcl sublingual*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Patient has a diagnosis of opioid dependence
Age Restrictions	16 years of age or older
Prescriber Restrictions	None
Coverage Duration	Initial - 3 months. Renewal - 9 months
Other Criteria	For renewal, patient meets all initial criteria

CABOMETYX

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients who have or are at risk for severe hemorrhage and/or patients with a recent history of bleeding or hemoptysis.
Required Medical Information	Diagnosis of advanced or metastatic renal cell cancer (RCC) OR Diagnosis of hepatocellular carcinoma (HCC) in patients previously treated with sorafenib.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

CALQUENCE

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	MANTLE CELL LYMPHOMA (MCL) (1) Patient must have a diagnosis of MCL AND (2) Patient has tried one other therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Must be prescribed by, or in consultation with an oncologist
Coverage Duration	Initial - 12 months, Renewal - 12 months
Other Criteria	None

CAPRELSA

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Congenital long QT syndrome
Required Medical Information	Diagnosis of medullary thyroid cancer (MTC), and disease is one of the following: A) unresectable, locally advanced, or B) metastatic AND one of the following: patient has symptomatic disease or patient has progressive disease.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

CARBAGLU

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of N-acetyl glutamate synthase (NAGS) deficiency AND patient is experiencing either acute or chronic hyperammonemia
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

CAYSTON

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Confirmation of P. aeruginosa in cultures of the airways. For continuation of therapy, a clinical reason to continue therapy, such as symptomatic improvement or pulmonary function tests have not deteriorated more than 10% from baseline.
Age Restrictions	7 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations)

CIMZIA

Products Affected

- CIMZIA PREFILLED
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active infection (including TB). Concurrent therapy with other biologics.
Required Medical Information	Ankylosing Spondylitis, Plaque Psoriasis, Rheumatoid Arthritis and Psoriatic Arthritis: patient has tried and failed, is intolerant to, or has a contraindication to Enbrel and Humira. Crohn's Disease: patient has had an inadequate response to AT LEAST ONE conventional therapy (corticosteroids, 5-aminosalicylates, azathioprine, 6-mercaptopurine, cyclosporine, methotrexate), AND has tried and failed, is intolerant to, or has a contraindication to Humira. Non-radiographic axial spondyloarthritis: patient has had an indequate response to AT LEAST TWO generic Formulary non-steroidal anti-inflammatory drugs (NSAIDs).
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 3 months for Crohn's disease, 1 year for all other indications. Renewal: Plan Year
Other Criteria	For re-authorization, patient's condition must have improved or stabilized.

CINRYZE

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of life-threatening immediate hypersensitivity reactions, including anaphylaxis to the product.
Required Medical Information	Diagnosis of hereditary angioedema type 1 or type 2 with submission of two sets of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis, AND medication will be used for routine prophylaxis against angioedema, AND patient has failed one previous optimized prophylactic treatment (e.g. danazol 600 mg total daily dose).
Age Restrictions	None
Prescriber Restrictions	Prescribed or overseen by a hematologist or immunologist or allergist
Coverage Duration	12 months
Other Criteria	None

COMETRIQ

Products Affected

- COMETRIQ (100 MG DAILY DOSE)
- COMETRIQ (140 MG DAILY DOSE)
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Gastrointestinal perforation. Fistula. Severe hemorrhage.
Required Medical Information	Diagnosis of progressive, metastatic medullary thyroid cancer.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

COPAXONE

Products Affected

- COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- *glatiramer acetate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease) OR diagnosis of first clinical episode with MRI features consistent with multiple sclerosis.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

COPIKTRA

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsed or refractory chronic lymphocytic leukemia OR small lymphocytic lymphoma in patients with history of at least 2 prior therapies. Diagnosis of relapsed or refractory follicular lymphoma in patients with at least 2 prior systemic therapies.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

CORLANOR

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Decompensated acute heart failure, hypotension (i.e. blood pressure less than 90/50 mmHg), sick sinus syndrome, sinoatrial block, or 3rd degree AV block, unless a functioning demand pacemaker is present and bradycardia (i.e., resting heart rate less than 60 bpm prior to treatment)
Required Medical Information	Diagnosis of one of the following A.) stable, symptomatic chronic heart failure with left ventricular ejection fraction 35% or less, who are in sinus rhythm with resting heart rate 70 beats per minute or more and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use, or B.) stable, symptomatic heart failure due to dilated cardiomyopathy in patients who are in sinus rhythm with an elevated heart rate
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

COSENTYX

Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Failure, contraindication, or intolerance to Enbrel (etanercept) AND Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Cosentyx therapy. All indications (Initial, reauth): Patient is not receiving Cosentyx in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Cosentyx in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]. For a diagnosis of PsA or plaque psoriasis, Patient is not receiving Cosentyx in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].
Age Restrictions	None
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS (Initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	All indications (Initial, reauth): 12 months
Other Criteria	All indications (Reauth): Documentation of positive clinical response to Cosentyx therapy.

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COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable OR metastatic malignant melanoma with BRAF V600E OR V600K mutation. Documentation of combination therapy with vemurafenib
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

CYSTARAN

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Demonstrated cysteamine hypersensitivity or penicillamine hypersensitivity
Required Medical Information	Patient has a diagnosis of cystinosis AND patient has corneal cystine crystal accumulation
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

DALIRESP

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Moderate to severe liver impairment (Child-Pugh B or C)
Required Medical Information	Diagnosis of severe chronic obstructive pulmonary disease (COPD) (defined as FEV1 less than or equal to 50% of predicted and FEV1/forced vital capacity [FVC] less than 0.7) associated with chronic bronchitis AND history of COPD exacerbations which requires the use of systemic corticosteroids, antibiotics, or hospital admission AND Medication will be used with a long-acting inhaled bronchodilator (i.e. long-acting anticholinergic, or long-acting beta agonist in combination with inhaled corticosteroid) or patient is at high-risk of COPD exacerbation and is not a candidate for long-acting inhaled bronchodilator therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

DAPTOMYCIN

Products Affected

- *daptomycin*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	For the treatment of Staphylococcus aureus bacteremia OR complicated skin and skin structure infections, including infections caused by methicillin-resistant Staphylococcus aureus (MRSA) OR endocarditis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	B vs D coverage determination per CMS guidelines

DAURISMO

Products Affected

- DAURISMO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of A) newly diagnosed acute myeloid leukemia and used in combination with cytarabine in adults 75 years of age or older or in patients who have comorbidities that preclude use of intensive induction chemotherapy
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist or Hematologist
Coverage Duration	12 months
Other Criteria	None

DEFERASIROX

Products Affected

- *deferasirox*
- JADENU
- JADENU SPRINKLE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Creatinine clearance less than 40 mL/min or evidence of overt proteinuria, platelet count less than 50 x 10(9)/L, advanced malignancy, high-risk myelodysplastic syndrome (MDS) with poor performance status, or concurrent use of deferoxamine or iron-containing products.
Required Medical Information	The patient must meet all of the following criteria: 1) Diagnosis of transfusion-dependent anemia with chronic iron overload due to blood transfusions, 2) Patient will have baseline and monthly monitoring of serum ferritin, serum creatinine, creatinine clearance, serum transaminases, and bilirubin. OR For the treatment of chronic iron overload in patients 10 years and older with nontransfusion-dependent thalassemia syndromes
Age Restrictions	Covered for those 2 years of age and older with chronic iron overload due to blood transfusions
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	None

DEMSER

Products Affected

- DEMSER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	For the short-term management of patients with pheochromocytoma who are awaiting surgery, or for long-term management of malignant pheochromocytoma when surgery is contraindicated.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

DEPEN

Products Affected

- DEPEN TITRATABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Previous penicillamine-induced agranulocytosis or aplastic anemia, breast-feeding, prior history of penicillamine hypersensitivity, evidence of renal insufficiency, including renal impairment, or renal failure, pregnancy (except in Wilsons disease).
Required Medical Information	Diagnosis of Wilson's disease, cystinuria, or rheumatoid arthritis. For RA: A) Must be prescribed by a rheumatologist, B) Patient must have failure to respond (or contraindication) to at least two of the following non-biologic DMARDs: Hydroxychloroquine, Leflunomide, Methotrexate, or Sulfasalazine within the past 365 days, C) Patient must have failure to respond (or contraindication) to each of the following biologic therapies: Enbrel, Humira within the past 365 days.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

DICLOFENAC TOPICAL

Products Affected

- *diclofenac sodium transdermal*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diclofenac 1% gel or 1.5% solution: Diagnosis of osteoarthritis, diclofenac 3% gel: Diagnosis of actinic keratosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

DRONABINOL

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Sesame oil hypersensitivity
Required Medical Information	A. The diagnosis is documented as anorexia associated with weight loss in a patient with AIDS a. AND the patient has had an involuntary weight loss of greater than 10% of pre-illness baseline body weight or a body mass index (BMI) less than 20kg/m2 in the absence of a concurrent illness or medical condition other than HIV that may cause weight loss b. AND the patient has failed to respond to a 30-day drug regimen of megestrol (Megace) c. AND if the patient has received previous dronabinol therapy, he/she must show a positive response to therapy by maintaining or increasing their initial weight and/or muscle mass before initiating dronabinol therapy. B. The diagnosis is documented as nausea and vomiting associated with cancer chemotherapy in a cancer patient a. AND the patient is receiving a chemotherapy or radiation regimen b. AND the patient has had a full trial and failure through at least one cycle of chemotherapy with IV ondansetron AND at least one of the following oral anti-emetic agents: metoclopramide, promethazine, prochlorperazine, meclizine, trimethobenzamide, oral 5-HT3 receptor antagonists e. AND if the patient has received previous dronabinol therapy, he/she must show a positive response by showing a reduced incidence of emesis and/or nausea.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	B vs D coverage determination per CMS guidelines

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pheochromocytoma. Patient is taking or will take any of the following: SSRIs, SNRIs, tricyclic antidepressants (TCAs), bupropion, buspirone, meperidine, tramadol, methadone, pentazocine, dextromethorphan, St. John's wort, mirtazapine, cyclobenzaprine, oral selegiline, other MAOIs, oxcarbazepine, carbamazepine, and/or sympathomimetic amines
Required Medical Information	Diagnosis of major depressive disorder AND Patient had adequate trial with at least 2 generic oral antidepressants from differing classes (at least one should be from the following list: selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors, mirtazapine, or bupropion unless contraindicated), unless unable to take any oral medication AND Patient had an adequate washout period (for patients previously on agents requiring a washout period)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, the patient has improved or stabilized on Emsam.

ENBREL

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active serious infection (including tuberculosis). Combined use with a biologic disease-modifying anti-rheumatic drugs or potent immunosuppressant (e.g., azathioprine or cyclosporine)
Required Medical Information	Diagnosis of moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs for at least 3 consecutive months OR Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis and patient had an inadequate response, intolerance or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) for at least 3 consecutive months OR Diagnosis of psoriatic arthritis and patient had an inadequate response, intolerance, or contraindication to methotrexate OR Diagnosis of ankylosing spondylitis and patient had an inadequate response, intolerance or contraindication to one or more NSAIDs OR Diagnosis of moderate to severe chronic plaque psoriasis (affecting more than 5% of body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) and patient had an inadequate response, intolerance or contraindication to conventional therapy with at least one of the following: phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA] for at least one continuous month or one or more oral systemic treatments (i.e. methotrexate, cyclosporine, acitretin, sulfasalazine) for at least 3 consecutive months.
Age Restrictions	2 years of age or older for JIA or JRA. 4 years of age or older for plaque psoriasis. 18 years of age or older for all other indications
Prescriber Restrictions	None

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PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	None

ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Must have: A) diagnosis of sickle cell anemia or sickle thalassemia AND B) documentation of at least two episodes of sickle cell crises in the last 12 months, AND C) inadequate treatment response to a 3 month trial of hydroxyurea OR intolerance, or contraindication to hydroxyurea.
Age Restrictions	5 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ENTRESTO

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of angioedema related to previous ACE inhibitor or ARB therapy, concomitant use or use within 36 hours of ACE inhibitors, concomitant use of aliskiren in patients with diabetes
Required Medical Information	Statement of diagnosis indicating Heart Failure (NYHA Class II through IV).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

EPIDIOLEX

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Lennox-Gastaut syndrome OR severe myoclonic epilepsy in infancy
Age Restrictions	2 years of age and older
Prescriber Restrictions	Prescriber by or consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic basal cell carcinoma OR Diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ERLEADA

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of one of the following: A.) Non-metastatic castration-resistant prostate cancer, or B.) Metastatic, castration-sensitive prostate cancer
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

ERLOTINIB

Products Affected

- *erlotinib hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer and erlotinib will be used in combination with gemcitabine OR Diagnosis of locally advanced or metastatic (stage III or IV) non-small cell lung cancer with one of the following: A) failure with at least one prior chemotherapy regimen and erlotinib will be used as monotherapy, or B) no evidence of disease progression after four cycles of first-line platinum-based chemotherapy and erlotinib will be used as maintenance treatment and erlotinib will be used as monotherapy, or C) Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

ESBRIET

Products Affected

- ESBRIET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Appropriate diagnosis (idiopathic pulmonary fibrosis [IPF]), monitoring (hepatic function/LFTs)
Age Restrictions	None
Prescriber Restrictions	Pulmonologist
Coverage Duration	12 months
Other Criteria	None

ESRD THERAPY

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE
- EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML
- PROCRIT
- RETACRIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	(1) Uncontrolled hypertension, (2) Cancer patients receiving chemotherapy when the anticipated outcome is cure, (3) Cancer patients receiving hormonal agents, biologic products, or radiotherapy without concomitant myelosuppressive chemotherapy, (4) Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML), or erythroid cancers, (5) Anemia due to folate deficiency, B-12 deficiency, iron deficiency, or bleeding, (6) Pure red cell aplasia that begins after ESA treatment.
Required Medical Information	Pre-treatment hemoglobin level less than 10 g/dL AND Adequate iron stores prior to initiation of therapy defined as ferritin greater than or equal to 100 ng/mL and serum transferrin saturation greater than or equal to 20% within the past 12 months AND Diagnosis of one of the following: A) Anemia due to chronic kidney disease (CKD) with or without dialysis, OR B) Anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy and two additional months of chemotherapy is anticipated, OR C) Anemia associated with Myelodysplastic Syndromes (MDS) (must also have an erythropoietin level less than or equal to 500 mUnits/mL), OR D) Treatment of anemia in a patient at high risk for perioperative blood loss from elective, noncardiac, nonvascular surgery to reduce the need for allogeneic blood transfusion, OR E) Anemia in zidovudine-treated HIV infection with serum erythropoietin levels 500 mUnits/mL or less and zidovudine doses 4,200 mg/week or less.
Age Restrictions	None

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PA Criteria	Criteria Details
Prescriber Restrictions	CKD - prescribed by a nephrologist or hematologist. Non-myeloid malignancies or MDS - prescribed by an oncologist/hematologist. Surgery - Prescribed by a surgeon. HIV - Prescribed by an infectious disease specialist.
Coverage Duration	3 months. For renewal: CKD-12 mont, Non-myeloid cancers or MDS-3 mont, HIV-4 mont, Surgery-3 mont
Other Criteria	ESRD and Cancer/MDS patients will require Part B versus Part D coverage determination. For renewal of CKD, for non-dialysis patients: Hgb less than 10 g/dL or physician will decrease or interrupt dose. Ferritin greater than or equal to 100 ng/mL and serum transferrin saturation greater than or equal to 20% within the past 12 months (applies to most recent value). For renewal of palliative non-myeloid malignancies: Concurrent myelosuppressive chemotherapy and Hgb is 10-12 g/dL or less and there is measurable response after eight weeks (defined as an increase in Hgb 1 g/dL or more or a reduction in red blood cell transfusion requirements). Ferritin greater than or equal to 100 ng/mL and serum transferrin saturation greater than or equal to 20% within the past 12 months (applies to most recent value). For renewal of anemia associated with Myelodysplastic Syndromes (MDS): Hgb is 10-12 g/dL or less and there is measurable response after eight weeks (defined as an increase in Hgb 1.5 g/dL or more or a reduction in red blood cell transfusion requirements). Ferritin greater than or equal to 100 ng/mL and serum transferrin saturation greater than or equal to 20% within the past 12 months (applies to most recent value). For renewal of zidovudine-treated HIV, Hgb is 12g/dL or less AND Zidovudine dose remains 4,200 mg/week or less and there is a measurable response after eight weeks (defined as an increase in Hgb or a reduction in RBC transfusion requirements or documented dose escalation [up to max of 300 units/kg/dose])

FARYDAK

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Multiple Myeloma (MM) Used in combination with both of the following: Velcade (bortezomib) and dexamethasone. Patient has received at least two prior treatment regimens which included both of the following: Velcade (bortezomib) and an immunomodulatory agent [eg, Revlimid (lenalidomide), Thalomid (thalidomide)].
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist/hematologist
Coverage Duration	12 months
Other Criteria	None

FENTANYL BUC

Products Affected

- FENTORA BUCCAL TABLET 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Management of acute or post-operative pain, including headache, migraine, dental pain, or use in the emergency room. Opioid non-tolerant patients.
Required Medical Information	Patient meets the following: A) Diagnosis of cancer and use is for breakthrough cancer pain, B) Patient is opioid tolerant and taking at least 60 mg morphine per day, at least 25 mcg transdermal fentanyl per hour, at least 30 mg of oxycodone daily, at least 8 mg oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer, C) At least one other formulary short-acting potent narcotic analgesic alternative (other than fentanyl) has been ineffective, not tolerated, or contraindicated, D) Prescriber and patient are registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy Access program, E) for brand requests, generic transmucosal fentanyl citrate has been ineffective, not tolerated, or contraindicated.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

FENTANYL TD

Products Affected

- *fentanyl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Management of acute or post-operative pain. Opioid non-tolerant patients.
Required Medical Information	Patient is opioid tolerant (taking for one week or longer at least 60mg of morphine or equivalent daily) AND has tried Morphine Sulfate extended release oral or is unable to take Morphine Sulfate extended release oral secondary to allergy, adverse events, swallowing difficulty, or uncontrollable nausea/vomiting.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

FERRIPROX

Products Affected

- FERRIPROX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of transfusional iron overload due to thalassemia syndromes AND patient has failed prior chelation therapy with deferasirox (failure is defined as a serum ferritin level greater than 2,500 mcg/L) or patient has a contraindication or intolerance to deferasirox AND Patient has an absolute neutrophil count greater than 1.5 x 109/L.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced at least a 20% reduction in serum ferritin levels and has an absolute neutrophil count greater than 0.5 x 109/L

FIRAZYR

Products Affected

- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hereditary angioedema type 1 or type 2, AND medication will be used for the treatment of acute attacks, AND patient is not currently on an ACE inhibitor, AND patient does not have a history of ischemic heart disease.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed or overseen by a hematologist or immunologist or allergist
Coverage Duration	12 months
Other Criteria	None

FIRMAGON

Products Affected

- FIRMAGON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced or metastatic prostate cancer
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

FORTEO

Products Affected

- FORTEO SUBCUTANEOUS SOLUTION 600 MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Patient has a diagnosis of one of the following: a) osteoporosis in a postmenopausal female, b) primary or hypogonadal osteoporosis in a male, or c) osteoporosis associated with sustained systemic glucocorticoid therapy AND patient is considered to be at high-risk for fracture by meeting one or more of the following: A) history of osteoporotic fracture, B) Low Bone Density less than 2.5 SD below normal, AND one or more of the following: i) failed one oral bisphosphonate and Tymlos, or ii) intolerant to one oral bisphosphonate and Tymlos. Patient has not received more than 2 years of therapy with Forteo.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

FYCOMPA

Products Affected

- FYCOMPA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of partial seizures with or without secondary generalization or primary generalized tonic-clonic seizure disorder and documented treatment failure, intolerance, or contraindication to any one of the following: Carbamazepine, Diazepam, Gabapentin, Lamotrigine, Levetiracetam, Oxcarbazepine, Phenobarbital, Phenytoin, Topiramate, or Valproic Acid, Divalproex Sodium.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

GALAFOLD

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Fabry disease with an amenable galactosidase alpha gene (GLA) mutation
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

GILENYA

Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500 ms. Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (quinidine, procainamide, amiodarone, sotalol).
Required Medical Information	Diagnosis of a relapsing form of multiple sclerosis (clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease) or diagnosis of first clinical episode with MRI features consistent with MS AND Patient will be observed for signs and symptoms of bradycardia in a controlled setting for at least 6 hours after the first dose
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	For renewal, the patient has experienced no or slowed disease progression.

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician in patients with: 1) metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test or 2) metastatic squamous NSCLC, progressing after platinum-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

GLEOSTINE

Products Affected

- GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Statement of diagnosis indicating Hodgkin's disease, OR intracranial tumor, OR carcinoma of the breast, OR colorectal cancer, OR lung cancer, OR malignant melanoma, OR malignant tumor of the thymus, OR multiple myeloma, OR non-Hodgkin's lymphoma. AND monitoring of blood counts for evidence of Bone Marrow Suppression (thrombocytopenia or leukopenia).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

GOCOVRI

Products Affected

- GOCOVRI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with a known amantadine hypersensitivity, rimantadine hypersensitivity, or hypersensitivity to any agent in the adamantine class or patients with end-stage renal disease, e.g., those with renal failure and CrCl less than 15 mL/minute.
Required Medical Information	INITIAL: A. FOR DYSKINESIA IN PARKISONS: (1) Must have a documented diagnosis of dyskinesia in Parkinson disease AND (2) Patient must be receiving levodopa based therapy AND (3) Must have a documented trial and failure to amantadine immediate release. RENEWAL: (1) Must meet the initial criteria above AND (2) Patient must have experienced an increase in ON time without troublesome dyskinesia while on therapy AND (3) Patient must have experienced a decrease in OFF time while on therapy AND (4) The patient has not experienced any severe adverse reactions.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	Initial - 12 months, Renewal - 12 months
Other Criteria	None

GROWTH HORMONE

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

HEPATITIS B

Products Affected

- *adefovir dipivoxil*
- BARACLUDE ORAL SOLUTION
- *entecavir*
- VEMLIDY

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients that have immune-tolerant chronic hepatitis B per AASLD guidelines
Required Medical Information	Must submit documenation of immune-active chronic hepatitis B per AASLD guidelines.
Age Restrictions	None
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	12 months
Other Criteria	None

HEPATITIS C

Products Affected

- MAVYRET
- *sofosbuvir-velpatasvir*
- VOSEVI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Must submit documentation of chronic hepatitis C genotype (confirmed by HCV RNA level within the last 6 months). Must submit laboratory results within 6 weeks of initiating therapy including: 1) CBC w Platelets, 2) AST/ALT, 3) Total Bilirubin, 4) Serum Albumin, 5) PT/INR, 6) Serum Creatinine, and 7) GFR. Must include subtype, trial/failure, contraindication to, or intolerance to Mavyret or Sofosbuvir-Velpatasvir prior to approval of Vosevi.
Age Restrictions	None
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Duration of approval per AASLD Guidelines
Other Criteria	None

HRM-ANALGESICS

Products Affected

- *meperidine hcl injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml*
- *meperidine hcl oral tablet*
- *pentazocine-naloxone hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Analgesics: APAP/codeine,hydrocodone/APAP,hydrocodone/IBU,hydromorphone,methadone,morphine sulfate,oxycodone,oxycodone/APAP,oxycodone/ASA,oxycodone/ibuprofen,oxymorphone IR,tramadol, tramadol/APAP

HRM-ANTIARRHYTHMICS

Products Affected

- *disopyramide phosphate oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anti-arrhythmics: DIGOXIN: digoxin 0.125mg dose, propranolol, or sotalol for atrial fibrillation, DISOPYRAMIDE: dofetilide, amiodarone, propafenone, mexiletine, multaq

HRM-ANTIDEMENTIA

Products Affected

- *ergoloid mesylates oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Antidementia: donepezil,galantamine,memantine,rivastigmine oral

HRM-ANTIINFLAMMATORY

Products Affected

- *indomethacin er*
- *indomethacin oral*
- *ketorolac tromethamine oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anti-inflammatories: celecoxib,diclofenac,diflunisal,etodolac,flurbiprofen,ibuprofen,ketoprofen, meclofenamate,meloxicam,nabumetone,naproxen,oxaprozin,piroxicam,sulindac,tolmetin

HRM-ANTINEOPLASTICS

Products Affected

- *megestrol acetate oral suspension 40 mg/ml*
- *megestrol acetate oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For Megestrol: dronabinol

HRM-ANTIPLATELET

Products Affected

- *dipyridamole oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anti-platelets: Anagrelide, asa/dipyridamole, Brilinta, cilostazol, clopidogrel

HRM-CARDIOVASCULAR

Products Affected

- *guanfacine hcl er*
- *guanfacine hcl oral*
- *methyldopa oral*
- *methyldopa-hydrochlorothiazide*
- *nifedipine oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Cardiovascular agents: acebutolol,amilor/hctz,amlod/benazp,amlod/valsar,amlodipine,atenol/chlorth,atenolol,benazep/hctz,benazepril,benicar,benicar hct,betaxolol,bisopr/hctz,bisoprolol,candesartan,candesartan/hctz,captopril/hctz,captopril,cartia xt,carvedilol,chlorothiazide,diltiazem,dilt-xr,doxazosin,enalapril,enalapril/hctz,eprosartan,felodipine,fosinopril,fosinopril/hctz, hctz,indapamide,irbesart/hctz,irbesartan,isradipine,labetalol,lisinopril,lisinopril/hctz,losartan/losartan/hctz,methylclothia,metolazone,metoprol/hctz,met

PA Criteria	Criteria Details
	oprolol,midodrine,moexipril/hctz,moexipril,nadolol,nadolol/bend,nicardipine,nifedical xl,nimodipine,nifedipine er,nisoldipine,perindopril,pindolol,prazosin,propran/hctz,propranolol,quinapril/quinapril/hctz,ramipril,spirono/hctz,taztia xt,telmis/amlod,telmis/hctz,telmisartan,terazosin,timolol,trandolapril,trandolapril/verapamil,triam/hctz,valsart/hctz,valsartan,verapamil

HRM-ORAL AND TRANSDERMAL ESTROGENS AND PROGESTINS

Products Affected

- AMABELZ
- DIVIGEL TRANSDERMAL GEL 1 MG/GM
- ELESTRIN
- *estradiol oral*
- *estradiol transdermal*
- *estradiol-norethindrone acet*
- EVAMIST
- FYAVOLV
- JINTELI
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- MIMVEY
- MIMVEY LO
- *norethindrone-eth estradiol*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months

American Health Advantage of Oklahoma (HMO SNP)
2019 Formulary
Prior Authorization Criteria

PA Criteria	Criteria Details
Other Criteria	Bone Density: alendronate, risedronate, ibandronate, raloxifene (zoledronic acid for bed-bound patients or for post-hip fracture). Vaginal Symptoms: vaginal estrogen cream

HRM-SEDATIVE HYPNOTICS

Products Affected

- BUTISOL SODIUM ORAL TABLET 30 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Sleep disorder agents: estazolam, flurazepam, rozerem ,temazepam, triazolam

HRM-SKELETAL MUSCLE RELAXANTS

Products Affected

- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*
- *orphenadrine citrate er*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

HRM-SULFONYLUREAS

Products Affected

- *glyburide micronized*
- *glyburide oral*
- *glyburide-metformin*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anti-Diabetics: glimepiride, glipizide IR and ER

HUMIRA

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER
- HUMIRA PEN-PS/UV/ADOL HS START
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active serious infection (including tuberculosis). Combined use with a biologic disease-modifying anti-rheumatic drugs or potent immunosuppressant (e.g., azathioprine or cyclosporine)
Required Medical Information	Diagnosis of ONE of the following: A) moderate to severe rheumatoid arthritis OR moderate to severe polyarticular juvenile idiopathic arthritis and patient had inadequate response, intolerance, or contraindication to one or more non-biologic DMARDs for at least 3 consecutive months B) psoriatic arthritis and patient had inadequate response, intolerance, or contraindication to methotrexate C) ankylosing spondylitis and patient had inadequate response, intolerance, or contraindication to one or more NSAIDs D) moderate to severe chronic plaque psoriasis (affecting more than 5% of body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) and patient had inadequate response, intolerance, or contraindication to conventional therapy with at least one of the following: phototherapy (including but not limited to UVA with a psoralen [PUVA] and/or retinoids [RePUVA] for at least one continuous month or one or more oral systemic treatments (Cyclosporine, acitretin, sulfasalazine, methotrexate, leflunomide, azathioprine) for at least 3 consecutive months E) moderate to severe Crohn's disease and patient had inadequate response, intolerance, or contraindication to conventional therapy with two or more of the following: corticosteroids or non-biologic DMARDs F) moderate to severe ulcerative colitis and patient had inadequate response, intolerance or contraindication to conventional therapy with two or more of the following: corticosteroids, 5-ASA (i.e. mesalamine, sulfasalazine, balsalazide) or non-biologic DMARDs (azathioprine, cyclosporine, hydroxychloroquine, leflunomide,

PA Criteria	Criteria Details
	penicillamine, sulfasalazine) G) non-infectious uveitis (including intermediate, posterior, and panuveitis) and patient had inadequate response, intolerance or contraindication to conventional therapy with one of the following following: systemic or topical corticosteroids or opthalmic antimuscarinics. OR H) moderate to severe hidradenitis suppurativa
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with an aromatase inhibitor in postmenopausal women or in men, as initial endocrine-based therapy OR in combination with fulvestrant in women with disease progression following endocrine therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	None

ICLUSIG

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic myelogenous leukemia(CML) AND One of the following: A) History of failure, resistance, relapse, contraindication, or intolerance to at least TWO other tyrosine kinase inhibitors (i.e., GLEEVEC [imatinib], SPRYCEL, TASIGNA, and BOSULIF), or B) Patient has the T315I mutation. OR Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) AND One of the following: A) History of failure, resistance relapse, contraindication, or intolerance to at least TWO other FDA-approved tyrosine kinase inhibitors (i.e., GLEEVEC [imatinib], SPRYCEL), or B) Patient has the T315I mutation.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsed or refractory acute myeloid leukemia with an isocitrate dehydrogenase 2 mutation as detected by an FDA approved test
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None

IMATINIB

Products Affected

- *imatinib mesylate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B) Ph+ acute lymphoblastic leukemia (ALL), C) Gastrointestinal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy, D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, E) hypereosinophilic syndrome or chronic eosinophilic leukemia, F) myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, G) aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown
Age Restrictions	1 year of age or older - newly diagnosed CML in the chronic phase or newly diagnosed Ph+ ALL. 18 years of age or older for other indications.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

IMBRUVICA

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of mantle cell lymphoma (MCL) who have received at least one prior therapy OR chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) OR chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) with 17p deletion OR Waldenstrom's macroglobulinemia (WM) OR marginal zone lymphoma who require systemic therapy and have received at least one prior anti-CD20-based therapy OR Diagnosis of graft versus host disease (GVHD)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Increlex is contraindicated in patients with allergies to mecasermin or any component of the Increlex formulation, for growth promotion in patients with closed epiphyses, for IV administration, in patients with active or suspected neoplasia. Increlex should be discontinued if neoplasia develops while on therapy.
Required Medical Information	Increlex (mecasermin [rDNA origin] injection) is indicated for the long-term treatment of growth failure in children with severe primary IGF-1 deficiency (Primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. Child has one of the following conditions: Severe primary IGF-1 deficiency, OR Growth hormone gene deletion with developed neutralizing antibodies to growth hormone, OR Genetic mutation of GH receptor (i.e. Laron Syndrome), AND Child has severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex, AND Child with IGF-1 level greater than or equal to 3 standard deviations below normal based on lab reference range for age and sex, AND Child with normal or elevated growth hormone (GH) levels based on at least one growth hormone stimulation test, AND Evidence of open epiphyses
Age Restrictions	2 years of age and older
Prescriber Restrictions	Pediatric or Endocrinologist
Coverage Duration	6 months
Other Criteria	For renewal, patient has experienced improvement

INHALED TOBRAMYCIN

Products Affected

- BETHKIS
- TOBI PODHALER
- *tobramycin inhalation*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis AND patient has evidence of P. aeruginosa in the lungs
Age Restrictions	6 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations).

INLYTA

Products Affected

- INLYTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced renal cell carcinoma AND patient failed one or more systemic therapies for renal cell carcinoma (e.g., sunitinib-, bevacizumab-, temsirolimus-, or cytokine-containing regimens)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

INREBIC

Products Affected

- INREBIC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None

INTRAROSA

Products Affected

- INTRAROSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia.
Required Medical Information	Diagnosis of moderate to severe dyspareunia or atrophic vaginitis AND A) Patient must be female, B) Patient must be menopausal or postmenopausal, C) Patient has tried and failed, has a contraindication or intolerance to a low dose vaginal estrogen preparation (e.g. Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem), D) Patient does not have renal or hepatic impairment.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 3 months, Reauthorization: 12 months
Other Criteria	None

INTRON A

Products Affected

- INTRON A

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Uncontrolled depression. Solid organ transplant other than liver. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon and ribavirin.
Required Medical Information	Diagnosis of hairy cell leukemia OR Diagnosis of Condylomata acuminata OR Diagnosis of AIDS-related Kaposi's sarcoma OR Clinically aggressive follicular lymphoma and the medication will be used concurrently with anthracycline-containing chemotherapy or is not a candidate for anthracycline-containing chemotherapy OR Malignant melanoma and the request for coverage is within 56 days of surgery and the patient is at high risk of disease recurrence OR Diagnosis of chronic hepatitis B with compensated liver disease and patient has evidence of hepatitis B viral replication and patient has been serum hepatitis B surface antigen-positive for at least 6 months OR Diagnosis of chronic hepatitis C with compensated liver disease and is receiving combination therapy with ribavirin, unless ribavirin is contraindicated, and the medication will not be used as part of triple therapy with a protease inhibitor and patient has a clinical reason for not using peginterferon
Age Restrictions	1 year of age or older for HBV. 3 years of age or older for HCV. 18 years of age or older for other indications.
Prescriber Restrictions	None
Coverage Duration	Condylomata: 3 mos. HBV e antigen pos: 16 wks, e antigen neg: 48 wks. KS: 16 wks. Others: 12 mos
Other Criteria	None

IRESSA

Products Affected

- IRESSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ITRACONAZOLE

Products Affected

- *itraconazole oral capsule*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Ventricular dysfunction. Congestive heart failure (CHF). History of CHF. Concurrent therapy with a CYP3A4 inhibitor (e.g., cisapride, lovastatin, methadone, etc.)
Required Medical Information	Patient meets one of the following conditions: A) Diagnosis of systemic fungal infection (e.g., aspergillosis, histoplasmosois, blastomycosis) OR B) Diagnosis of onychomycosis confirmed by one of the following: positive potassium hydroxide (KOH) preparation, culture, or histology and the patient has extensive nail involvement causing significant pain and/or debilitation and Patient has tried or had a contraindication or intolerance to oral terbinafine OR C) Diagnosis of one of the following: tinea corporis (ringworm), tinea cruris (jock itch), tinea pedis (athlete's foot), tinea capitis (scalp ringworm), pityriasis versicolor and the patient is resistant to topical treatment.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Systemic infection: 6 months. Onychomycosis 2 months (fingernail), 3 months (toenail)
Other Criteria	None

IVIG

Products Affected

- GAMMAGARD INJECTION SOLUTION 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML
- GAMMAGARD S/D LESS IGA
- GAMMAKED INJECTION SOLUTION 1 GM/10ML
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	A) Acute corn or maltose hypersensitivity or hereditary fructose intolerance or hyperprolinemia, B) IgA deficiency with antibody formation and a history of hypersensitivity, C) history of anaphylaxis or severe systemic reaction to human immune globulin.
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	B vs D coverage determination per CMS guidelines

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Acute graft-versus-host disease: Diagnosis of acute graft-versus-host disease AND disease is refractory to steroid therapy. Myelofibrosis: Diagnosis of primary myelofibrosis, OR post-polycythemia vera myelofibrosis, OR post-essential thrombocythemia myelofibrosis. Polycythemia vera: Diagnosis of polycythemia vera, AND history of failure, contraindication, or intolerance to hydroxyurea.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

JYNARQUE

Products Affected

- JYNARQUE ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with anuria, history of hepatic disease or in patients with signs or symptoms of significant liver impairment (hepatotoxicity), uncorrected hyponatremia or hypernatremia, or hypovolemia.
Required Medical Information	Diagnosis of: A) Hypervolemic and euvolemic hyponatremia (i.e., serum sodium less than 125 mEq per L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction), including in patients with heart failure and syndrome of inappropriate antidiuretic hormone (SIADH) OR B) Autosomal dominant polycystic kidney disease (ADPKD).
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial - 3 months, Renewal - 12 months
Other Criteria	None

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis AND the patient has 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced benefit from therapy (i.e. improvement in pulmonary lung function [FEV1], decreased number of pulmonary exacerbations)

KINERET

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active infection, concurrent therapy with other biologics.
Required Medical Information	Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Kineret as first-line therapy with MTX for severely active RA. For diagnosis of CAPs, Kineret will be approved. For rheumatoid arthritis member needs trial or intolerance/contraindication to Humira and Enbrel.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For re-authorization, patient's condition must have improved or stabilized.

KISQALI

Products Affected

- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)
- KISQALI FEMARA(200 MG DOSE)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	KISQALI: Breast Cancer: A) Metastatic or advanced, HER-2 negative, hormone receptor-positive, postmenopausal women in combination with fulvestrant as initial endocrine based therapy or following disease progression on endocrine therapy, B) Metastatic or advanced, HER-2 negative, hormone receptor-positive, premenopausal, perimenopausal or postmenopausal women, in combination with an aromatase inhibitor for initial endocrine-based treatment. KISQALI FEMARA: HER-2 NEGATIVE, HORMONE RECEPTOR-POSITIVE ADVANCED OR METASTATIC BREAST CANCER IN PREMENOPAUSAL, PERIMENOPAUSAL OR POSTMENOPAUSAL WOMEN.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	12 months
Other Criteria	None

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of hyperglycemia secondary to endogenous Cushing's syndrome in patients who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Must be prescribed by or in consultation with an endocrinologist
Coverage Duration	12 months
Other Criteria	None

KUVAN

Products Affected

- KUVAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU). Appropriate for use in patients who: a) have been diagnosed with PKU, b) have a baseline blood Phe measured within 2 weeks prior to initiating therapy. Also require that the prescriber be a specialist with knowledge and expertise in metabolic diseases or genetic diseases or has consulted with a specialist in metabolic or genetic diseases. Initial approval will be for two months of therapy if the initial dose is 5 mg/kg/day to less than 20 mg/kg/day, it will be for one month if the initial dose is 20 mg/kg/day. Renewal for continued use will be for 6 months if patient response is seen based on prescriber determination.
Age Restrictions	1 month of age or older
Prescriber Restrictions	Specialist knowledgeable in the management of PKU
Coverage Duration	Initial Approval: 2 months. Extended Approval: 6 month intervals
Other Criteria	Blood Phe levels should be checked after 1 week of therapy and periodically up to one month during a therapeutic trial.

LENVIMA

Products Affected

- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer OR advanced renal cell carcinoma following one prior anti-angiogenic therapy in combination with everolimus OR unresectable hepatocellular carcinoma (HCC) OR diagnosis of advanced endometrial carcinoma, that is not microsatellite instability-high or mismatch repair deficient, in combination with pembrolizumab in patients who have disease progression following prior systemic therapy and are not candidates for surgery or radiation.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

LEUKINE

Products Affected

- LEUKINE INJECTION SOLUTION RECONSTITUTED
- LEUKINE INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Concurrent use with myelosuppresive chemotherapy or radiation or excessive (greater than or equal to 10%) leukemic myeloid blasts in bone marrow or peripheral blood
Required Medical Information	Diagnosis of one of the following: A) Patient has undergone allogeneic or autologous bone marrow transplant (BMT) and engraftment is delayed or failed OR B) Patient is undergoing autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis OR C) Medication will be used for myeloid reconstitution after an autologous or allogeneic BMT OR D) Patient has acute myeloid leukemia and administration will be after completion of induction chemotherapy
Age Restrictions	2 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

LEUPROLIDE

Products Affected

- ELIGARD
- *leuprolide acetate injection*
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) advanced or metastatic prostate cancer, B) Diagnosis of central precocious puberty and patient had early onset of secondary sexual characteristics (male: earlier than 9 years of age. female: earlier than 8 years of age) and advanced bone age of at least one year compared with chronological age and has undergone gonadotropin-releasing hormone agonist (GnRHa) testing with peak luteinizing hormone (LH) level above pre-pubertal range or random LH level in pubertal range and Patient had the following diagnostic evaluations to rule out tumors, when suspected: diagnostic imaging of the brain (MRI or CT scan), Pelvic/testicular/adrenal ultrasound, Human chorionic gonadotropin levels, Adrenal steroids to rule out congenital adrenal hyperplasia, C) the medication will be used for stimulation testing to confirm the diagnosis of central precocious puberty or D) management of endometriosis OR E) anemia caused by uterine leiomyomata
Age Restrictions	None
Prescriber Restrictions	CPP - Prescribed by or in consultation with a pediatric endocrinologist
Coverage Duration	12 months. CPP testing: one time dose.
Other Criteria	For renewal of CPP, LH levels have been suppressed to pre-pubertal levels and consideration for discontinuation of therapy when the patient is 11 years of age for girls and 12 years of age for boys.

LIDOCAINE EXT

Products Affected

- *lidocaine external ointment*
- *lidocaine hcl external solution*
- *lidocaine hcl urethral/mucosal external gel*
- *lidocaine-prilocaine external cream*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Amide hypersensitivity
Required Medical Information	For topical anesthesia of skin and mucous membranes
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

LIDOCAINE PATCH

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of pain associated with diabetic neuropathy OR pain asociated with cancer-related neuropathy OR post-herpetic neuralgia.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

LINEZOLID

Products Affected

- *linezolid intravenous solution 600 mg/300ml*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Linezolid should not be used concurrently or within 14 days of MAOI therapy.
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	VRE: 4 weeks. Nosocomial and community acquired pneumonia: 3 weeks. All other indications: 2 weeks
Other Criteria	None

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) metastatic colorectal cancer, previously treated with fluoropyrimidine, oxaliplatin, and irinotecan-based regimens, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy, or B.) metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least 2 prior lines of chemotherapy that include a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate HER2/neu-targeted therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For initial treatment: Absolute neutrophil count 1,500/mm(3) or greater or febrile neutropenia resolved, platelet count 75,000/mm(3) or greater, and grade 3 or 4 nonhematological reactions resolved to grade 0 or 1

LORBRENA

Products Affected

- LORBRENA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Current use of strong CYP3A inducers, due to potential for hepatotoxicity
Required Medical Information	Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) in patients which have disease progression on alectinib OR ceritinib OR crizotinib AND at least 1 other ALK inhibitor for metastatic disease
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

LYNPARZA

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement with diagnosis of 1) deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) advanced ovarian cancer and have been treated with 3 or more prior lines of chemotherapy OR 2) recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and have a complete or partial response to platinum-based chemotherapy OR 3) HER2-negative, deleterious or suspected deleterious germline BRCA mutated (gBRCAm) metastatic breast cancer and have been previously treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

MATULANE

Products Affected

- MATULANE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Severe bone marrow suppression.
Required Medical Information	Treatment of Hodgkins Lymphoma OR medulloblastoma in combination with nitrogen mustard, vincristine and prednisone OR high-grade malignant glioma in combination with lomustine and vincristine
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

MEKINIST

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Malignant melanoma: Diagnosis of unresectable or metastatic malignant melanoma in patients with BRAF V600E or V600K mutations and used as a single agent or in combination with dabrafenib OR asymptomatic brain metastases in patients with BRAF V600E- or V600K-mutation metastatic melanoma and no previous local brain-directed therapy, in combination with dabrafenib OR complete resection in patients with BRAF V600E or V600K mutation-positive melanoma and lymph node involvement, in combination with dabrafenib. Non-small cell lung cancer (NSCLC): Diagnosis of metastatic BRAF V600E mutation-positive NSCLC, in combination with dabrafenib. Thyroid cancer: Diagnosis of locally advanced or metastatic anaplastic thyroid cancer (ATC) in patients with the BRAF V600E mutation who have no satisfactory locoregional treatment options, in combination with dabrafenib.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

MEKTOVI

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable or metastic malignant melanoma with documented BRAF V600E or V600K mutation as detected by an FDA-approved test used in combination with encorfenib
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

METHOXSALEN

Products Affected

- *methoxsalen rapid*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Aphakia, melanoma or a history of melanoma, invasive squamous cell carcinomas, history of a light sensitive disease/skin photosensitivity disorder such systemic lupus erythematosus (SLE), porphyria cutanea tarda, erythropoietic protoporphyria, variegate porphyria, xeroderma pigmentosum, and albinism.
Required Medical Information	FOR the diagnosis of Psoriasis: Trial ad failure of 1 of the following: topical corticosteroid, calcipotriene, coaltar, or anthralin. FOR CTCL: trial and failure on bexarotene FOR Vitiligo: Trial and failure on either calcipotriene or fluocinolone.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, immunologist, or dermatologist
Coverage Duration	Initial 6 months, Renewal 12 months
Other Criteria	None

MIGLUSTAT

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of mild to moderate type 1 Gaucher disease and patient has tried and failed enzyme replacement therapy (trial of 30 days or less is acceptable) or unable to tolerate OR patient is not a suitable candidate for enzyme replacement therapy due to allergy, hypersensitivity or poor venous access
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

MODAFINIL

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome confirmed by sleep lab evaluation, e.g., multiple sleep latency test, polysomnography), B) excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine), OR C) excessive sleepiness associated with shift work disorder with a primary complaint of excessive sleepiness or insomnia which is temporally associated with a work period (usually night work) that occurs during the habitual sleep phase or polysomnography and the MSLT demonstrate loss of a normal sleep-wake pattern.
Age Restrictions	17 years of age and older
Prescriber Restrictions	None
Coverage Duration	OSA/hypopnea syndrome: 6 months (initial), 12 months (renewal). Other diagnoses: 12 months.
Other Criteria	None

MS INTERFERONS

Products Affected

- AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT
- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT
- PLEGRIDY
- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR
- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing form of multiple sclerosis (clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease) OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease)

MYTESI

Products Affected

- MYTESI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	CLINICAL NOTES TO SUPPORT A DIAGNOSIS OF CHRONIC DIARRHEA, DEFINED AS DIARRHEA PERSISTING FOR MORE THAN FOUR WEEKS, CAUSED BY THEIR MEDICATION REGIMEN OR HIV ENTEROPATHY PROVEN BY BIOPSY, AND NOT A VIRUS, PARASITE OR BACTERIUM AS EVIDENCED BY STOOL SAMPLE TAKEN IN THE PREVIOUS 3 MONTHS. PATIENT MUST HAVE TRIED AND FAILED OR HAD INTOLERANCE TO LOPERAMIDE OR DIPHENOXYLATE-ATROPINE TRIALS OF A MINIMUM OF 30 DAYS.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Infectious Disease Specialist or GI Consult for new starts
Coverage Duration	12 months
Other Criteria	None

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	1. Diagnosis of hypoparathyroidism, 2. Two consecutive serum Calcium levels less than 8.9 mg/dL
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	12 months
Other Criteria	None

NERLYNX

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of early stage HER2- overexpressed breast cancer. Must be used after trastuzumab therapy.
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

NEUPOGEN

Products Affected

- NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML
- NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE
- ZARXIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) congenital, cyclic, or idiopathic neutropenia, B) severe febrile neutropenia (FN) with the following: Has not received prophylactic pegfilgrastim and Used as adjunct to appropriate antibiotics in high-risk patients and any one of the following: 65 years or older, Uncontrolled primary disease, Pneumonia, Hypotension and multiorgan dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalization when developed fever, Prior FN, Severe (ANC less than 100/mcL) or anticipated prolonged (more than 10 days) neutropenia, C) Autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis, D) Undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT, E) Acute myeloid leukemia and will be given after completion of induction or consolidation chemotherapy, F) Acute lymphoblastic leukemia and will be given after completion of the first few days of chemotherapy of the initial induction or first post-remission course, G) Myelodysplastic syndrome with severe neutropenia and recurrent infection, H) Receiving radiation therapy, not on chemotherapy, and expected to have prolonged delays in treatment due to neutropenia, I) Neutropenia associated with HIV infection and antiretroviral therapy, J) Aplastic anemia, K)Primary prophylaxis of FN in one of the following patients: 20% or higher risk of FN based on chemotherapy regimen OR Less than 20% risk of FN based on chemotherapy regimen with one of the following: 65 years or older, Poor performance status, Poor nutritional status, Previous FN, Extensive prior treatment including large radiation ports, Cytopenias due to bone marrow involvement by tumor, Administration of combined chemoradiotherapy, Presence of open wounds or active infections, Other

PA Criteria	Criteria Details
	serious comorbidities (including renal or liver dysfunction) or Receiving dose-dense chemotherapy regimen in breast or small cell lung cancer or non-Hodgkins lymphoma.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NEXAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	squamous cell lung cancer being treated with carboplatin and paclitaxel.
Required Medical Information	Diagnosis of unresectable hepatocellular carcinoma OR Diagnosis of advanced renal cell carcinoma OR Diagnosis of locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment
Age Restrictions	18 years and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma, documentation of combination therapy with lenalidomide and dexamethasone. History of 1 prior therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NORTHERA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Prior authorization will be approved for the following indication(s): orthostatic dizziness, light-headedness, or the feeling that you are about to black out in adults with neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure (i.e., Parkinson disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NOXAFIL

Products Affected

- NOXAFIL ORAL
- *posaconazole*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant treatment with sirolimus, CYP 3A4 substrates that prolong QT interval (pimozide, quinidine), HMG-CoA Reductase inhibitors primarily metabolized through CYP 3A4, or ergot alkaloids
Required Medical Information	Diagnosis of oropharyngeal candidiasis and patient tried itraconazole and/or fluconazole OR Medication will be used as prophylaxis of invasive Aspergillus and Candida infections and the patient is at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy.
Age Restrictions	13 years of age or older for prophylaxis of invasive aspergillus or candidal infection
Prescriber Restrictions	None
Coverage Duration	12 weeks
Other Criteria	None

NUBEQA

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of non-metastatic, castration-resistant prostate cancer.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of severe asthma (eosinophilic phenotype) OR eosinophilic granulomatosis with polyangiitis (EGPA)
Age Restrictions	None
Prescriber Restrictions	Must be prescribed by a pulmonologist or immunologist
Coverage Duration	12 months
Other Criteria	None

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Diagnosis of heart failure, QT prolongation, congenital long QT syndrome, history suggestive of torsade de pointes, complete AV block without implanted pacemakers, high risk of complete AV block OR concurrent MAOI therapy or utlization within the preceeding 14 days of initiating Nuedexta.
Required Medical Information	Diagnosis of pseudobulbar affect.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced basal cell carcinoma of the skin and specific documentation of negative pregnancy status
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ONFI

Products Affected

- *clobazam*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of seizures associated with Lennox-Gastaut syndrome and documented treatment failure, intolerance, or contraindication to any one of the following: Clonazepam, Lamotrigine, or Topiramate.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of pulmonary arterial hypertension WHO group I AND diagnosis was confirmed by right heart catheterization AND female patients are enrolled in the OPSUMIT REMS program.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	None

ORENCIA

Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active infection (including TB). Concurrent therapy with other biologics.
Required Medical Information	Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis - Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Orencia as first-line therapy with MTX for severely active RA. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. For PAJIA, member needs trial or intolerance/contraindication to Humira. For RA, member needs trial or intolerance/contraindication to Humira and Enbrel.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For re-authorization, patient's condition must have improved or stabilized.

ORFADIN

Products Affected

- ORFADIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hereditary tyrosinemia type 1
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months if patient currently on a liver transplant list, otherwise 12 months
Other Criteria	None

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Initial Therapy: Diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test AND if less than 18 years of age, baseline ophthalmological exam completed. Continuation of therapy: Documentation patient is tolerating and responding to medication (i.e. improved FEV1, weight gain, decreased exacerbations, etc.)
Age Restrictions	Must be greater than or equal to 2 years of age
Prescriber Restrictions	Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation
Coverage Duration	12 months
Other Criteria	None

OSPHENA

Products Affected

- OSPHENA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia, acute thromboembolism or a past history of thromboembolic disease (including patients with a history of DVT, pulmonary embolism, retinal vein thrombosis, stroke, or myocardial infarction, known or suspected pregnancy.
Required Medical Information	Diagnosis of moderate to severe dyspareunia or atrophic vaginitis or moderate to severe vaginal dryness AND A) Patient must be female, B) Patient must be menopausal or postmenopausal, C) Patient has tried and failed, has a contraindication or intolerance to a low dose vaginal estrogen preparation (e.g. Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem), D) Dose must not exceed 1 tablet per day, E) Osphena will not be used with estrogens, estrogen agonist-antagonists, fluconazole or rifampin, F) Patient does not have hepatic impairment.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

OTEZLA

Products Affected

- OTEZLA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Plaque Psoriasis: Clinically diagnosed with plaque psoriasis involving 5% of body surface area AND failed, intolerant or contraindicated to both of the following: Humira and Enbrel. Psoriatic Arthritis: Clinically diagnosed with psoriatic arthritis AND failed, intolerant or contraindicated to both Humira and Enbrel. Oral Ulcers: Diagnosis of Behcet disease and member is being treated for ulcers of the mouth.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For re-authorization, patient is tolerating treatment and patient has disease stabilization or improve-ment in disease.

OTREXUP

Products Affected

- OTREXUP SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.4ML, 12.5 MG/0.4ML, 15 MG/0.4ML, 20 MG/0.4ML, 22.5 MG/0.4ML, 25 MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy, breastfeeding, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndrome, or preexisting blood dyscrasias
Required Medical Information	Diagnosis of Psoriasis or Rheumatoid Arthritis, including polyarticular juvenile idiopathic arthritis, AND documented trial and failure, contraindication, or intolerance to oral methotrexate.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

OXANDROLONE

Products Affected

- *oxandrolone oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Breast or prostate cancer in men. Breast cancer in women with hypercalcemia. Pregnancy. Nephrosis or nephrotic phase of nephritis. Hypercalcemia.
Required Medical Information	Patient is receiving treatment as an adjunct therapy to promote weight gain and has one of the following: Extensive surgery, Chronic infections, Severe trauma, Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons OR Oxandrin (oxandrolone) will be used to counterbalance protein catabolism associated with chronic corticosteroid administration OR Patient has bone pain associated with osteoporosis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Osteoporosis bone pain: 1 month. Other diagnoses: 3 months
Other Criteria	For renewal, patient has experienced an objective improvement (i.e. weight gain, increase in lean body mass, or reduction in muscle pain/weakness)

OXERVATE

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of A) Neurotrophic keratitis
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an Ophthalmologist or Optometrist
Coverage Duration	2 months
Other Criteria	None

PANRETIN

Products Affected

- PANRETIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cutaneous lesions in patients with AIDS-related Kaposi's sarcoma.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Oncologist or HIV specialist
Coverage Duration	12 months
Other Criteria	None

PCSK9 INHIBITOR

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- PRALUENT SUBCUTANEOUS SOLUTION PEN-INJECTOR
- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	For PRALUENT: MUST MEET CRITERIA #1 OR #3. For REPATHA: MUST MEET CRITERIA #1, #2, OR #3. 1. Diagnosis of primary hyperlipidemia or heterozygous familial hypercholesterolemia (HeFH) or utilized in myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD, 2. Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genotyping OR diagnosis based on the following: a. History of untreated LDL-C greater than 500 mg/dL AND xanthoma before 10 years of age OR b. Documentation of HeFH in both parents. 3. Diagnosis of clinical atherosclerotic cardiovascular disease as defined as one of the following: a. acute coronary syndrome, b. history of myocardial infarction, c. stable/unstable angina, d. coronary or other arterial revascularization, e. stroke, f. transient ischemic stroke, g. peripheral arterial disease presumed to be atherosclerotic region AND MEETS CRITERIA #4, #5, and #6. 4. Provide baseline and current LDL-C. 5. LDL-C greater than or equal to 70mg/dL. 6. Used in combination with maximally tolerated high-intensity statin OR MEETS CRITERIA #7 AND #8. 7. Statin intolerant 8. LDL-C greater than or equal to 70mg/dL. CONTINUING THERAPY: 1. Documented response to Praluent or Repatha, defined as ONE of the following: a. The patient is tolerating medication b. Will continue to be used in combination with maximally tolerated statin (unless statin intolerant).
Age Restrictions	Repatha: 13 years of age or older for diagnosis HoFM, Diagnosis CVD or HeFH AND Praluent or Repatha : 18 years of age or older

American Health Advantage of Oklahoma (HMO SNP)
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Prior Authorization Criteria

PA Criteria	Criteria Details
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist
Coverage Duration	Initial approval: 8 weeks, Renewal approval: 12 months
Other Criteria	None

PEGYLATED INTERFERON

Products Affected

- PEGASYS PROCLICK SUBCUTANEOUS SOLUTION 180 MCG/0.5ML
- PEGASYS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Uncontrolled depression. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon.
Required Medical Information	Chronic Hepatitis C: Criteria will be applied consistent with current AASLD-IDSA guidance OR Chronic Hepatitis B: Diagnosis of HBeAg-positive or HBeAg-negative infection
Age Restrictions	Hepatitis C: 5 years of age and older. Hepatitis B: 3 years of age and older.
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist, gastroenterologist, oncologist or infectious disease specialist
Coverage Duration	HepC: Initial: 28 wks. Reauth: 20 wks. HepB: 48 weeks
Other Criteria	None

PHENOXYBENZAMINE

Products Affected

- *phenoxybenzamine hcl oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of excessive sweating and hypertension associated with pheochromocytoma.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

PIQRAY

Products Affected

- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of hormone receptor (HR) positive, HER2-negative, PIK3CA-mutated, advanced or metastatic breast cancer and used in combination with fulvestrant for postmenopausal women, and men following progression on or after endocrine- based regimen.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Documentation of ALL of the following: 1. Disease has progressed within 60 days of completion of the last therapy 2. If female of reproductive potential ALL of the below: Two negative pregnancy tests obtained prior to initiating therapy with Pomalyst, monthly negative pregnancy tests during therapy 3. Patient has been counseled about the use of reliable contraception before, during, and 1 month after initiation of therapy with Pomalyst 4. Patient assessment to determine if prophylactic aspirin or antithrombic treatment (warfarin, clopidogrel) will need to be taken to reduce the risk of VTE (embolism, stroke) 5. Registered and certified to be compliant with Pomalyst REMS (Risk Evalutation and Mitigation Strategy) program
Age Restrictions	None
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	12 months
Other Criteria	A documented diagnosis of multiple myeloma and received at least two prior therapies including lenalidomide (Revlimid) and bortezomib (Velcade)

PREVYMIS

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Member is receiving pimozide or ergot alkaloids OR if member is receiving cyclosporine co-administered with pitavastatin or simvastatin.
Required Medical Information	Prescribed for cytomegalovirus (CMV) disease prophylaxis in CMV-seropositive recipients R+ or an allogeneic hematopoietic stem cell transplant (HSCT) in adult patients with or without concurrent cyclosporine. Dose should not exceed 480mg orally once daily throughout the course of therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an immunologist or infectious disease or transplant specialist or oncologist
Coverage Duration	Through day 100 post-transplantation
Other Criteria	None

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) Relapsed/refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) for greater than 6 months AND Baseline platelet count is less than 50,000/mcL AND Degree of thrombocytopenia and clinical condition increase the risk of bleeding AND Patient had an insufficient response, intolerance, contraindication to corticosteroids or immune globulin or inadequate response or contraindication to splenectomy, B)Chronic hepatitis C and patient has thrombocytopenia defined as platelets less than 90,000/mcL for initiation (pre-treatment) of interferon therapy, C) Severe aplastic anemia in patients who have had an insufficient response to immunosuppressive therapy OR in combination with standard immunosuppressive therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal of ITP, after at least 4 weeks of therapy at the maximum weekly dose (10 mcg/kg) the platelet count increased to a sufficient level to avoid clinically important bleeding. For renewal of Hepatitis C, platelets less than 75,000/mcL for maintenance of optimal interferon-based therapy.

PULMONARY FIBROSIS

Products Affected

- OFEV

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Idiopathic pulmonary fibrosis (IPF), or B.) Systemic sclerosis-associated interstitial lund disease (ILD)
Age Restrictions	None
Prescriber Restrictions	Prescriber must be a pulmonologist
Coverage Duration	12 months
Other Criteria	None

PULMOZYME

Products Affected

- PULMOZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations). Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

PURIXAN

Products Affected

- PURIXAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of acute lymphoblastic leukemia AND failure of mercaptopurine tablets unless contraindicated or clinically significant adverse effects are experienced, AND OR member has a documented swallowing disorder or an inability to swallow tablets or capsules, AND dose does not exceed 5 mg/kg/day.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

QUININE SULFATE

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Prolongation of QT interval. Glucose-6-phosphate dehydrogenase deficiency. Myasthenia gravis. Known hypersensitivity to mefloquine or quinidine. Optic neuritis. Diagnosis of Blackwater fever
Required Medical Information	Patient has a diagnosis of one of the following: A) uncomplicated Plasmodium falciparum malaria B) uncomplicated Plasmodium vivax malaria C) babesiosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	One month
Other Criteria	None

RANOLAZINE

Products Affected

- *ranolazine er*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Hepatic cirrhosis. Pre-existing QT prolongation. Concurrent therapy with a strong CYP3A4 inhibitor. Concurrent therapy with a CYP3A4 inducer.
Required Medical Information	Diagnosis of chronic angina AND patient has tried at least 2 combined anti-anginal therapies such as nitrates, beta-blockers, and calcium channel blockers OR unable to take full doses of conventional angina drugs due to low blood pressure and heart rate.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient had an objective response to therapy

RASUVO

Products Affected

- RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy or treatment of neoplastic diseases
Required Medical Information	Diagnosis of severe, active rheumatoid arthritis, polyarticular juvenile idiopathic arthritis or severe, recalcitrant, disabling psoriasis AND Failure or clinically significant adverse effects to generic methotrexate injection
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Neonates and infants younger than 2 months of age.
Required Medical Information	Diagnosis of urea cycle disorder involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamoylase (OTC), or argininosuccinic acid synthetase (AAS) confirmed via enzymatic, biochemical, or genetic testing.
Age Restrictions	2 months of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

REGRANEX

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diabetic Neuropathic Ulcers: Diabetic patient with ulcer wound. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Diabetic Neuropathic Ulcers: Maximum 5 months.
Other Criteria	None

REVLIMID

Products Affected

- REVLIMID
- THALOMID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of previously treated follicular lymphoma and medication will be used in combination with a rituximab product OR previously treated marginal zone lymphoma and medication will be used in combination with a rituximab product OR multiple myeloma and medication will be used in combination with dexamethasone OR diagnosis of multiple myeloma following autologous hematopoietic stem cell transplantation OR diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities OR diagnosis of mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib OR FOR THALOMID, DIAGNOSIS OF ERYTHEMA NODOSUM LEPROSUM (ENL) AND patient is enrolled in the REMS Program
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

RILUTEK

Products Affected

- *riluzole*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ROZLYTREK

Products Affected

- ROZLYTREK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) ROS1-positive metastatic non-small cell lung cancer (NSCLC), OR B) Solid tumors that 1) have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, AND 2) are metastatic or where surgical resection is likely to result in severe morbidity, AND 3) have either progressed following treatment or have no satisfactory alternative therapy
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of deleterious BRCA mutation (germline and or somatic) epithelial ovarian, fallopian tube, or primary peritoneal cancer and all of the following criteria: 1. BRCA mutation positive detected by an approved FDA laboratory test, 2. Previous trial/failure with two or more chemotherapy regimens, 3. Used as monotherapy, 4. Agreement of provider to perform a complete blood count at baseline and monthly thereafter, 5. Women of reproductive potential must use an effective method of contraception during therapy and for 6 months after last dose OR Diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and all of the following: 1. Complete or partial response to platinum-based chemotherapy, 2. Used as monotherapy, 3. Agreement of provider to perform a complete blood count at baseline and monthly thereafter, 4. Women of reproductive potential must use an effective method of contraception during therapy and for 6 months after last dose.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Hematologist or Oncologist
Coverage Duration	12 months
Other Criteria	None

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Angioedema
Required Medical Information	Diagnosis of treatment naive FLT3 mutation-positive acute myelogenous leukemia (AML) and must be used in combination with standard cytarabine and daunorubicin induction and consolidation therapy or diagnosis of systemic mastocytosis.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	12 months
Other Criteria	None

SABRIL

Products Affected

- *vigabatrin*
- VIGADRONE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) infantile spasms B) complex partial seizures and patient had an inadequate response to at least one generic first-line agents (carbamazepine, lamotrigine, levetiracetam, oxcarbazepine, valproic acid, divalproex sodium) and at least one adjunctive agent (carbamazepine, clobazam, gabapentin, lamotrigine, levitiracetam, oxcarbazepine, valproic acid, divalproex sodium, topiramate) AND patient and prescriber are enrolled in the SHARE restricted distribution program.
Age Restrictions	Seizures - 10 years of age or older. Infantile spasms - at least one month to 2 years of age
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

SAMSCA

Products Affected

- SAMSCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients requiring intervention to raise serum sodium urgently or to treat serious neurological symptoms, patients with hypovolemic hyponatremia, patients experiencing anuria or who are unable to respond to thirst, patients with pre-existing liver dysfunction or disease or Autosomal dominant polycystic kidney disease (ADPKD)
Required Medical Information	Diagnosis of clinically significant hypervolemic and euvolemic hyponatremia (i.e., serum sodium less than 125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction), including in patients with heart failure and syndrome of inappropriate antidiuretic hormone (SIADH).
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or a nephrologist.
Coverage Duration	12 months
Other Criteria	None

SANDOSTATIN

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of acromegaly and patient had an inadequate response or cannot be treated with surgical resection, pituitary irradiation, and/or bromocriptine mesylate at maximally tolerated doses OR Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea and flushing episodes OR Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal of acromegaly, IGF-1 level has normalized or improved. For renewal of metastatic carcinoid tumor, patient has improvement in diarrhea and flushing episodes. For renewal of vasoactive intestinal peptide tumor, improvement in diarrhea episodes.

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly AND History of failure to surgery or patient is not a candidate for surgery. Cushing's disease (initial): Diagnosis of endogenous Cushing's disease (i.e, hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Either pituitary surgery has not been curative for the patient OR patient is not a candidate for pituitary surgery. (Reauthorization): Documentation of positive clinical response to Signifor therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months trial. Reauthorization: 12 months if demonstrated benefit
Other Criteria	Cushing's disease (reauth): a clinically meaningful reduction in 24-hour urinary free cortisol levels or improvement in signs or symptoms of the disease. Acromegaly (reauth): patient's growth hormone (GH) level or insulin-like growth factor 1 (IGF-1) level for age and gender has normalized/improved

SILDENAFIL

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients who are currently on nitrate or nitrite therapy.
Required Medical Information	Clinical diagnosis of pulmonary hypertension WHO group I, patients with NYHA class II-IV.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Continuation of therapy: patient is tolerating and responding to medication and has improved exercise capacity or a delay in clinical worsening.

SIMPONI

Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall) OR failure, contraindication, or intolerance to methotrexate (Rheumatrex/Trexall). One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Patient is corticosteroid dependent (ie, an inability to successfully taper corticosteroids without a return of the symptoms of UC), OR history of failure, contraindication, or intolerance to one of the following: oral aminosalicylate, oral corticosteroid, azathioprine, 6-mercaptopurine. One of the following: Failure, contraindication, or intolerance to Humira (adalimumab), OR for continuation of prior Simponi therapy. All indications (Initial, reauth): Patient is not receiving Simponi in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)]. Patient is not receiving Simponi in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]. For a diagnosis of PsA, Patient is not receiving Simponi in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].

American Health Advantage of Oklahoma (HMO SNP)
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Prior Authorization Criteria

PA Criteria	Criteria Details
Age Restrictions	None
Prescriber Restrictions	RA, AS (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. UC (Initial): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	UC (Initial): 12 weeks. UC (Reauth): 12 months. RA, AS, PsA (Initial, reauth): 12 months
Other Criteria	All indications (Reauth): Documentation of positive clinical response to Simponi therapy.

SOLTAMOX

Products Affected

- SOLTAMOX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis for use. Documentation of inability to swallow tablet formulation.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

SOMATULINE DEPOT

Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of acromegaly AND Inadequate response to surgery and/or radiation therapy or patient cannot be treated with surgery and/or radiotherapy OR Diagnosis of gastroenteropancreatic neuroendocrine tumors OR Diagnosis of carcinoid syndrome
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient's IGF-1 levels has normalized or improved.

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	IV administration of Somavert, concomitant use of Sandostatin or Somatuline.
Required Medical Information	Diagnosis of acromegaly was confirmed by an elevated IGF-1 level or elevated GH level with a glucose tolerance test. Patient has tried and failed at least a 3 month trial of Sandostatin or Somatuline. For renewal, reduction in IGF-1 level from baseline.
Age Restrictions	None
Prescriber Restrictions	Endocrinologist
Coverage Duration	12 months
Other Criteria	None

SPRYCEL

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) that is newly diagnosed in the chronic phase OR Ph+ CML with resistance or intolerance to prior therapy, including imatinib OR Diagnosis of Ph+ acute lymphoblastic leukemia with resistance or intolerance to prior therapy OR Diagnosis of Ph+ acute lymphoblastic leukemia in combination with chemotherapy OR Gastrointestinal stromal tumors (GIST) after disease progression on Gleevec (imatinib) or Sutent (sunitinib)
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

STELARA

Products Affected

- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. Plaque psoriasis (Initial): One of the following: a) History of failure, contraindication, or intolerance (F/C/I) to Enbrel (etanercept) and Humira (adalimumab) OR b) for continuation of prior Stelara therapy. PsA (Initial): One of the following: a) History of failure, contraindication, or intolerance (F/C/I) to Enbrel (etanercept) and Humira (adalimumab) OR b) for continuation of prior Stelara therapy. For Crohn's disease, history of failure, contraindication, or intolerance (F/C/I) to Humira (adalimumab).
Age Restrictions	None
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	All uses (Initial, reauth): 12 months
Other Criteria	Reauthorization (all indications): Documentation of positive clinical response to Stelara therapy. All indications (initial, reauth): Patient is not receiving Stelara in combination with either of the following: Biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia

PA Criteria	Criteria Details
	(certolizumab), Simponi (golimumab), Otezla (apremilast)] or a Janus Kinase Inhibitor [eg, Xeljanz (toficitinib)].Patient is not receiving Stelara in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	A documented diagnosis of metastatic colorectal cancer AND documentation of prior therapy with ALL of the following per the indication: 1. (fluoropyrimidine-, oxaliplatin-, and irinotecan)-based chemotherapy 2. bevacizumab (Avastin) 3. panitumumab (Vectibix) OR cetuximab (Erbitux) (for KRAS mutation-negative patients only) OR a documented diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate (Gleevec) and sunitinib malate (Sutent) OR a documented diagnosis of hepatocellular carcinoma in patients previously treated with sorafenib (Nexavar).
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

SUTENT

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of renal cell carcinoma (RCC) and used for adjuvant treatment in patients at high risk of recurrence following nephrectomy or the treatment of advanced renal cell cancer OR Diagnosis of gastrointestinal stromal tumors after disease progression on or intolerance to Gleevec OR Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumors in a patient with unresectable locally advanced or metastatic disease.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

SYLATRON

Products Affected

- SYLATRON SUBCUTANEOUS KIT
  200 MCG, 300 MCG, 600 MCG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Autoimmune hepatitis. Hepatic decompensation (Child-Pugh score greater than 6 [Class B or C])
Required Medical Information	Melanoma: Diagnosis of melanoma with microscopic or gross nodal involvement AND The prescribed medication will be used as adjuvant therapy within 84 days of definitive surgical resection, including complete lymphadenectomy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis and patient is homozygous for the F508del mutation in the CFTR gene OR have at least 1 mutation in the CFTR gene that is responsive to Symdeko.
Age Restrictions	6 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	Initial-6 months, Renewal-12 months
Other Criteria	None

SYMLIN

Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Confirmed diagnosis of gastroparesis. Concurrent use of drugs that stimulate gastrointestinal motility. Recurrent severe hypoglycemia requiring assistance during the past 6 months. Presence of hypoglycemia unawareness. Poor compliance with current insulin regimen. Poor compliance with prescribed self-blood glucose monitoring. Hemoglobin A1c level higher than 9%.
Required Medical Information	Diagnosis of type 1 or type 2 diabetes mellitus AND Patient is taking concurrent mealtime insulin therapy (e.g., Humulin, Humalog, Novolin, Novolog)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, the patient had an objective response to therapy.

SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of seizures associated with Lennox-Gastaut syndrome and documented treatment failure, intolerance, or contraindication to any one of the following: Clonazepam, Lamotrigine, or Topiramate.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None

SYNAREL

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Synarel should not be administered to patients who are hypersensitive to GnRH, GnRH agonist analogues or any of the excipients of SYNAREL, have undiagnosed vaginal bleeding, are pregnant or may become pregnant as major fetal abnormalities were observed in rats (not applicable when used in invitro fertilization programs), are breast feeding.
Required Medical Information	Diagnosis of endometriosis OR precocious puberty.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

SYNRIBO

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic myelogenous leukemia AND patient has tried and failed or has a contraindication or intolerance to 2 tyrosine kinase inhibitors
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

SYPRINE

Products Affected

- *trientine hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Wilson's disease and intolerance to penicillamine
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Malignant melanoma: Diagnosis of unresectable or metastatic malignant melanoma in patients with BRAF V600E or V600K mutations and used as a single agent or in combination with trametinib OR asymptomatic brain metastases in patients with BRAF V600E- or V600K-mutation metastatic melanoma and no previous local brain-directed therapy OR complete resection in patients with BRAF V600E or V600K mutation-positive melanoma and lymph node involvement, in combination with trametinib. Non-small cell lung cancer (NSCLC): Diagnosis of metastatic BRAF V600E mutation-positive NSCLC, in combination with trametinib. Thyroid cancer: Diagnosis of locally advanced or metastatic anaplastic thyroid cancer (ATC) in patients with the BRAF V600E mutation who have no satisfactory locoregional treatment options, in combination with trametinib.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Tafinlar should not be used in patients with wild-type BRAF melanoma due to the potential risk of tumor promotion in these patients

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic, non-small cell lung cancer with one of the following: confirmed presence of T790M EGFR tumor mutation OR confirmed presence of epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R tumor mutations, as detected by an FDA-approved test.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

TAKHZYRO

Products Affected

- TAKHZYRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hereditary angioedema and used for prophylaxis
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist
Coverage Duration	12 months
Other Criteria	None

TALZENNA

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of deleterious or suspected deleterious germline BRCA-mutated HER2-negative locally advanced or metastatic breast cancer
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Long QT syndrome. Uncorrected hypokalemia. Uncorrected hypomagnesemia. Concomitant use with a drug known to prolong the QT interval or strong cytochrome P450 3A4 inhibitors
Required Medical Information	Diagnosis of newly diagnosed Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) in the chronic phase OR Diagnosis of Ph+ CML with resistance or intolerance to prior therapy that include imatinib.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

TAVALISSE

Products Affected

- TAVALISSE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of thrombocytopenia in patients with chronic idiopathic thrombocytopenic purpura (ITP) AND 1) have had an insufficient response to ONE previous therapy (e.g. corticosteroids, IVIG, anti-D immunoglobulin, Promacta, Nplate, Rituxan) OR 2) have undergone splenectomy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	Initial - 3 months, Renewal - 12 months
Other Criteria	Renewal will be approved if there has been an improvement in platelet count to a level sufficient to avoid clinically important bleeding per prescribing physician.

TAZORAC

Products Affected

- *tazarotene external*
- TAZORAC EXTERNAL CREAM 0.05 %
- TAZORAC EXTERNAL GEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of acne vulgaris and patient has tried an adequate trial with at least one other topical acne product (e.g., benzoyl peroxide, salicylic acid, clindamycin, erythromycin, adapalene, azelaic acid, and/or tretinoin) OR Diagnosis of stable moderate to severe plaque psoriasis and 20% or less body surface area involvement and patient has a contraindication or tried adequate trial with at least one other topical psoriasis product (e.g., medium to high potency corticosteroid and/or vitamin D analogs) AND females of child-bearing potential are using adequate birth control measures during therapy.
Age Restrictions	12 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TECFIDERA

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting MS or progressive-relapsing MS, or secondary-progressive MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TEFLARO

Products Affected

- TEFLARO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with known serious hypersensitivity to ceftaroline or other cephalosporin hypersensitivity.
Required Medical Information	Diagnosis of acute bacterial skin and skin structure infection or community acquired pneumonia AND A) Patient has been started and stabilized on Teflaro while in the hospital or has documented sensitivity to Teflaro, AND B) Patient has a contraindication, intolerance, drug-drug interaction, or a history of treatment failure with first-line antibiotics.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	1 week for community-acquired pneumonia, 2 weeks for other diagnoses
Other Criteria	B vs D coverage determination per CMS guidelines

TEGSEDI

Products Affected

- TEGSEDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	One of the following A) Platelet count less than 100,000 per microliter OR B) urinary protein to creatinine ratio (UPCR) of 1000 mg/g or higher
Required Medical Information	Diagnosis of A) Polyneuropathy of hereditary transthyretin-mediated amyloidosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Tegsedi REMS program enrollment

TESTOSTERONE

Products Affected

- *methyltestosterone oral*
- *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml*
- *testosterone enanthate intramuscular solution*
- *testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Known or suspected carcinoma of the prostate
Required Medical Information	Diagnosis of hypogonadism (primary or hypogonadotropic) AND patient is male AND patient's serum testosterone (total or free) value and the laboratory reference value range reported by laboratory service AND diagnosis has been confirmed by a low-for-age serum testosterone (total or free) level defined by the normal laboratory reference value OR Diagnosis of inoperable metastatic (skeletal) mammary cancer in women
Age Restrictions	12 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient experienced an objective response to therapy.

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Actively suicidal. Untreated or inadequately treated depression. Impaired hepatic function. Concomitant use of monoamine oxidase inhibitors. Concomitant use of reserpine or within 20 days of discontinuing reserpine.
Required Medical Information	Diagnosis of chorea associated with Huntington's disease AND any medication possibly contributing to the underlying symptoms of chorea has been discontinued (e.g., antipsychotics, metoclopramide, amphetamines, methylphenidate, dopamine agonists, etc.) unless cessation would be detrimental to the underlying condition AND patient has been genotypes to CYP2D6 to determine whether the patient is a poor, intermediate or extensive metabolizer.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Dosing will be approved per the FDA labeling based on CYP2D6 testing. For renewal, patient had an objective response to therapy.

TIBSOVO

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Acute myeloid leukemia in relapsed or refractory patients, with susceptible isocitrate dehydrogenase-1 mutation, or B.) Acute myeloid leukemia in newly-diagnosed patients, with susceptible isocitrate dehydrogenase-1 mutation AND one of the following 1.) patient is 75 years or older , or 2.) patient has comorbidities that preclude intensive induction chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	12 months
Other Criteria	None

TIGLUTIK

Products Affected

- TIGLUTIK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TOPICAL RETINOIDS

Products Affected

- *adapalene external cream*
- *adapalene external gel*
- AVITA
- *tretinoin external cream*
- *tretinoin external gel 0.01 %, 0.025 %*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of mild to moderate acne vulgaris
Age Restrictions	PA applies to patients older than 26 years of age
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, medication has been effective in treating the patient's condition.

TOREMIFENE

Products Affected

- *toremifene citrate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic breast cancer and patient must have previous inadequate response or intolerance to tamoxifen
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	6 months
Other Criteria	None

TRACLEER

Products Affected

- TRACLEER ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Receiving concomitant cyclosporine A or glyburide therapy. Aminotransferase elevations are accompanied by signs or symptoms of liver dysfunction or injury or increases in bilirubin at least 2 times the upper limit of normal.
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH AND Patient has New York Heart Association (NYHA) Functional Class II-IV AND pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with two forms of reliable contraception in female patients of reproductive potential.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	Liver aminotransferases will be measured prior to initiation of treatment and then monthly.

TRELSTAR

Products Affected

- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of FDA approved indications not otherwise excluded from Part D AND palliative treatment of advanced prostate cancer, central precocious puberty, endometrial hyperplasia, endometriosis, fibrocystic disease of breast, uterine leiomyoma
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TURALIO

Products Affected

- TURALIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

TYKERB

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of breast cancer with tumors that overexpress human epidermal growth factor receptor 2 (HER2) AND a) the medication will be used in combination with Xeloda in a patient with advanced or metastatic disease and the patient has received prior therapy including an anthracycline, a taxane, and trastuzumab or b) The medication will be used in combination with Femara for the treatment of a postmenopausal woman with hormone receptor-positive metastatic disease for whom hormonal therapy is indicated.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients at increased risk of osteogenic sarcoma.
Required Medical Information	Diagnosis of osteoporosis in post-menopausal women at high risk for fracture. Member must have failed therapy with a bisphosphonate (defined by a fracture while on therapy or worsening bone density) unless such a trial is shown to be inappropriate or contraindicated (i.e., presence of severe osteoporosis [T-scores -3.0 or worse in lumbar spine, femoral neck, or total hip region], history of major osteoporotic fracture, presence of renal insufficiency, etc) AND member has at least one of the following: T-score equal to or worse than -2.5 in the lumbar spine, femoral neck, or total hip region OR a FRAX calculator based 10-year risk of at least 20% for a major osteoporotic fracture (spine, shoulder, hip, or wrist), or a 10-year risk of at least 3% for a hip fracture OR presence or history of osteoporotic fracture.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 12 months. Reauth: Treatment duration has not exceeded 24 months during patient lifetime.
Other Criteria	None

UPTRAVI

Products Affected

- UPTRAVI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization AND patient has tried and had an insufficient response to at least one other PAH agent (e.g., sildenafil) therapy and one other ERA agent (e.g. letairis, opsumit, tracleer).
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Stage 1A or 1B mycosis fungoides-type cutaneous T-cell lymphoma AND patient was intolerant or refractory to at least one prior skin-directed therapy such as topical corticosteroids, phototherapy, or topical nitrogen mustard.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Initial 6 months, Renewal 12 months
Other Criteria	None

VARIZIG

Products Affected

- VARIZIG INTRAMUSCULAR SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of hypersensitivity (including anaphylaxis or severe systemic reaction) to immune globulin or any component of the preparation. Severe thrombocytopenia or coagulation disorder where IM injections are contraindicated.
Required Medical Information	To be used for post-exposure varicella infection prophylaxis to reduce varicella severity in high-risk patients defined as premature neonates, neonates and infants less than 1 year old, pregnant women, newborns of women with varicella shortly before or after delivery, immunocompromised children and adults without a past history of varicella unless the patient is undergoing a bone marrow transplantation, and adults without evidence of immunity.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None

VARUBI

Products Affected

- VARUBI ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis for delayed chemotherapy-induced nausea/vomiting prophylaxis, in combination with other antiemetic agents.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	B vs D coverage determination per CMS guidelines

VENCLEXTA

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of A) chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), or B) Newly-diagnosed acute myeloid leukemia (AML) and used in combination with azacitidine, decitabine or low-dose cytarabine in patients 75 years or older, OR in patients that have comorbidities that preclude use of intensive induction chemotherapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	BREAST CANCER (1) Patient must have a diagnosis of advanced or metastatic breast cancer AND (2a) must be used in combination with fulvestrant for the treatment of disease progression following endocrine therapy OR (2b) used as monotherapy for treatment of disease progression following endocrine therapy and patient has already received at least one prior chemotherapy regimen of Ibrance or Kisqali OR (2c) used as initial endocrine-based treatment in combination with an aromatase inhibitor AND (3) disease is hormone receptor positive AND human epidermal growth factor 2 (HER2)- negative
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

VITRAKVI

Products Affected

- VITRAKVI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of A) Solid tumors that have a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, and have no satisfactory alternative treatments or that have progressed following treatment
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist
Coverage Duration	12 months
Other Criteria	None

VIZIMPRO

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic non-small cell lung cancer with confirmed epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced/metastatic renal cell carcinoma OR Diagnosis of advanced soft tissue sarcoma and patient received at least one prior chemotherapy (e.g., doxorubicin, dacarbazine, ifosfamide, epirubicin, docetaxel, or vinorelbine).
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic (stage III or IV) non-small cell lung cancer AND patient has non-squamous cell histology AND Patient has anaplastic lymphoma kinase (ALK)-positive disease as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility or are ROS1-positive
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

XELJANZ

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Psoriatic arthritis (PsA) or Rheumatoid arthritis (RA) (Initial): Diagnosis of psoriatic arthritis or moderately to severely active RA and an inadequate response or intolerance to methotrexate AND One of the following: Failure, contraindication, or intolerance to Enbrel (etanercept) OR Humira (adalimumab), OR patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-IV-TR 300.29 for specific phobia diagnostic criteria), OR for continuation of prior tofacitinib therapy. Patient is not receiving tofacitinib in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving tofacitinib in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine). Ulcerative colitis (UC) (Initial): Diagnosis of moderate to severe ulcerative colitis and patient had inadequate response, intolerance or contraindication to therapy with two of the following: corticosteroids, OR 5-ASA (eg, mesalamine, sulfasalazine, balsalazide), OR non-biologic DMARDs (azathioprine, cyclosporine, hydroxychloroquine, leflunomide, penicillamine, sulfasalazine), OR Humira.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist or gastroenterologist.
Coverage Duration	12 months
Other Criteria	Reauthorization: Documentation of positive clinical response to tofacitinib therapy. Patient is not receiving tofacitinib in combination with a biologic

PA Criteria	Criteria Details
	DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving tofacitinib in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine).

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Hypocalcemia (calcium less than 8.0 mg/dL).
Required Medical Information	Diagnosis of hypercalcemia of malignancy, refractory to bisphosphonate therapy OR diagnosis of giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity OR treatment used for prevention of skeletal-related events in patients with multiple myeloma or bone metastases from solid tumors.
Age Restrictions	13 years and older for treatment of giant cell tumor of the bone, 18 years and older for all other indications
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Documentation of the following: A)moderate to severe chronic idiopathic urticaria and has remained symptomatic despite at least 2 weeks of H1 antihistamine therapy OR intolerance or contraindication of H1 antihistamine therapy OR B)Mod-severe persistent asthma (NHLBI definition) meeting all the following criteria: Evidence of reversible disease (12% or greater improvement in FEV1 with at least a 200ml increase or 20% or greater improvement in PEF as a result of a short-acting bronchodilator challenge). Evidence of specific allergic sensitivity to a perennial aeroallergen (+ skin test or in vitro test). Failure of an adequate trial of standard therapy as defined by a trial of at least a 3 month course of high-dose inhaled corticosteroids and long-acting beta2-agonists OR maximally tolerated doses of standard therapy OR intolerance or contraindication to standard therapy. Extended approval for 6 months if demonstrated benefit, meeting at least 2 of the following criteria: PEF improvement (12% or greater from baseline (prior to start of Xolair)), OR FEV1 improvement (12% or greater from baseline (prior to start of Xolair)), OR reduction in symptoms (wheezing, sob, cough, chest tightness), OR reduction in systemic corticosteroids and rescue drug use, OR reduction of asthma-related hospitalizations and other medical contacts.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Allergist, immunologist, pulmonologist or dermatologist
Coverage Duration	Initial: 6 months trial. Extended approval: 6 months if demonstrated benefit

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PA Criteria	Criteria Details
Other Criteria	If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

XOSPATA

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of A) Acute myeloid leukemia, relapsed or refractory, with presence of FLT3 mutation as detected by an FDA-approved test
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist or Hematologist
Coverage Duration	12 months
Other Criteria	None

XPOVIO

Products Affected

- XPOVIO (100 MG ONCE WEEKLY)
- XPOVIO (60 MG ONCE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY)
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsed or refractory multiple myeloma being used in combination with dexamethasone in patient who has received at least 4 prior therapies and is refractory to at least 2 proteasome inhibitors, at least 2 immunomodulatory agents, and an anti-CD38 monoclonal antibody.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	A) Diagnosis of metastatic or non-metastatic castration-resistant prostate cancer (CRPC), B) History of failure, contraindication or intolerance to Zytiga (abiraterone) (for metastatic castration-resistant prostate cancer only).
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant treatment with sedative hypnotic agents. Succinic semialdehyde dehydrogenase deficiency.
Required Medical Information	Diagnosis of narcolepsy with excessive daytime sleepiness, cataplexy or both and for patients with excessive daytime sleepiness, patient has had a previous trial with or has a contraindication, intolerance, or allergy to Provigil or Nuvigil.
Age Restrictions	7 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, the patient had a positive response to the medication (increased sleep quality for patients with narcolepsy)

YONSA

Products Affected

- YONSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	A) Diagnosis of metastatic castration-resistant prostate cancer, and used in combination with methylprednisolone, B) Documented history of trial with, inadequate treatment response, adverse event, or contraindication to Zytiga (abiraterone).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None

ZEJULA

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer and patient had a complete or partial response to platinum-based chemotherapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist or gynecologist
Coverage Duration	12 months
Other Criteria	None

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable or metastatic melanoma and patient has positive BRAF-V600E mutation documented by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility OR Diagnosis of Erdheim-Chester Disease with BRAF V600 mutation
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cutaneous T-cell lymphoma AND progressive, persistent or recurrent disease or patient is not a candidates for or following 2 systemic therapies (e.g., bexarotene, romidepsin, etc.)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ZORTRESS

Products Affected

- ZORTRESS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Medication is being used for: A) Prevention of kidney transplant organ rejection AND patient is at low-to-moderate immunologic risk AND member is prescribed concurrent therapy with reduced doses of cyclosporine and corticosteroids, or B) Prevention of liver transplant organ rejection AND 30 or more days have passed since the transplant procedure AND the member is prescribed concurrent therapy with reduced doses of tacrolimus and corticosteroids
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescriber is experienced in immunosuppressive therapy and management of transplant patients.
Coverage Duration	12 months
Other Criteria	Part B if transplant covered by Medicare. otherwise Part D

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The patient has one of the following diagnoses: A) chronic lymphocytic leukemia AND The medication will be used in combination with rituximab AND The patient has relapsed on at least one prior therapy (e.g., purine analogues [fludarabine, pentostatin, cladribine], alkylating agents [chlorambucil, cyclophosphamide], or monoclonal antibodies [rituximab]) AND the patient does not have any co-morbidities that prevents the use of cytotoxic chemotherapy (i.e. severe neutropenia or thrombocytopenia, creatinine clearance less than 60 mL/minute), B) follicular lymphoma AND the patient has relapsed on at least two prior systemic therapies (e.g., rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine]), or C) small lymphocytic lymphoma AND The patient has relapsed on at least two prior systemic therapies(e.g., rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine]).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ZYTIGA

Products Affected

- *abiraterone acetate*
- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic prostate cancer, castration-resistant or high-risk, castration-sensitive and Zytiga (abiraterone) will be used in combination with prednisone.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

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PART B VERSUS PART D

Products Affected

- ABELCET
- *acetylcysteine inhalation*
- *acyclovir sodium intravenous solution*
- *albuterol sulfate inhalation*
- AMBISOME
- *amikacin sulfate injection solution 500 mg/2ml*
- AMINOSYN II INTRAVENOUS SOLUTION 10 %
- AMINOSYN-PF
- *amphotericin b intravenous*
- *ampicillin-sulbactam sodium injection solution reconstituted 15 (10-5) gm*
- *ampicillin-sulbactam sodium intravenous solution reconstituted 15 (10-5) gm*
- *aprepitant*
- ASTAGRAF XL
- AZACTAM
- AZASAN
- *azathioprine oral*
- *azithromycin intravenous*
- BACTOCILL IN DEXTROSE
- *budesonide inhalation*
- *calcitonin (salmon)*
- *calcitriol oral*
- *cefoxitin sodium intravenous*
- *ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg*
- *cinacalcet hcl*
- *ciprofloxacin in d5w intravenous solution 200 mg/100ml*
- *clindamycin phosphate injection solution 300 mg/2ml, 900 mg/6ml*
- CLINIMIX E/DEXTROSE (2.75/5)
- CLINIMIX E/DEXTROSE (4.25/10)
- CLINIMIX E/DEXTROSE (4.25/5)
- CLINIMIX E/DEXTROSE (5/15)
- CLINIMIX E/DEXTROSE (5/20)
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- CLINIMIX/DEXTROSE (5/20)
- CLINIMIX/DEXTROSE (5/25)
- CLINISOL SF
- *cromolyn sodium inhalation*
- *cyclophosphamide oral capsule*
- *cyclosporine modified*
- *cyclosporine oral capsule*
- DEPO-MEDROL
- DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML
- *dexamethasone sodium phosphate injection solution 120 mg/30ml, 20 mg/5ml, 4 mg/ml*
- *dextrose intravenous solution 10 %, 5 %*
- *dextrose-nacl intravenous solution 10-0.2 %, 10-0.45 %, 2.5-0.45 %, 5-0.2 %, 5-0.225 %, 5-0.33 %, 5-0.45 %, 5-0.9 %*
- *diphtheria-tetanus toxoids dt*
- DOXY 100
- ENGERIX-B INJECTION
- ENVARSUS XR
- ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG
- *fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%*
- FREAMINE HBC
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- GENGRAF ORAL SOLUTION
- *granisetron hcl oral*
- HEPATAMINE
- *imipenem-cilastatin*
- IMOVAX RABIES
- INTRALIPID
- IONOSOL-MB IN D5W
- *ipratropium bromide inhalation*

- *ipratropium-albuterol*
- ISOLYTE-P IN D5W
- ISOLYTE-S
- *kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%-%, 20-5-0.2 meq/l-%-%, 20-5-0.33 meq/l-%-%, 20-5-0.45 meq/l-%-%, 20-5-0.9 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%, 40-5-0.9 meq/l-%-%*
- *kcl-lactated ringers-d5w*
- *lactated ringers intravenous*
- *levofloxacin in d5w intravenous solution 500 mg/100ml, 750 mg/150ml*
- *levofloxacin intravenous*
- *meropenem*
- *methotrexate oral*
- *methotrexate sodium (pf) injection solution 50 mg/2ml*
- *methotrexate sodium injection solution 250 mg/10ml*
- *methylprednisolone acetate injection suspension 40 mg/ml, 80 mg/ml*
- *methylprednisolone sodium succ injection solution reconstituted 125 mg, 40 mg*
- *metronidazole in nacl intravenous solution 500-0.79 mg/100ml-%*
- *moxifloxacin hcl in nacl*
- *mycophenolate mofetil*
- *mycophenolate sodium*
- NEBUPENT
- NEPHRAMINE
- NORMOSOL-M IN D5W
- NORMOSOL-R IN D5W
- NORMOSOL-R PH 7.4
- *nutrilipid*
- *oxacillin sodium in dextrose*
- *paricalcitol oral*
- *penicillin g sodium*
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- *piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm*
- PLASMA-LYTE 148
- PLASMA-LYTE A
- PLENAMINE
- *potassium chloride in dextrose intravenous solution 20-5 meq/l-%, 40-5 meq/l-%*
- *potassium chloride in nacl intravenous solution 20-0.45 meq/l-%, 20-0.9 meq/l-%, 40-0.9 meq/l-%*
- *potassium chloride intravenous solution 10 meq/100ml, 2 meq/ml, 2 meq/ml (20 ml), 20 meq/100ml, 40 meq/100ml*
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- PROSOL
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- RECOMBIVAX HB
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- *sirolimus oral*
- *sodium chloride intravenous solution 0.45 %, 0.9 %, 3 %, 5 %*
- *sodium lactate intravenous solution 5 meq/ml*
- SOLU-MEDROL
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- TDVAX
- TENIVAC
- *tigecycline*
- TPN ELECTROLYTES INTRAVENOUS SOLUTION
- TRAVASOL
- TREXALL
- *triamcinolone acetonide injection suspension 40 mg/ml*
- TROPHAMINE INTRAVENOUS SOLUTION 10 %
- TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE
- *vancomycin hcl in dextrose intravenous solution 750-5 mg/150ml-%*
- *vancomycin hcl in nacl intravenous solution 1-0.9 gm/200ml-%, 500-0.9 mg/100ml-%, 750-0.9 mg/250ml-%*

- *vancomycin hcl intravenous solution reconstituted 1 gm, 250 mg, 500 mg, 750 mg*
- *voriconazole intravenous*
- XATMEP
- ZERBAXA
- ZOSYN INTRAVENOUS SOLUTION 2-0.25 GM/50ML, 3-0.375 GM/50ML

Details

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

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