MEDICATION(S)
ACTIMMUNE

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for 1 year.

OTHER CRITERIA
N/A
MEDICATION(S)
ADEMPAS

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Adempas is contraindicated during pregnancy.

REQUIRED MEDICAL INFORMATION
For initiation of single agent treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.
For the approval of combination therapy with other PAH medications, the provider should identify the physiologic or functional endpoint that would be considered successful and report success within three months for continued prior authorization approval.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a Pulmonologist or Cardiologist

COVERAGE DURATION
Initial: 3 months, up to 6 months. Reauthorization: 12 months.

OTHER CRITERIA
For the treatment of Pulmonary Arterial Hypertension, the following criteria must be documented:
1. Catheterization-proven diagnosis of Pulmonary Arterial Hypertension as defined by: a. Mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest or greater than 30 mmHg with exercise, AND b. Pulmonary capillary wedge pressure (PCWP) less than 15 mmHg
MEDICATION(S)
AFINITOR, AFINITOR DISPERZ

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an oncologist.

COVERAGE DURATION
Initial: 3 months, up to 6 months. Reauthorization: 6 months.

OTHER CRITERIA
NA
MEDICATION(S)
ALECENSA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
N/A
ALLERGENS

MEDICATION(S)
GRASTEK, ORALAIR, RAGWITEK

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
These allergen extracts must be prescribed by or in consultation with an Allergist, an Immunologist, an Otolaryngologist or other physician currently providing subcutaneous immunotherapy to patients in their practice.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
For treatment with sublingual immunotherapy, patients must meet all the following for initial authorization: 1. Diagnosis of allergic rhinitis, with or without conjunctivitis, if the member remains symptomatic when treated with two conventional formulary allergy medications (e.g. levocetirizine, fluticasone nasal spray) AND 2. Documentation that the sublingual immunotherapy will begin at least 12 weeks (for Grastek or Ragwitek) before the start of the allergy season. AND 3. Documentation of a positive skin test to the relevant perennial aeroallergen. AND 4. No other allergens are being treated concurrently with subcutaneous immunotherapy.
**MEDICATION(S)**
DONEPEZIL HCL 23 MG TABLET, NAMENDA XR

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D

**EXCLUSION CRITERIA**
NA

**REQUIRED MEDICAL INFORMATION**
Diagnosis of AD as defined by DSM-IV criteria and MMSE OR SLUMS exam. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
Not approved for pediatrics.

**PRESCRIBER RESTRICTION**
NA

**COVERAGE DURATION**
Initial: 3 months, up to 6 months. Reauthorization: 12 months.

**OTHER CRITERIA**
1. Patients should have documented in their medical record a diagnosis of AD (Alzheimer's dementia) according to the criteria of the Diagnostic and Statistical Manual IV (American Psychiatric Association, 1994). 2. Have moderate to severe AD as defined by a Mini-Mental State Exam (MMSE) or Saint-Louis University Mental Status (SLUMS) Exam of less than 20. 3. Must be able to perform with minor assistance at least one self-care ADL (activity of daily living) as defined by toileting, feeding, grooming, ambulation, bathing, or dressing. If unable to perform any of the self-care ADL or fully dependent on all of those ADL, patient would not be a good candidate for therapy. Ongoing authorization for six month durations will require documentation that patient is still able to perform with minor assistance at least one self-care ADL and that there has been documented benefit from the medication.
MEDICATION(S)
AMPYRA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
25-foot walk test. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a Neurologist.

COVERAGE DURATION
Initial authorization will be for 3 months and reauthorization will be approved for 1 year.

OTHER CRITERIA
1. Documentation of a baseline timed 25-foot walk test. Reauthorization will require documentation that 
2. Patient has improvement of at least one activity of daily living AND 2. Improved completion of the 
25-foot walk test from baseline following an initial trial of therapy (one month or more) to determine that 
the patient is a responder to therapy. Annual reauthorization will require documentation of continued 
clinical benefit.
ANTI-INFECTIVE AGENTS

**MEDICATION(S)**
DALVANCE, ORBACTIV, SIVEXTRO

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consultation with an infectious disease specialist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for 30 days subject to criteria.

**OTHER CRITERIA**
Documentation of medical necessity from an infectious disease specialist provider.
MEDICATION(S)
APOKYN

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Concomitant use with any of the 5HT3 receptor antagonists -(eg. ondansetron, granisetron, dolasetron, or palonosetron).

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist specializing in movement disorders/Parkinson's Disease.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
1. Patient has significant "off" episodes lasting at least 2 hours AND 2. Patient is on the maximum tolerable dose of levodopa and one of the following: a. Selegiline (Eldepryl: max dose = 10 mg/day) b. Ropinirole (Requip: max dose = 24 mg/day) c. Pramipexole (Mirapex: max dose = 4.5 mg/day) d. Entacapone (Comtan: max dose = 1,600 mg/day) e. Rasagiline (Azilect: max dose= not well established, usual dose= 1mg daily)
MEDICATION(S)
ARCALYST

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for adults and children 12 years and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization may be approved for 1 yr.

OTHER CRITERIA
Member must meet all criteria below for initial approval: Diagnosis of Cryopyrin-Associated Periodic Syndrome (CAPS) confirmed by: a. Laboratory evidence of genetic mutation NLRP-3 (Nucleotide-binding domain, leucine rich family (NLR) pyrin domain containing 3) or CIAS1 (Cold-Induced Auto-inflammatory Syndrome-1), and b. Classic symptoms associated with Familial Cold Auto-Inflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS) recurrent intermittent fever and rash typically associated with natural or artificial cold. Reauthorization: Documentation submitted of improvement of CAPS symptoms, such as fever, urticaria-like rash, arthralgia, myalgia, fatigue, and conjunctivitis.
MEDICATION(S)
AUBAGIO, GILENYA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Aubagio: Severe hepatic impairment. Gilenya: Recent (less than 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or class III/IV heart failure. The use of Aubagio and Gilenya in combination with other multiple sclerosis disease modifying therapy has not been studied and concomitant use with other MS medications will not be covered.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a neurologist.

COVERAGE DURATION
Initial authorization for six months and reauthorization will be approved for one year.

OTHER CRITERIA
Documentation of trial and failure, contraindication, or intolerance to 1 of the following 5 drug therapies: interferon beta-1a (Avonex), interferon beta-1a (Rebif), interferon beta-1a (Plegridy), glatiramer acetate (Copaxone), or dimethyl fumarate (Tecfidera), OR medical rationale why primary therapies cannot be tried.
MEDICATION(S)
AURYXIA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documented trial, failure, intolerance or contraindication to calcium acetate (Phoslo).
AVASTIN

MEDICATION(S)
AVASTIN

COVERED USES
All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist.

COVERAGE DURATION
Initial: 3 months, up to 6 months. Reauthorization: 6 months.

OTHER CRITERIA
NA
MEDICATION(S)
BANZEL

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Use for the treatment of neuropathic pain.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for children 1 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 3 months, up to 12 months. Reauthorization: 12 months.

OTHER CRITERIA
Documentation of trial and failure, intolerance or contraindication to two (2) of the following anti-epileptic medications: sodium valproate, topiramate and/or lamotrigine as adjunctive treatment. OR Prescriber is a neurologist.
MEDICATION(S)
PHENOBARBITAL 100 MG TABLET, PHENOBARBITAL 15 MG TABLET, PHENOBARBITAL 16.2
MG TABLET, PHENOBARBITAL 20 MG/5 ML ELIX, PHENOBARBITAL 20 MG/5 ML SOLN,
PHENOBARBITAL 30 MG TABLET, PHENOBARBITAL 32.4 MG TABLET, PHENOBARBITAL 60 MG
TABLET, PHENOBARBITAL 64.8 MG TABLET, PHENOBARBITAL 97.2 MG TABLET

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical
rationale are required and for continuation of therapy, ongoing documentation of successful response
to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 1 year.

OTHER CRITERIA
1. Member is less than 65 years of age OR 2. For use in epilepsy: documented trial, failure,
contraindication or intolerance to at least two formulary anticonvulsant agents or medical rationale is
provided why formulary anticonvulsants are not indicated. AND For all FDA-approved indications,
prescribing provider indicates that medical benefits exceed the risks associated with these
medications.
**BENLYSTA**

**MEDICATION(S)**
BENLYSTA

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
Belimumab will not be approved if any of the following are present: 1. Severe active lupus nephritis (presence of proteinuria of greater than or equal to 3.5gm/day). 2. Severe active Central Nervous System Lupus. 3. Current use of other biologic immunomodulator. 4. Current use of IV cyclophosphamide.

**REQUIRED MEDICAL INFORMATION**
Antinuclear antibody (ANA), anti-dsDNA. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consultation with a Rheumatologist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for 6 months.

**OTHER CRITERIA**
All of the following must be met: 1. Documented diagnosis of Systemic Lupus Erythematosus (SLE) by a rheumatologist AND 2. Documentation that patient is auto-antibody positive, defined as either: a. Antinuclear antibody (ANA) positive defined as: i. Titer greater than or equal to 1:80 by immunofluorescence assay (IFA) OR ii. Definite and consistent positive result report by ELISA ANA greater than upper limit of normal as defined by laboratory OR, b. Anti-double-stranded DNA (anti-dsDNA) positive (concentration greater than or equal to 30 IU/ml). AND 3. Documentation that patient requires daily use of oral corticosteroids unless contraindicated or not tolerated. AND 4. Documented trial and failure of, contraindication to, or intolerance to an adequate treatment course with at least two of the following: Azathioprine, Methotrexate, Mycophenolate moefitil, Hydroxychloroquine, Chloroquine, Cyclophosphamide.
Reauthorization: 1. Documentation of response to Benlysta. AND 2. Documentation that oral corticosteroid use is stable or decreased.
MEDICATION(S)
CLONAZEPAM 0.125 MG DIS TAB, CLONAZEPAM 0.25 MG ODT, CLONAZEPAM 0.5 MG DIS TABLET, CLONAZEPAM 0.5 MG TABLET, CLONAZEPAM 1 MG DIS TABLET, CLONAZEPAM 1 MG TABLET, CLONAZEPAM 2 MG ODT, CLONAZEPAM 2 MG TABLET, CLORAZEPATE DIPOTASSIUM, DIAZEPAM 10 MG TABLET, DIAZEPAM 2 MG TABLET, DIAZEPAM 5 MG TABLET, DIAZEPAM 5 MG/5 ML ORAL SOLN, DIAZEPAM 5 MG/5 ML SOLUTION, DIAZEPAM 5 MG/ML ORAL CONC

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial: 3 months. Reauthorization: 12 months.

OTHER CRITERIA
1. Member is under 65 years old OR 2. For anxiety a. Documented trial, failure, contraindication or intolerance to two of the following generic medications buspirone, paroxetine, escitalopram, or venlafaxine ER. OR 3. For panic disorder a. Documented trial, failure, contraindication or intolerance to two of the following generic medications paroxetine, sertraline, or venlafaxine ER. AND 4. For all FDA approved indications, prescribing provider indicates that medical benefits exceed the risks associated with these medications. Reauthorization Criteria: 1. Documentation demonstrating improvement in symptoms. AND 2. Documentation demonstrating that the benefits continue to outweigh risks of therapy (e.g., delirium, falls, fractures) with chronic use.
MEDICATION(S)
BETASERON, EXTAVIA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documentation of trial and failure, contraindication, or intolerance to 2 of the following 4: Interferon beta-1a (Avonex), Interferon beta-1a (Rebif), Glatiramer Acetate (Copaxone), or Dimethyl Fumarate (Tecfidera).
BOSULIF

MEDICATION(S)
BOSULIF

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for adult patients 18 years or older. The safety and efficacy of Bosulif in patients less than 18 years of age have not been established.

PRESCRIBER RESTRICTION
Must be prescribed by an oncologist.

COVERAGE DURATION
Initial: 3 months, up to 6 months. Reauthorization: 6 months.

OTHER CRITERIA
Documented trial, failure, intolerance or contraindication to imatinib, dasatanib, or nilotinib.
MEDICATION(S)
BRINTELLIX

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documented trial, failure, intolerance or contraindication to at least two formulary antidepressants for the treatment of Major Depressive Disorder (e.g. citalopram, fluoxetine, sertraline, paroxetine).
BUTALBITAL

MEDICATION(S)

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
1. Member is less than 65 years of age. OR 2. Documented trial, failure, contraindication or intolerance to at least two formulary alternative agents used for migraines (drugs must be from a unique therapeutic category): triptans, NSAIDs, Ergots or Antiemetics, or medical rationale is provided why these alternative drug therapies are not indicated. AND 3. Documentation that the risks of the medication (e.g., drowsiness, dizziness, confusion, physical dependence) have been discussed with the patient, including that these risks increase with age. AND 4. Documentation that the provider feels this medication is appropriate for the patient’s age despite the risks outlined above. Reauthorization requires: 1. Documentation that the patient is responding well to therapy without side effects AND 2. Documentation that the risks of the medication have been discussed at least annually with the patient.
and the provider and patient both feel continuation of therapy is medically necessary despite risks.
BYSTOLIC

MEDICATION(S)
BYSTOLIC

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year

OTHER CRITERIA
Nebivolol is covered for patients with hypertension who meet the following criteria: Hypertension not controlled after an adequate trial of, or member is intolerant to two formulary cardioselective beta-blockers (e.g., atenolol, metoprolol/metoprolol XL, carvedilol)
MEDICATION(S)
CABOMETYX

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an oncologist

COVERAGE DURATION
Initial authorization and reauthorization will be approved for six months.

OTHER CRITERIA
N/A
MEDICATION(S)
CAPRELSA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist or endocrinologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
N/A
MEDICATION(S)
CHENODAL

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication is necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For use in cerebrotendinous xanthomatosis, must be prescribed by, or in consultation with, a Genetics or Metabolism Specialist.

For use for gallstone dissolution, must be prescribed by a Gastroenterologist.

COVERAGE DURATION
Initial 6 months. Reauthorization for 1 year. A total of 2 years for the diagnosis of gallstones.

OTHER CRITERIA
For use in gallstone dissolution: 1. Documentation that the patient is not a candidate for surgery, AND 2. Documentation of trial and failure, contraindication or intolerance to ursodiol.
CHOLBAM

MEDICATION(S)
CHOLBAM

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a Genetics Specialist or Hepatologist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for up to 1 yr

OTHER CRITERIA
N/A
CINRYZE

MEDICATION(S)
CINRYZE

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Complement Component C4 and C1-Esterase inhibitor OR C1-Esterase Functional. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an immunologist or an allergist.

COVERAGE DURATION
Initial prior auth will be approved for 3 months. Reauth may be approved for 1 yr.

OTHER CRITERIA
All of the following must be met: 1. Diagnosis of Hereditary Angioedema Types I, II or III and one of the following clinical criteria: a) Self-limiting, noninflammatory subcutaneous angioedema without urticaria, recurrent, and lasting more than 12 hours, b) Self-remitting abdominal pain without clear organic etiology, recurrent, and lasting more than six hours, c) Recurrent laryngeal edema. AND 2. For Type I and Type II HAE, one of the following laboratory criteria: a) C1 inhibitor levels less than 50 percent of the lower limit of normal at two separate determinations (at least one month apart) with the patient in their basal condition and after the first year of life, b) C1 inhibitor functional of less than 50 percent of normal at two separate determinations (at least one month apart) with the patient in their basal condition and after the first year of life, c) Mutation in C1 inhibitor gene altering protein synthesis and/or function. This is the only laboratory criterion that can be used to make the diagnosis in patients younger than one year of age, AND 3. Documentation of frequent HAE attacks defined as greater than or equal to 2 attacks per month on average. AND 4. Trial and failure, intolerance or contraindication to
long-term prophylaxis with androgen therapy, such as danazol, oxymetholone or stanozolol. Dosing regimens that exceed the manufacturer recommendations of 1 gram every 3-4 days will only be approved if evidence-based-rationale is provided. After initial 3 month authorization and at least annually, documentation must be provided showing benefit of therapy with reduction of frequency and severity of HAE attack episodes.
MEDICATION(S)
COMETRIQ

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist or endocrinologist.

COVERAGE DURATION
Initial: 3 months, up to 6 months. Reauthorization: 6 months.

OTHER CRITERIA
NA
MEDICATION(S)
CORLANOR

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documented stable, symptomatic heart failure with all of the following: a) Left-ventricular ejection fraction of 35% or less, b) Normal sinus rhythm with resting heart rate of at least 70 bpm (documented within the last 60 days), c) Maximal use of beta-blocker (i.e., carvedilol, metoprolol succinate, bisoprolol) or contraindication to their use.
MEDICATION(S)
CYSTARAN

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
NA
DAKLINZA

**MEDICATION(S)**
DAKLINZA

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
Co-administration with strong inducers of CYP3A, including phenytoin, carbamazepine, rifampin or St. John’s wort.

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting specific HCV genotype, pathology report demonstrating chronic HCV infection with fibrosis staging, prior treatment history, and baseline HCV RNA count.

**AGE RESTRICTION**
Approved for 18 years and older.

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist

**COVERAGE DURATION**
12 to 24 weeks based on indication and established treatment guidelines

**OTHER CRITERIA**
1. Documentation of confirmed diagnosis of CHC infection, AND 2. Documentation of any prior chronic hepatitis C treatment history and response to therapy, AND 3. In genotype 3 patients who have compensated cirrhosis, documentation that the patient is not eligible to receive a) sofosbuvir (Sovaldi), pegylated interferon and ribavirin for 12 weeks, OR b) sofosbuvir (Sovaldi) and ribavirin for 24 weeks, due to medical contraindication(s).
**MEDICATION(S)**
DALIRESP

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
Asthma without COPD, Moderate-severe hepatic impairment (Child Pugh B or C)

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
NA

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consultation with a pulmonologist

**COVERAGE DURATION**
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

**OTHER CRITERIA**
Daliresp will be approved when the following criteria are met: 1) A confirmed diagnosis of severe (stage III) or very severe (stage IV) COPD (FEV1 less than or equal to 50% predicted) associated with chronic bronchitis (daily cough with production of sputum for 3 months, two years in a row). AND 2) An adequate trial and failure, contraindication or intolerance to maintenance treatment with either a long-acting beta2-agonist (LABA) or long acting anticholinergic (LAMA). AND 3) An adequate trial and failure, contraindication or intolerance to treatment with inhaled corticosteroids up to maximum daily doses.
MEDICATION(S)
DAYTRANA

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale for drug choice are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for members 6 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
1. Documentation of trial and failure, contraindication or intolerance to two (2) formulary long-acting stimulant agents for ADHD (e.g., generic Adderall, generic Dexedrine, generic Ritalin, generic Ritalin SR, Adderall XR, Concerta, Metadate CD, Ritalin LA, or Strattera). AND 2. Documentation or medical rationale why member cannot use a formulary stimulant medication in chewable or solution form (e.g., Methylin Chewable tablets or methylphenidate solution) if unable to swallow tablets/capsules. AND 3. For members 65 years and older, documentation that medical benefits exceed the risks (drug dependence, hypertension, myocardial ischemia, agitation, insomnia, and/or seizures associated with these medications) associated with these medications is needed.
**MEDICATION(S)**
DESVENLAFAXINE ER, KHEDEZLA, PRISTIQ

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D

**EXCLUSION CRITERIA**
NA

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
NA

**PRESCRIBER RESTRICTION**
NA

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for one year.

**OTHER CRITERIA**
1. Documentation of trial and failure, contraindication or intolerance to venlafaxine immediate release or extended release (Effexor XR) AND 2. Documentation of trial and failure, contraindication or intolerance to a formulary generic SSRI (e.g. citalopram, fluoxetine, sertraline, paroxetine).
**MEDICATION(S)**
DRONABINOL

**COVERED USES**
ALL FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for one year.

**OTHER CRITERIA**
Patient must meet the following criteria: 1. Documentation of trial and failure, contraindication or intolerance to ondansetron unless contraindicated. AND 2. Documentation of trial and failure, contraindication or intolerance to one of the following formulary medications unless contraindicated: - prochlorperazine -chlorpromazine -metoclopramide OR 3. Loss of appetite in AIDS-related anorexia.
MEDICATION(S)
EGRIFTA

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Active malignancy or history of hypopituitarism.

REQUIRED MEDICAL INFORMATION
Waist circumference. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an Infectious Disease Specialist or Endocrinologist.

COVERAGE DURATION
Initial auth will be approved for 6 months. Reauthorization will be approved for 1 year.

OTHER CRITERIA
1. Documentation of patient's waist circumference: a. Waist circumference greater than 37.4 inches (95 cm) for males OR b. Waist circumference greater than 37 inches (94 cm) for females. Reauthorization will require documentation of improvement in waist circumference and stable blood glucose levels.
ELIDEL/PROTOPIC

MEDICATION(S)
ELIDEL, TACROLIMUS 0.03% OINTMENT, TACROLIMUS 0.1% OINTMENT

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
ELIDEL Cream 1% is approvable for adults and children 2 years of age and older. Tacrolimus ointment 0.03% is approvable for adults and children 2 years of age and older. Tacrolimus ointment 0.1% is approvable for adults and children 16 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
For Atopic Dermatitis: Documentation of trial and failure of an adequate treatment course (2 weeks or longer) of two (2) topical corticosteroids. One of the agents should be a high potency corticosteroid (such as betamethasone dipropionate augmented ointment, clobetasol propionate cream or ointment, or halobetasol cream/ointment), unless member has a contraindication to corticosteroid therapy (such as the location of the atopic dermatitis).
MEDICATION(S)
EMVERM

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
see "other criteria"

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 3 months.

OTHER CRITERIA
For diagnoses other than pinworm (Enterobius vermicularis), must be prescribed by or in consultation with an infectious disease specialist.
MEDICATION(S)
ENTRESTO

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUiRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a cardiologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documentation must be submitted that all of the following criteria are met: 1.) Patient is currently on maximally tolerated dose or contraindication to a beta blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) AND 2.) Trial and failure of maximally tolerated dose of an ACE inhibitor (e.g., lisinopril, enalapril) or ARB (e.g., losartan, valsartan)
ERIVEDGE

MEDICATION(S)
ERIVEDGE

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, an oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
N/A
MEDICATION(S)
FARYDAK

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
N/A
**FASLODEX**

**MEDICATION(S)**
FASLODEX

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
NA

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
NA

**PRESCRIBER RESTRICTION**
Must be prescribed by an Oncologist.

**COVERAGE DURATION**
Initial authorization for 3 months, up to 6 months. Reauthorization for 6 months.

**OTHER CRITERIA**
1. Trial, failure, intolerance, or contraindication to an anti-estrogen treatment such as tamoxifen. OR
2. Trial, failure, intolerance, or contraindication to oral aromatase inhibitors (AIs) [such as anastrozole (Arimidex) or exemestane (Aromasin)]. Therapy may be dependent on pre or postmenopausal status.
   For all indications, documentation of response to Faslodex must be submitted in order for continued authorization.
FENTANYL CITRATE

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

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
NA

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
Approved for 16 years or older.

**PRESCRIBER RESTRICTION**
NA

**COVERAGE DURATION**
Initial authorization for 6 months. Reauthorization for 1 year.

**OTHER CRITERIA**
Documentation of all the following: 1. Treatment of breakthrough cancer pain. AND 2. Failure of or intolerance to two formulary oral or parenteral short-acting narcotic agents. AND 3. Pain is not controlled with long-acting narcotic analgesics.
**MEDICATION(S)**
FETZIMA

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D

**EXCLUSION CRITERIA**
NA

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
NA

**PRESCRIBER RESTRICTION**
NA

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for one year.

**OTHER CRITERIA**
Documented trial, failure, intolerance or contraindication to at least two formulary antidepressants for the treatment of Major Depressive Disorder (e.g. citalopram, fluoxetine, sertraline, paroxetine).
MEDICATION(S)
FIRAZYR

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Use for prophylaxis.

REQUIRED MEDICAL INFORMATION
Complement Component C4 and C1-Esterase inhibitor OR C1-Esterase Functional. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for 18 years or older.

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an immunologist or an allergist.

COVERAGE DURATION
Initial authorization for 3 months. Reauthorization for 12 months.

OTHER CRITERIA
All of the following must be met: 1. Diagnosis of Hereditary Angioedema Types I, II or III and one of the following clinical criteria: a) Self-limiting, noninflammatory subcutaneous angioedema without urticaria, recurrent, and lasting more than 12 hours, b) Self-remitting abdominal pain without clear organic etiology, recurrent, and lasting more than six hours, c) Recurrent laryngeal edema. AND 2. For Type I and Type II HAE, one of the following laboratory criteria: a) C1 inhibitor levels less than 50 percent of the lower limit of normal at two separate determinations (at least one month apart) with the patient in their basal condition and after the first year of life, b) C1 inhibitor function of less than 50 percent of normal at two separate determinations (at least one month apart) with the patient in their basal condition and after the first year of life, c) Mutation in C1 inhibitor gene altering protein synthesis and/or function. This is the only laboratory criterion that can be used to make the diagnosis in patients younger than one year of age, AND 3. Documentation of frequent HAE attacks defined as greater than or equal to 2 attacks per month on average. AND 4. Trial and failure, intolerance or contraindication to
long-term prophylaxis with androgen therapy, such as danazol, oxymetholone or stanozolol. Dosing regimens that exceed the manufacturer recommendations of 1 gram every 3-4 days will only be approved if evidence-based-rationale is provided. After initial 3 month authorization and at least annually, documentation must be provided showing benefit of therapy with reduction of frequency and severity of HAE attack episodes.
MEDICATION(S)
FYCOMPA

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for 12 years and older.

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documented trial, failure, intolerance or contraindication to at least two formulary agents used for the treatment of seizure disorder (e.g. carbamazepine, oxcarbazepine, phenytoin, levetiracetam, valproic acid, divalproex).
GAMMA GLOBULIN - IGG

MEDICATION(S)
BIVIGAM, CARIMUNE NF NANOFILTERED, FLEBOGAMMA DIF 10% VIAL, GAMMAGARD LIQUID, GAMMAKED, GAMMAPLEX, GAMUNEX-C, PRIVIGEN

COVERED USES
All FDA-approved indications not otherwise excluded from Part D. The following off-label uses will be covered: Prophylaxis for serious bacterial infection, normalization of development and increase weight for pediatric patients with HIV infection, Immunosuppressed allogeneic bone marrow transplant recipients over age 20 with interstitial pneumonia or graft vs.host disease (GVHD), Prophylaxis in allogeneic bone marrow transplant recipients, Acute Guillian Barre Syndrome, Dermatomyositis associated with severe disability complicated by sensitivity or resistance to steroid therapy, CMV seronegative solid organ transplant patients who receive an organ from a CMV-Seropositive donor, Chronic inflammatory demyelinating polyneuropathy, Post-transfusion purpura, Autoimmune neutropenia, Stiff-person syndrome and Multifocal motor neuropathy, Relapsing-remitting type multiple sclerosis, Acute severe decompensation of Myasthenia gravis.

EXCLUSION CRITERIA

REQUIRED MEDICAL INFORMATION
IgA, IgM. T4 cell count, anti-GM1 For initiation, a prior authorization form and documentation of medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary

AGE RESTRICTION
N/A
**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Initial authorization for 3 months, up to 6 months. Reauthorization for 12 months.

**OTHER CRITERIA**
For primary immune deficiency disorders (such as X-linked and congenital agammaglobulinemia, common variable immunodeficiency): 1) Reduction of IgG (and possibly IgA and IgM) greater than 2 SDs below the mean for age (less than 500gm/dL in adults), 2) Deficiency not caused by other conditions, and 3) Absent isohemagglutinins and/or poor response to vaccines. For Wiskott-Aldrich syndrome, Kawasaki syndrome and Immunoglobulin subclass deficiency: Demonstrated deficiency of antibody production to common pathogens. For ITP: Documentation of active bleeding, high-risk of bleeding, or a platelet count less than 30 per microliter. For hypogammaglobulinemia and chronic B cell lymphocytic leukemia: Documented need to prevent bacterial infections and/or documented recurrent infections. For pediatric patients with HIV infection 1) Documented infection, slow development and low weight, and 2) T4 cell count greater than 200. For dermatomyositis: disease is associated with severe disability complicated by sensitivity or resistance to steroid therapy treatment beyond the initial 3 month treatment. Reauthorization requires objective evidence of treatment efficacy. For stiff-person syndrome and multifocal motor neuropathy: Documented trial with conventional therapy (e.g. cyclophosphamide). For relapsing-remitting type multiple sclerosis: Documentation of trial, failure, intolerance or contraindication to standard therapies (e.g. glatiramer, interferon beta, dimethyl fumarate). For prophylaxis in allogeneic bone marrow transplant recipients: 1) Treatment is after 4 months following transplantation and 2) demonstrated hypogammaglobulinemia. For acute Guillian Barre Syndrome: 1) symptoms have been present for less than two weeks and 2) Patient is unable to ambulate independently, has compromised respiratory function or bulbar weakness. For chronic inflammatory demyelinating polyneuropathy: 1) Documented severe disability and 2) Documentation of sensitivity or resistance to steroid therapy. For post-transfusion purpura: only in severely affected patients. For autoimmune neutropenia: Documented sensitivity or resistance to steroid therapy.
MEDICATION(S)
CERVARIX, GARDASIL, GARDASIL 9

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
A prior authorization form and relevant chart notes documenting medical rationale are required.

AGE RESTRICTION
Cervarix: Covered for girls and women age 9 - 25 years. Gardasil and Gardasil 9: Covered for persons (male and female) age 9-26 years.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Authorization will be approved for the entire course of 3 injections over 6 months.

OTHER CRITERIA
N/A
MEDICATION(S)
GATTEX

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for 18 years and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a Gastroenterologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for six months.

OTHER CRITERIA
Gattex treatment is indicated for adult members when the following criteria are met:
1. An initial nutritional assessment has been completed by a registered dietitian who has determined that oral/enteral nutrition is not sufficient to meet nutritional goals
2. Member is stable and dependent on parenteral support (fluids, electrolytes and/or nutrients) delivered at least three times per week
3. Gattex has been made part of a treatment plan established by a gastroenterologist or a hospital Metabolic Support Team
   a. Member evaluation indicates the possibility of success with treatment
   b. Parameters have been defined to identify goals and measure improvement.
**MEDICATION(S)**
GILOTTRIF

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
NA

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
NA

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consultation with an oncologist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for 6 months.

**OTHER CRITERIA**
Verification of EGFR mutation status on exon 19 and exon 21 identified by an FDA approved test such as Qiagen's Therascreen EGFR RGQ PCR kit. Documentation of response to Gilotrif must be submitted in order for continued authorization.
GLEEVEC

MEDICATION(S)
GLEEVEC, IMATINIB MESYLATE

COVERED USES
All FDA-approved indications not otherwise excluded from part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
For all indications, documentation of response to Gleevec must be submitted in order for continued authorization.
**MEDICATION(S)**
HARVONI

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
HCV genotype, HCV RNA, CrCl. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required.

**AGE RESTRICTION**
Approved for 18 years and older.

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist.

**COVERAGE DURATION**
12 to 24 weeks based on indication and established treatment guidelines.

**OTHER CRITERIA**
1. Documentation of HCV genotype AND 2. Baseline HCV RNA level within 6 months prior to the start of therapy to guide treatment duration. AND 3. Documentation of prior chronic hepatitis C treatment history and response to therapy to guide treatment duration. AND 4. Documentation of liver fibrosis status to guide treatment duration. AND 5. Documentation that patient will be monitored for adherence.
**HEMATOLOGY**

**MEDICATION(S)**
ARANESP 10 MCG/0.4 ML SYRINGE, ARANESP 100 MCG/0.5 ML SYRINGE, ARANESP 100 MCG/ML VIAL, ARANESP 150 MCG/0.3 ML SYRINGE, ARANESP 200 MCG/0.4 ML SYRINGE, ARANESP 200 MCG/ML VIAL, ARANESP 25 MCG/0.42 ML SYRING, ARANESP 25 MCG/ML VIAL, ARANESP 300 MCG/0.6 ML SYRINGE, ARANESP 300 MCG/ML VIAL, ARANESP 40 MCG/0.4 ML SYRINGE, ARANESP 40 MCG/ML VIAL, ARANESP 500 MCG/1 ML VIAL, ARANESP 60 MCG/0.3 ML SYRINGE, ARANESP 60 MCG/ML VIAL, EPOGEN 2,000 UNITS/ML VIAL, EPOGEN 20,000 UNITS/2 ML VIAL, EPOGEN 20,000 UNITS/ML VIAL, EPOGEN 3,000 UNITS/ML VIAL, EPOGEN 4,000 UNITS/ML VIAL, PROCRIT

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
- Patients with uncontrolled hypertension
- darbepoetin alfa or erythropoietin is not indicated for treating patients with anemia induced from hepatitis C therapy.

**REQUIRED MEDICAL INFORMATION**
Hemoglobin and Hematocrit levels within 30 days prior to initiation of therapy. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Initial authorization will be for 2 months. Reauthorization will be for 1 month.

**OTHER CRITERIA**
1. All diagnoses with the exception of 2f, preoperative use in anemic patients scheduled for elective hip or knee surgery, must have documented Hemoglobin (HGB) levels of less than or equal to 10g/dl or Hematocrit levels of less than or equal to 30% within 30 days prior to initiation of therapy, AND 2. Must
meet listed criteria below for each specific diagnosis: a. Treatment of Anemia in Chronic Renal Failure (CRF) i. Aranesp/Epogen/Procrit may be covered.  
b. Treatment of anemia due to chemotherapy in cancer and related neoplastic conditions (see exclusion criteria for non-covered indications).  
i. Aranesp/Epogen/Procrit may be used.  
ii. Must be secondary to myelosuppressive anticancer chemotherapy.  
iii. May only be used up to 8 weeks following the final dose of myelosuppressive chemotherapy (subject to audit).  
c. Treatment of Anemia in Myelodysplastic Syndrome (MDS).  
i. Aranesp/Epogen/Procrit may be approved.  
ii. Must have documented endogenous erythropoietin levels of less than 500 mIU/ml.  
d. Anemia associated with zidovudine-treated HIV-infection patients:  
i. Coverage is for epoetin only (Procrit, Epogen).  
ii. Documented endogenous serum erythropoietin level is less than or equal to 500 mIU/ml.  
iii. Zidovudine dose is less than or equal to 4200mg/week.  
e. Anemia associated with the treatment of specific chronic diseases with agents known to cause anemia [rheumatoid arthritis, regional enteritis (or Crohns Disease), and ulcerative colitis]:  
i. Coverage is for epoetin only (Procrit, Epogen).  
ii. Treatment may not be continued beyond 8 weeks after therapy with agent known to cause anemia is complete.  
f. Preoperative use in anemic patients scheduled for elective hip or knee surgery.  
i. Coverage is for epoetin only (Procrit, Epogen).  
ii. All of the following must be met.  
1. Member must be scheduled to undergo elective hip or knee surgery.  
2. Member has preoperative anemia with pretreatment HGB between 10 and 13 g/dL.  
3. Member is expected to lose more than 2 units of blood.  
4. Member has received an appropriate preoperative workup revealing that the anemia appears to be that of chronic disease.  
- Covered range during treatment: HGB 10-12g/dL or HCT 30-36%.  
- Dosing should be adjusted for patients to achieve and maintain target HGB not to exceed 12g/dL.  
- HGB and HCT levels must be drawn and documented within 30 days of the requested date of service.
MEDICATION(S)
HETLIOZ

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Sleep disorders other than Non-24

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a sleep specialist

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for 1 year.

OTHER CRITERIA
1. Member is blind AND 2. Documented diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24), as characterized by: a. Distinct pattern of sleeping and waking that drifts by a consistent time period every night, b. History of periods of insomnia, excessive sleepiness, or both, which alternate with short asymptomatic periods. Reauthorization criteria: Documentation of entrainment to the 24-hour circadian period
HUMAN GROWTH HORMONES

MEDICATION(S)
OMNITROPE

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication is necessary. May require the following specific tests depending on indication: Insulin Tolerance stimulation test (ITT), GHRH/arginine stimulation test (GHRH/Arg stim), glucagon stimulation test (Glu stim), arginine-only stimulation test (Arg stim), Insulin-like Growth Factor (IGF-1) levels, pituitary hormone levels (LH, FSH, TSH, ACTH), BMI, and/or genetic testing.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or on the recommendation of an endocrinologist.

COVERAGE DURATION
Initial authorization and reauthorization approved for 1 year.

OTHER CRITERIA
GHD in Adults Due to Destructive Lesions of the Pituitary:
1.GHD due to head injury, radiation therapy, surgery, or trauma, and one of following biochemical confirmation tests:
   a.IGF-I below 2.5 percentile for age/sex
   b.ITT with peak GH less than/equal to 5.0 mcg/L
   c.GHRH/Arg stim with low peak GH based on BMI:
      i.BMI less than 25: Peak GH less than/equal to 11.0 mcg/L
      ii.BMI 25-30: Peak GH less than/equal to 8.0 mcg/L
      iii.BMI greater than/equal to 30: Peak GH less than/equal to 4.0 mcg/L
   d.Glu stim with peak GH less than/equal to 3.0 mcg/L
e. Arg stim with peak GH less than/equal to 0.4 mcg/L
2. GHD due to organic disease (e.g. hypothalamic or pituitary disease)
a. At least 2 other pituitary hormone deficiencies (i.e. TSH, ACTH, Gonadotropins, and ADH)
AND one of the biochemical confirmation tests above (1. a-e)

Reauthorization: Requires evidence of improved quality of life, good tolerability and annual documentation of IGF-I levels with appropriate dosage adjustments. (GH requirements often decrease with age)

GHD in Adults who had GHD as a child: Retesting should occur unless known mutation/genetic cause, embryopathic lesions, or irreversible structural damage.
1. After linear growth has stopped (GV less than 2.5cm/yr), GH is stopped for at least 1 month, members retested, and have the following results:
a. At least 2 other pituitary hormone deficiencies (i.e. TSH, ACTH, Gonadotropins, and ADH), AND two of the following:
b. IGF-I less than 50th percentile for age/sex
i. If IGF-I less than 2.5 percentile, no further testing is required.
c. ITT with peak GH less than/equal to 5.0 mcg/L
d. GHRH/Arg stim with low peak GH based on BMI:
i. BMI less than 25: Peak GH less than/equal to 11.0 mcg/L
ii. BMI 25-30: Peak GH less than/equal to 8.0 mcg/L
iii. BMI greater than/equal to 30: Peak GH less than/equal to 4.0 mcg/L
e. Glu stim with peak GH less than/equal to 3.0 mcg/L
f. Arg stim with peak GH less than/equal to 0.4 mcg/L

Reauthorization: Requires evidence of improved quality of life, good tolerability and annual documentation of IGF-I levels with appropriate dosage adjustments (GH requirements often decrease with age).

AIDS Wasting
1. Involuntary loss of at least 10% body weight
AND
2. Absence of other related illnesses contributing to weight loss
AND
3. Documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents.
Authorization will be given for a maximum of 12 months.

Short Bowel Syndrome (Zorbtive Only)
1. Ability to ingest solid food
AND
2. Must be receiving specialized nutrition support (i.e. high carbohydrate, low-fat diet, enteral feedings, parenteral nutrition)

Authorization will be given for a maximum of 4 weeks. Efficacy beyond 4 weeks has not been established.
MEDICATION(S)
IBRANCE

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
N/A
ICLUSIG

MEDICATION(S)
ICLUSIG

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
Must be prescribed by an oncologist

COVERAGE DURATION
Initial authorization and reauthorization will be approved for six months.

OTHER CRITERIA
NA
MEDICATION(S)
ILARIS

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for 4 years of age and older in patients with Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS). Approved for 2 years of age and older in patients with Active Systemic Juvenile Idiopathic Arthritis.

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months, up to 6 months. Re-authorization for 12 months.

OTHER CRITERIA
Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) has been confirmed by: 1. Laboratory evidence of genetic mutation NLRP-3 (Nucleotide-binding domain, leucine rich family (NLR) pyrin domain containing 3) or CIAS1 (Cold-Induced Auto-inflammatory Syndrome-1), AND 2. Classic symptoms associated with Familial Cold Auto-Inflammatory Syndrome (FCAS) or Muckle-Wells Syndrome (MWS) recurrent intermittent fever and rash typically associated with natural or artificial cold. Reauthorization: Documentation of adequate response to therapy is needed for reauthorization.
MEDICATION(S)
IMBRUVICA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for 18 years and older

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
NA
MEDICATION(S)
INCRELEX

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Subjects with secondary forms of IGF-1 deficiency: GH deficiency, Malnutrition, Hypothyroidism, Chronic treatment with pharmacologic doses of anti-inflammatory steroids.

REQUIRED MEDICAL INFORMATION
Plasma IGF-1 activity, blood glucose, plasma insulin, C-peptide, glycosylated hemoglobin, serum electrolytes, liver enzymes. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for children ages 2 to 18 years old.

PRESCRIBER RESTRICTION
Must be prescribed by an endocrinologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Height standard deviation score of less than or equal to -3.0 AND Basal IGF-1 standard deviation score of less than or equal to -3.0 AND Normal or elevated growth hormone (GH) based on at least one elevated growth hormone stimulation test. AND X-Ray Confirmation of open epiphyses. Reauthorization will require evidence that the medication remains effective and, growth velocity is above 2.0 cm/year, and X-ray confirmation of open epiphyses.
**INLYTA**

**MEDICATION(S)**
INLYTA

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consultation with an oncologist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for 6 months.

**OTHER CRITERIA**
N/A
IRESSA

MEDICATION(S)
IRESSA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
N/A
MEDICATION(S)
IXEMPRA 45 MG KIT

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an Oncologist.

COVERAGE DURATION
Initial authorization for 3 months, up to 6 months. Reauthorization for 6 months.

OTHER CRITERIA
Ixempra is approved, subject to benefits, when ALL of the following criteria are met:1. Diagnosis of locally advanced or metastatic breast cancer AND 2. Trial and failure (disease progression/resistance or intolerance) of all of the following: a. An anthracycline AND b. A taxane AND c. Capecitabine (or may be used in combination with capecitabine after failure or intolerance to a and b) Note: Anthracycline resistance is defined as progression while on therapy or within 6 months in the adjuvant setting or 3 months in the metastatic setting. Taxane resistance is defined as progression while on therapy or within 12 months in the adjuvant setting or 4 months in the metastatic setting.
**MEDICATION(S)**
JAKAFI

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
NA

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
NA

**PRESCRIBER RESTRICTION**
Must be prescribed by, or in consultation with, a Hematologist/Oncologist.

**COVERAGE DURATION**
Initial authorization for 3 months, up to 6 months. Reauthorization for 6 months.

**OTHER CRITERIA**
Reauthorization will require documentation of treatment response including reduction in spleen size or improvements in constitutional symptoms.
MEDICATION(S)
JUXTAPID, KYNAMRO

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
LDL level or genetic confirmation of Homozygous Familial Hypercholesterolemia For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization approved for six months. Reauthorization will be approved for one year.

OTHER CRITERIA
All of the following must be met: 1. Diagnosis of Homozygous Familial Hypercholesterolemia (HoFH) as evidenced by a. Genetic confirmation OR b. Both parents are heterozygous FH AND 2. An adequate trial (30 days of therapy), failure, contraindication or intolerance to the use of high intensity statin therapy (atorvastatin 80 mg or rosuvastatin 40 mg). Documentation of response to therapy must be submitted in order for continued authorization. For reauthorization must show documentation that LDL-C has decreased from pre-treatment levels.
MEDICATION(S)
KALYDECO

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FDA-cleared CF mutation test. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 2 years or older.

PRESCRIBER RESTRICTION
Must be prescribed by or under the order of a Pulmonologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
MEDICATION(S)
CLONIDINE HCL ER

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for ages 6 years and older

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
To obtain prior authorization one of the following criteria must be met: 1. Member is 65 years or older OR 2. Trial and failure or intolerance to two (2) formulary stimulant medications indicated for the treatment of ADHD (e.g., generic Ritalin SR, Adderall XR, Concerta, Metadate CD, Ritalin LA). OR 3. Documented contraindication or adverse reaction to stimulant medications OR 4. Severe motor tics or tics exacerbated by stimulant medications.
MEDICATION(S)
KORLYM

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Mifepristone 200mg will not be covered. In pregnancy (Black box warning- Category X), With use of simvastatin or lovastatin and CYP 3A substrates with narrow therapeutic range, When used with long-term corticosteroids, In women with history of unexplained vaginal bleeding, In women with endometrial hyperplasia or endometrial carcinoma.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required for continuation of therapy, ongoing documentation of successful response to medication may be necessary.

Confirmation of Cushing’s disease with 2 of the 3 following tests: 1. 24 hr urine cortisol (UFC), (Normal range can vary per laboratory: Usually a positive for this test is above 10 - 100 micrograms per 24 hours (mcg/24h)). 2. Overnight dexamethasone suppression test (1mg DST) (1 mg dexamethasone is given at 11 PM, cortisol next day should be less than 1.8ug/dl). 3. Three midnight salivary cortisol specimens (Depending on test utilized, a positive for this test would be above 145ng/dl) AND Negative pregnancy test (if appropriate)

AGE RESTRICTION
Approved for 18 years of age and older

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
NA
MEDICATION(S)
KUVAN

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Doses greater than 20mg/kg/day will not be approved.

REQUIRED MEDICAL INFORMATION
Average blood Phe levels. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Metabolic specialists.

COVERAGE DURATION
Initial authorization for 2 months. Reauthorization for 12 months.

OTHER CRITERIA
Must meet both of the following criteria for initial authorization, 1. Diagnosis of phenylketonuria (PKU) by a metabolic specialist AND 2. Documentation that blood Phe levels cannot be maintained in the following NIH recommended ranges despite adherence to a Phe-restricted diet (requires submission of average blood Phe levels), Neonates through 12 years old, 2-6mg/dL (120-360 umol/dL), Greater than 12 years old, 2-15mg/dL (120-900 umol/dL), During Pregnancy, 2-6mg/dL (120-360 umol/dL). For reauthorization, 1. Documentation that average blood Phe levels have decreased by at least 30% and remain 30% below pretreatment baseline AND 2. Documentation of continued dietary Phe-restriction.
MEDICATION(S)
LATUDA

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
For schizophrenia: Documentation of trial and failure, contraindication or intolerance to two generic formulary medications indicated for the treatment of schizophrenia (e.g., olanzapine, risperidone, ziprasidone). For depression with bipolar disorder: Documentation of trial and failure of or contraindication or intolerance to generic formulary quetiapine and the combination of olanzapine/fluoxetine (generic Symbyax).
MEDICATION(S)
LAZANDA 100 MCG NASAL SPRAY, LAZANDA 400 MCG NASAL SPRAY

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for 18 years or older.

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization is for six months and reauthorization will be for one year.

OTHER CRITERIA
Documentation of all the following: 1. Treatment of breakthrough cancer pain. AND 2. Failure of or intolerance to at least two other oral or parenteral short-acting narcotic formulary agents. AND 3. Pain is not controlled with long-acting narcotic analgesics.
**MEDICATION(S)**
LENVIMA 10 MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consultation with an oncologist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for six months.

**OTHER CRITERIA**
N/A
**MEDICATION(S)**
LIDOCAINE 5% PATCH

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Initial authorization for 3 months, up to 6 months. Reauthorization for 6 months.

**OTHER CRITERIA**
Documented trial, failure, intolerance, or contraindication to gabapentin. Reauthorization will require documentation submitted showing adequate response to therapy.
**MEDICATION(S)**
LONSURF

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
None

**PRESCRIBER RESTRICTION**
Must be prescribed by an Oncologist

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for 6 months.

**OTHER CRITERIA**
N/A
LUMIZYME

MEDICATION(S)
LUMIZYME

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
NA
**MEDICATION(S)**
LYNPARZA

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consultation with an oncologist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for one year.

**OTHER CRITERIA**
N/A
MEKINIST, TAFINLAR, ZELBORAF

MEDICATION(S)
MEKINIST, TAFINLAR, ZELBORAF

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Mekinist is not indicated for the treatment of patients who have received prior BRAF-inhibitor therapy.

REQUIRED MEDICAL INFORMATION
BRAFV600E mutation for Mekinist, Zelboraf, and Tafinlar. BRAFV600K mutation for Mekinist. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary. For all indications, documentation of response to therapy must be submitted in order for continued authorization.

AGE RESTRICTION
Approved for 18 years and older.

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
Tafinlar and Zelboraf will only be approved for use in patients with the BRAFV600E mutation as detected by a FDA-approved test. Mekinist will only be approved for use in patients with the BRAFV600K and BRAFV600E mutation as detected by a FDA-approved test.
MUSCULOSKELETAL DRUGS

MEDICATION(S)
CYCLOBENZAPRINE 10 MG TABLET, CYCLOBENZAPRINE 5 MG TABLET, CYCLOBENZAPRINE 7.5 MG TABLET, METHOCARBAMOL 500 MG TABLET, METHOCARBAMOL 750 MG TABLET

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months. Reauthorization for 12 months.

OTHER CRITERIA
1. Member is under 65 years old, OR 2. If over 65 years: a. Documentation that the risks of the medication (CNS depression) have been discussed with the patient, including that these risks increase with age. AND b. Documentation that the provider feels this medication is appropriate for the patient's age despite the risks outlined above. Reauthorization requires: 1. Documentation that the patient is responding well to therapy without side effects AND 2. If over 65 years, documentation that the risks of the medication have been discussed at least annually with the patient, and the provider and the patient both feel continuation of therapy is medically necessary despite risks.
**MEDICATION(S)**
MYALEPT

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**
Circulating leptin levels. Metabolic parameters (HbA1c, triglyceride levels, fasting insulin levels). For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
NA

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consultation with an endocrinologist.

**COVERAGE DURATION**
Initial auth will be approved for 6 months. Reauthorization approved for one year.

**OTHER CRITERIA**
1. Diagnosis of congenital or acquired generalized lipodystrophy AND 2. Documentation of at least one of the following metabolic complications of leptin deficiency: a. Diabetes mellitus, b. Triglyceride levels greater than 200 mg/dL, c. Increased fasting insulin levels greater than 30 uU/mL AND 3. Documentation of trial and failure of at least one generic, formulary conventional medications to treat each metabolic complication present, as follows: a. Diabetes: metformin, sulfonylureas, pioglitazone, insulin, b. Hypertriglycerideridemia: gemfibrozil, fenofibrate, statins (e.g. simvastatin, atorvastatin) Reauthorization: requires documentation of response to therapy (e.g. improvement in metabolic parameters)
MEDICATION(S)
MYOZYME

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
NA
MEDICATION(S)
NAGLAZYME

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
NA
MEDICATION(S)
NATPARA

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Corrected serum-albumin calcium levels, Serum levels of 25 OH vitamin D. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an endocrinologist.

COVERAGE DURATION
Initial authorization for 6 months and reauthorization will be approved for 1 year

OTHER CRITERIA
1. Patient must be diagnosed with permanent/chronic hypoparathyroidism AND 2. Documentation of failure to maintain serum-albumin corrected calcium with the chronic use of calcium and vitamin D supplementation for a minimum of 6 months. AND 3. Documentation that Natpara will be used concurrently with calcium and vitamin D. AND 4. Confirm serum albumin corrected calcium is above 7.5 mg/dL AND 5. Confirm serum 25-hydroxyvitamin D greater than or equal to 30 ng/mL (75 nmol/L). Reauthorization requires annual documentation of regular monitoring of serum calcium levels with appropriate dosage adjustments to meet patient specific goal.
MEDICATION(S)
NEXAVAR

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication is necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist/Hematologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
NA
MEDICATION(S)
NINLARO

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
N/A
MEDICATION(S)
NORTHERA

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be for six months. Reauthorization will be for one year.

OTHER CRITERIA
1. Documentation of a diagnosis of symptomatic orthostatic hypotension caused by primary autonomic failure (Parkinson's disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND 2. Documented trial, failure, intolerance or contraindication to midodrine.
MEDICATION(S)
NUDEXTA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
N/A
**NUPLAZID**

**MEDICATION(S)**
NUPLAZID

**COVERED USES**
All FDA approved indications, not otherwise excluded from Part D

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with a Neurology, Psychiatry, or Geriatrics specialist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for one year

**OTHER CRITERIA**
1. Confirmed diagnosis of hallucinations and delusions associated with Parkinson’s disease psychosis
2. Mini-mental status examination (MMSE) score of 21 or greater, to indicate ability to self-report symptoms.
NUVIGIL

MEDICATION(S)
ARMODAFINIL, NUVIGIL

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Full nocturnal polysomnogram and a multiple sleep latency test (for diagnosis of narcolepsy and obstructive sleep apnea). For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization for 3 months, up to 6 months. Reauthorization for 12 months.

OTHER CRITERIA
For Narcolepsy, all of the following criteria must be met: a. Established diagnosis of Narcolepsy from a sleep specialist. b. Full nocturnal polysomnogram and a multiple sleep latency test showing mean onset to sleep less than 10 minutes. c. No other polysomnographic reasons to explain sleepiness, d. For members who are under 65 years of age documentation of trial and failure, contraindication or intolerance to one formulary stimulant (e.g. methylphenidate, dextroamphetamine/amphetamine). For Obstructive Sleep Apnea: Established diagnosis of Sleep Apnea from a sleep specialist. For Shift Work Sleep Disorder all of the following criteria must be met: a. Diagnosis of shift-work sleep disorder in accordance with criteria stipulated in the International Classification of Sleep Disorders: i. The patient has a primary complaint of insomnia or excessive sleepiness, AND ii. The primary complaint is temporally associated with a work period (usually night work) that occurs during the habitual sleep phase, AND iii. No medical or mental disorder accounts for the symptoms, AND iv. The symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness (i.e. time-
zone changes). b. Documentation of specific functional impairment for a minimum of 3 months (social or occupational). Ongoing approval will require documentation that armodafinil (Nuvigil®) has been effective.
MEDICATION(S)
OCALIVA

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Laboratory monitoring: total bilirubin (tBili), alkaline phosphatase (ALP), and aspartate aminotransferase (AST) and Child-Pugh class. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with, a Gastroenterology or Hepatology specialist.

COVERAGE DURATION
Initial authorization will be approved for 4 months. Reauthorization will be approved for one year.

OTHER CRITERIA
1) Confirmed diagnosis of Primary Biliary Cirrhosis with two of three of the following criteria are met: A) Elevated alkaline phosphatase (greater than upper limit of normal [ULN]), B) Presence of antimitochondrial antibody (AMA), C) Liver biopsy consistent with primary biliary cirrhosis AND 2) One of the following: A) Use of ursodiol for a minimum of 6 months and failure to achieve any of the following: alkaline phosphatase (ALP) less than or equal to 1.5 X ULN, aspartate aminotransferase (AST) less than or equal to 1.5 X ULN, or total bilirubin (tBili) less than or equal to ULN. If laboratory reference values for ALP are not available, the values used in a clinical trial may be used for this assessment (ULN = 117 U/L for women; 129 U/L for men). AND Documentation that ursodiol will be continued OR B) Intolerable adverse effect with ursodiol AND 3) Dose is appropriate based on an assessment of hepatic function (Child-Pugh class). Reauthorization Criteria, for use beyond 4 months: Dose is titrated, if indicated and medication is tolerated. Reauthorization Criteria, for use beyond 1 year: 1) Maintenance of biochemical response (ie. alkaline phosphatase (ALP) less than or equal to 1.5
X ULN, aspartate aminotransferase (AST) less than or equal to 1.5 X ULN, and total bilirubin (tBili) greater than or equal to ULN) AND 2) Continuation of ursodiol, if tolerated.
OCTREOTIDE

MEDICATION(S)
OCTREOTIDE 1,000 MCG/5 ML VIAL, OCTREOTIDE 1,000 MCG/ML VIAL, OCTREOTIDE 5,000 MCG/5 ML VIAL, OCTREOTIDE ACET 0.05 MG/ML VL, OCTREOTIDE ACET 100 MCG/ML AMP, OCTREOTIDE ACET 100 MCG/ML VL, OCTREOTIDE ACET 200 MCG/ML VL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE ACET 50 MCG/ML VIAL, OCTREOTIDE ACET 500 MCG/ML AMP, OCTREOTIDE ACET 500 MCG/ML VL

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Baseline cardiac status including ECG, renal function. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Safety and efficacy has not been established in the pediatric population.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
N/A
MEDICATION(S)
ODOMZO

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months

OTHER CRITERIA
N/A
MEDICATION(S)
ESBRIET, OFEV

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Forced Vital Capacity (FVC), high-resolution computed tomography

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a pulmonologist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
Confirmed diagnosis of Idiopathic Pulmonary Fibrosis and presence of a histological pattern associated with usual interstitial pneumonia (UIP) on high-resolution computed tomography or lung biopsy.
MEDICATION(S)
OLYSIO

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
In patients with decompensated liver disease. Simeprevir and PEG/Ribavirin combination use in HCV genotype 1a with Q80K polymorphism. Use in patients that are prior relapers to protease inhibitors (PIs).

REQUIRED MEDICAL INFORMATION
HCV Genotype, Q80K Polymorphism Test, Bilirubin, INR, albumin, CBC. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required.

AGE RESTRICTION
Approved for 18 years and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist.

COVERAGE DURATION
12 to 24 weeks based on indication and established treatment guidelines.

OTHER CRITERIA
1. Documentation of confirmed diagnosis of CHC infection with genotypes 1 AND 2. Documentation that simeprevir will be given in combination with sofosbuvir AND 3. Documentation of prior chronic hepatitis C treatment history and response to therapy AND 4. Documentation that patient will be monitored for adherence.
MEDICATION(S)
ONFI 10 MG TABLET, ONFI 2.5 MG/ML SUSPENSION, ONFI 20 MG TABLET

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for 2 years and older.

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
1. Documentation of trial and failure, intolerance or contraindication to two (2) of the following anti-epileptic medications: sodium valproate, topiramate, and/or lamotrigine as adjunctive treatment. OR 2. Prescriber is a neurologist. AND 3. For members 65 years and older: a. Prescribing provider indicates that medical benefits exceed the risks associated with this medication.
ORAL ANTIDIABETIC AGENTS

MEDICATION(S)
ALOGLIPTIN, ALOGLIPTIN-METFORMIN, ALOGLIPTIN-PIOGLITAZONE, FARXIGA, GLYXAMBI, INVOKAMET, INVOKANA, JANUMET, JANUMET XR, JANUVIA, JARDIANE, JENTADUETO, JENTADUETO XR, KAZANO, KOMBIGLYZE XR, NESINA, ONGLYZA, OSENI, SYNJARDY, TRADJENTA, XIGDUO XR

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
HbA1c. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months, up to 6 months. Reauthorization for 12 months.

OTHER CRITERIA
All the following criteria are required: 1. Documentation of trial and failure, contraindication or intolerance to metformin therapy, up to a maximum effective dose of 2000 mg/day AND 2. Documented trial and failure of a sulfonylurea or pioglitazone therapy OR contraindications exist to both of these therapies that precludes trial of a sulfonylurea (e.g., known hypersensitivity reactions to components of product) OR pioglitazone e.g., Class III or IV heart failure). AND 3. A documented HbA1c, obtained within the last six months, that is greater than or equal to 7% and less than or equal to 10%. Criteria for evaluation of effective response: Reauthorization requires that the HbA1c remains less than or equal to 9%
MEDICATION(S)
ORKAMBI 200 MG-125 MG TABLET

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FDA-cleared CF mutation test results. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication is necessary, as specified in reauthorization criteria.

AGE RESTRICTION
Approved for patients 12 years or older

PRESCRIBER RESTRICTION
Must be prescribed by a Pulmonologist or provider at a Cystic Fibrosis Center.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
Diagnosis of cystic fibrosis with documentation of homozygous F508del mutation in the CFTR gene, through an FDA-cleared CF mutation test. For reauthorization: Documented response to therapy as defined as one of the following: a) A lack of decline in lung function as measured by the FEV1 when the patient is clinically stable. b) A reduction in the incidence of pulmonary exacerbations. c) A significant improvement in BMI by 10% from baseline.
OSTEOPOROSIS

MEDICATION(S)
FORTEO, MIACALCIN 200 UNIT/ML VIAL, MIACALCIN 400 UNIT/2 ML VIAL

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For the treatment or prevention of osteoporosis: BMD T-score or FRAX. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Forteo: Endocrinologists or Rheumatologists

COVERAGE DURATION
Initial approval and renewal for 1 year. Total duration of Forteo in lifetime limited to 2 years.

OTHER CRITERIA
For the treatment or prevention of osteoporosis: Documentation of trial and failure, contraindication, or intolerance to a formulary generic bisphosphonate therapy AND One of the following criteria: Documented clinical diagnosis of osteoporosis [defined as a non-traumatic, non-pathologic spinal fracture OR spine or hip bone mineral density (BMD) T-score less than or equal to -2.5].OR Documented risk of osteoporosis (defined as BMD T-score between -1.0 and -2.5) AND meeting one of two risk assessments: one of the following risk factors: previous fracture history of hip or spine fracture in first degree relative low body weight (less than127 lbs. for women),smoking, excess alcohol intake secondary osteoporosis (e.g. rheumatoid arthritis)history of falls B.FRAX Hip fracture probability greater than or equal to 3% or other major osteoporosis fracture probability greater than or equal to 20% OR One of the following chronic glucocorticosteroid use: A.greater than 20 mg/day for longer than 1 month B.5-20 mg/day for longer than 3 months in post menopausal women not on estrogen C.5-20 mg/day for longer than 3 months AND T-score less than-1.5.
OTEZLA

MEDICATION(S)
OTEZLA

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Use in combination with biologic DMARDs (e.g., Humira, Enbrel, Stelara)

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for adults 18 years of age and older

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a rheumatologist or dermatologist.

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
1. For Psoriatic Arthritis documentation of trial, failure, intolerance or contraindication to two of the following targeted immune modulators: Enbrel, Humira, Remicade, Simponi, or Stelara OR 2. For moderate to severe Plaque Psoriasis, documentation of trial, failure, intolerance or contraindication to two of the following targeted immune modulators: Enbrel, Humira, Remicade, or Stelara. Reauthorization requires documentation of adequate response to therapy.
MEDICATION(S)
OXYMORPHONE HCL

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
Documentation of trial and failure, contraindication or intolerance to immediate release morphine sulfate and immediate release oxycodone.
PART D VS PART B

MEDICATION(S)
ACETYLICYSTEINE 10% VIAL, ACETYLICYSTEINE 20% VIAL, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL 5 MG/ML SOLUTION, ALBUTEROL SUL 0.63 MG/3 ML SOL, ALBUTEROL SUL 1.25 MG/3 ML SOL, ALBUTEROL SUL 2.5 MG/3 ML SOLN, AMINOSYN II 15% IV SOLUTION, ASTAGRAF XL, AZATHIOPRINE 50 MG TABLET, AZATHIOPRINE SODIUM, BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, CALCITRIOL 0.25 MCG CAPSULE, CALCITRIOL 0.5 MCG CAPSULE, CALCITRIOL 1 MCG/ML AMPUL, CALCITRIOL 1 MCG/ML SOLUTION, CELLCEPT 200 MG/ML ORAL SUSP, CROMOLYN 20 MG/2 ML NEB SOLN, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 100 MG/ML SOLN, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE 50 MG/ML AMPUL, CYCLOSPORINE MODIFIED, DOXERCALCIFEROL, ENGERIX-B 20 MCG/ML SYRN, ENGERIX-B PEDIATRIC-ADOLESCENT, GENGRAF, INTRALIPID, IPRATROPIUM BR 0.02% SOLN, IPRATROPIUM-ALBUTEROL, LEVOCARNITINE 100 MG/ML SOLN, LEVOCARNITINE 200 MG/ML VIAL, LEVOCARNITINE 330 MG TABLET, LIDOCAINE 5% OINTMENT, LIDOCAINE-PRILOCAINE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID, NEBUPENT, NULOJIX, NUTRILIPID, PARICALCITOL, PROGRAF 5 MG/ML AMPULE, PULMOZYME, RAPAMUNE 1 MG/ML ORAL SOLN, RECOMBIVAX HB 10 MCG/ML VIAL, RECOMBIVAX HB 40 MCG/ML VIAL, SIROLIMUS 0.5 MG TABLET, SIROLIMUS 1 MG TABLET, SIROLIMUS 2 MG TABLET, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 1 MG CAPSULE, TACROLIMUS 5 MG CAPSULE, TOBRAMYCIN 300 MG/5 ML AMPULE, VIMPAT 200 MG/20 ML VIAL, ZEMPLAR 10 MCG/2 ML VIAL, ZEMPLAR 2 MCG/ML VIAL, ZEMPLAR 5 MCG/ML VIAL, ZOLEDRONIC ACID 4 MG VIAL, ZOLEDRONIC ACID 4 MG/5 ML VIAL, ZOMETA 4 MG/100 ML INJECTION, ZORTRESS

DETAILS
This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
**MEDICATION(S)**
PRALUENT PEN, PRALUENT SYRINGE, REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Low-density lipoprotein cholesterol (LDL-C) levels. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
For ASCVD: must be prescribed by or in consultation with a cardiologist. For FH: must be prescribed by or in consultation with a cardiologist, endocrinologist, or board certified lipidologist.

**COVERAGE DURATION**
Initial authorization for six months. Reauthorization approved for one year subject to criteria.

**OTHER CRITERIA**
1. For all indications must have documentation of one of the following: a) Current use of high-intensity statin therapy for at least 3 months, defined as atorvastatin 40-80 mg daily or rosuvastatin (Crestor) 20-40 mg daily, OR b) The patient has a documented intolerance, FDA labeled contraindication or hypersensitivity to a statin AND 2. Must meet listed criteria below for each specific diagnosis: a) For familial hypercholesterolemia (FH), confirmed diagnosis by one of the following: i) Genetic mutation in one of the following genes: LDLR, APOB, or PCSK9, OR ii) LDL-C greater than 330 mg/dl, OR iii) LDL-C greater than 190 mg/dl and two of the following: 1) Presence of tendon xanthomas in patient or in first- or second-degree relatives, 2) History of premature atherosclerotic cardiovascular disease (ASCVD) in men less than 55 years or women less than 60 years, 3) First-degree relative with premature ASCVD (men less than 55 years and women less than 60 years), b.) For atherosclerotic cardiovascular disease (ASCVD), documentation of one of the following LDL-C level and
cardiovascular risk combinations. LDL-C levels must be taken after at least 3 months of continuous therapy with statin outlined in criterion 1 above: i) LDL-C greater than 70 mg/dl and history of clinical ASCVD, defined as one of the following: NSTEMI, myocardial infarction, unstable angina, coronary revascularization, or clinically significant multi-vessel coronary heart disease. ii) LDL-C of greater than 100 mg/dl and one of the following risk factors: peripheral artery disease, history of ischemic stroke, chronic kidney disease, or diabetes mellitus with at least two additional cardiovascular risk factors (e.g. hypertension, retinopathy, or family history of premature CVD). Reauthorization: Documentation of response to therapy, defined as a decrease in LDL-C levels from pre-treatment levels.
**MEDICATION(S)**
POMALYST

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting drug medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consultation with an oncologist.

**COVERAGE DURATION**
Initial authorization for 3 months, up to 6 months. Reauthorization for 6 months.

**OTHER CRITERIA**
Documentation of trial, failure, intolerance or contraindication to lenalidomide and bortezomib.
MEDICATION(S)
PROCYSBI

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documentation of trial and failure, contraindication or intolerance to Cystagon immediate release tablets.
PROLIA

MEDICATION(S)
PROLIA

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
BMD T-score

For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
Must meet all criteria below for the treatment of men or postmenopausal women with osteoporosis at high risk of fracture:

1. Documentation of trial and failure, contraindication or intolerance to bisphosphonate therapy

AND

2. One of the following criteria:
   A. Documented clinical diagnosis of osteoporosis (defined as a non-traumatic, non-pathologic spinal fracture OR spine or hip bone mineral density (BMD) T-score less than or equal to -2.5)
B. Documented risk of osteoporosis (defined as BMD T-score between -1.0 and -2.5) AND meeting one of the following two risk assessments:

1. One of the following risk factors:
   a. previous fracture
   b. history of hip or spine fracture in first degree relative
   c. low body weight (less than 127 lbs for women)
   d. smoking, excess alcohol intake
   e. secondary osteoporosis (e.g. rheumatoid arthritis)
   f. history of falls

2. FRAX Hip fracture probability greater than or equal to 3% or other major osteoporosis fracture probability greater than or equal to 20%

OR

C. One of the following chronic glucocorticosteroid use:
   a. greater than 20 mg/day for longer than 1 month
   b. 5-20 mg/day for longer than 3 months in post menopausal women not on estrogen
   c. 5-20 mg/day for longer than 3 months AND T-score less than -1.5
**MEDICATION(S)**
PROMACTA

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
NA

**REQUIRED MEDICAL INFORMATION**
Platelet Count AND For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
NA

**PREScriber RESTRICTION**
Prescribed by or in consultation with an Oncologist/Hematologist/Hepatologist.

**COVERAGE DURATION**
Initial auth will be approved for 3 months. Reauth will be approved for 6 months.

**OTHER CRITERIA**
Chronic immune thrombocytopenia (ITP): 1. Patient is at risk for bleeding with a platelet count of less than 30 x 10 to the ninth power/L. AND 2. Treatment by at least one of the following was ineffective or not tolerated: a. Systemic corticosteroids, OR b. Immune globulin, OR c. Splenectomy.
Thrombocytopenia in patients with chronic hepatitis C: 1. Not to be taken with direct-acting antiviral agents for treatment of chronic hepatitis C genotype 1. AND 2. Patient must not be able to initiate interferon therapy OR the optimal interferon-based therapy is prevented by the patient’s thrombocytopenia. Severe aplastic anemia: 1. Patient is at risk for bleeding with a platelet count of less than or equal to 30 x 10 to the ninth power/L. AND 2. Documented trial, failure, intolerance or contraindication to an immunosuppressive therapy (e.g. cyclosporine).
MEDICATION(S)
LETAIRIS, OPSUMIT, ORENITRAM ER, TRACLEER, UPTRAVI, VENTAVIS

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Tracleer, Letairis, and Opsumit are contraindicated during pregnancy.

REQUIRED MEDICAL INFORMATION
For initiation of single agent treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary. For the approval of combination therapy with PAH medications, the provider should identify the physiologic or functional endpoint that would be considered successful and report success within three months for continued PA approval.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a Pulmonologist or Cardiologist.

COVERAGE DURATION
Initial authorization for 3 months, up to 6 months. Reauthorization for 12 months.

OTHER CRITERIA
The following criteria must be documented: 1. Catheterization-proven diagnosis of Pulmonary Arterial Hypertension as defined by: a. Mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest or greater than 30 mmHg with exercise, AND b. Pulmonary capillary wedge pressure (PCWP) less than 15 mmHg AND 2. Patient has WHO classification of Functional Status of Patients with Pulmonary Hypertension OR New York Heart Association (NYHA) Functional Class II to IV for Tracleer, Class III or IV for Ventavis, Class II or III for Letairis. In addition, for Tracleer the following must be met: 3. Patients must be enrolled in the TAP post-marketing program. In addition, for Letairis the following must be met: 4. Patients must be enrolled in the Letairis Education and Access Program (LEAP). In addition, for Opsumit the following must be met: 5. Patients must be enrolled in the Opsumit REMS Program.
MEDICATION(S)
REGRANEX

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and one reauthorization will be approved for 90 days.

OTHER CRITERIA
For initiation, must submit the following: 1. Documentation of adequate blood tissue supply to the affected area AND 2. The record must demonstrate use of good ulcer care for a minimum of 8 weeks prior to request for initiation of therapy. Good ulcer care will generally include documentation of the following: Establishment of adequate blood supply as indicated above. Determination of adequate nutritional status with a serum albumin level of greater than 2g/dL. Appropriate debridement to remove dead tissue with ongoing debridement as necessary. No weight on affected area to relieve pressure points. Systemic treatment of wound infections if present. Maintenance of a moist wound environment (dressing changes including alginates, foams, hydrocolloids, hydro gels, and transparent films). For reauthorization for a second 90 day course must submit documentation showing an adequate response defined by a 30% reduction or greater in ulcer size. There is no medical evidence to justify ongoing treatment after 180 days of Regranex treatment.
**MEDICATION(S)**
RELISTOR 12 MG/0.6 ML SYRINGE, RELISTOR 12 MG/0.6 ML VIAL, RELISTOR 8 MG/0.4 ML SYRINGE

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Initial authorization for 6 mo. Reauthorization for 1 year ONLY for use in chronic non-cancer pain.

**OTHER CRITERIA**
Documentation must be submitted that all of the following criteria are met: 1. Member with advanced illness receiving palliative care AND 2. Chronic opioid therapy AND 3. Trial and failure of polyethylene glycol 3350.
MEDICATION(S)
ARALAST NP, GLASSIA, PROLASTIN C, ZEMAIRA

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Alpha1-antitrypsin (AAT) serum concentrations. FEV1. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization for 3 months, up to 6 months. Reauthorization for 12 months.

OTHER CRITERIA
Documentation of: 1. Serum alpha 1 antitrypsin (AAT) concentrations less than 80 mg/dL (11 uM/L) AND 2. Clinical evidence of emphysema
**REVATIO/ADCIRCA**

**MEDICATION(S)**
ADCIRCA, REVATIO 10 MG/ML ORAL SUSP, SILDENAFIL, SILDENAFIL 10 MG/12.5 ML VIAL

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
Patients using organic nitrates, either regularly and/or intermittently.

**REQUIRED MEDICAL INFORMATION**
For initiation, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary. For the approval of combination therapy with PAH medications, the provider should identify the physiologic or functional endpoint that would be considered successful.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with a cardiologist or pulmonologist.

**COVERAGE DURATION**
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

**OTHER CRITERIA**
The following criteria must be documented: 1. Catheterization-proven diagnosis of Pulmonary Arterial Hypertension as defined by: a. Mean pulmonary artery pressure (mPAP) greater than 25 mmHg at rest or greater than 30 mmHg with exercise. AND b. Pulmonary capillary wedge pressure (PCWP) less than 15 mmHg AND 2. Patient has WHO classification of Functional Status of Patients with Pulmonary Hypertension OR New York Heart Association (NYHA) Functional Class II or III. When sildenafil (Revatio) or Tadalafil (Adcirca) are used in conjunction with other treatment for PAH, specifically epoprostenol (Flolan), treprostinil (Remodulin) or bosentan (Tracleer), the combination will be reviewed on a case-by-case basis and must be prescribed by a physician specializing in the management of pulmonary arterial hypertension. For continued approval of combination therapy with PAH medications, successful improvement of predefined endpoints (as defined in required medical information) within three months of therapy is needed.
MEDICATION(S)
REVLIMID

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Patients who are pregnant.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed or recommended by a hematologist or oncologist.

COVERAGE DURATION
Initial authorization for 3 months, up to 6 months. Reauthorization for 6 months.

OTHER CRITERIA
Verification of enrollment in the RevAssist program.
MEDICATION(S)
REXULTI

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
For adjunctive treatment of major depressive disorder: 1. Documentation of current use of a formulary, generic antidepressant (e.g., citalopram, sertraline, paroxetine, duloxetine), AND 2. Documented trial, failure, intolerance or contraindication to two formulary, antipsychotics approved for use in this condition (e.g. Seroquel XR, aripiprazole). For schizophrenia: Documented trial, failure, intolerance or contraindication to two formulary, generic antipsychotics (e.g., quetiapine, olanzapine, ziprasidone, risperidone)
RITUXAN

MEDICATION(S)
RITUXAN

COVERED USES
All FDA Approved Indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist or Rheumatologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for six months.

OTHER CRITERIA
1. Documentation of trial, failure, intolerance, or contraindication to two of the following targeted immune modulators: Enbrel, Humira, Remicade, Simponi 50mg or Simponi Aria. At least one of the agents must be an intravenously infused drug (Remicade or Simponi Aria). AND 2. Documentation that Rituxan will be used concurrently with methotrexate. If intolerance or contraindication to methotrexate, then in combination with another DMARD, unless medical rationale is provided to support monotherapy. Reauthorization requires documentation of adequate response to therapy.
MEDICATION(S)
SAPHRIS

COVERED USES
All FDA-approved indications not otherwise excluded from part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
Documentation of trial and failure, contraindication or intolerance to two generic formulary medications indicated for the treatment of schizophrenia or bipolar disorder (e.g., olanzapine, risperidone, ziprasidone).
**MEDICATION(S)**
SIGNIFOR

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
NA

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
NA

**PREScriber restriction**
NA

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for six months.

**OTHER CRITERIA**
Confirmation of Cushing’s disease with 2 of the 3 following tests: 1. 24 hr urine cortisol (UFC) (normal range can vary per laboratory: usually a positive test is above 10 mcg/24h) 2. Overnight dexamethasone suppression test (1 mg dexamethasone is given at 11 PM, cortisol next day should be less than 1.8ug/dl). 3. Three midnight salivary cortisol specimens (depending on test utilized, a positive test would be above 145 ng/dl).
MEDICATION(S)
SIMVASTATIN 80 MG TABLET

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization for 12 months.

OTHER CRITERIA
Documentation demonstrating that member has been maintained on simvastatin 80 mg for 12 months or more without evidence of muscle toxicity.
MEDICATION(S)
SOMAVERT

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
All of the criteria below must be met: Confirmed diagnosis of acromegaly. Documented failure of response to surgery and/or radiation therapy or documentation that surgery/radiation is not clinically appropriate. Documented failure of response or contraindication to octreotide acetate (Sandostatin) therapy.
**MEDICATION(S)**
SOVALDI

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
HCV genotype, CrCl, CBC. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required.

**AGE RESTRICTION**
Approved for 18 years and older.

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist.

**COVERAGE DURATION**
12 wks. 24 wks for GT3 and IFN ineligible GT 1&4. 48 wks in transplant candidates with liver cancer.

**OTHER CRITERIA**
1. Documentation of confirmed diagnosis of CHC infection AND 2. One of the following: a) For genotype 2, documentation that sofosbuvir will be given in combination with ribavirin OR b) for genotype 3, documentation that sofosbuvir will be given in combination with therapies that are established by treatment guidelines AND 3. Documentation of prior chronic hepatitis C treatment history and response to therapy.
**SPRITAM**

**MEDICATION(S)**
SPRITAM

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for one year.

**OTHER CRITERIA**
Documented trial, failure, contraindication or intolerance to generic levetiracetam tablets and generic levetiracetam oral solution.
**SPRYCEL**

**MEDICATION(S)**
SPRYCEL

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by an oncologist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for six months.

**OTHER CRITERIA**
For all indications, documentation of response to Sprycel must be submitted in order for continued authorization.
STIMULANTS

MEDICATION(S)
DEXMETHYLPHENIDATE HCL, DEXTROAMPHETAMINE 10 MG TAB, DEXTROAMPHETAMINE 5 MG TAB, DEXTROAMPHETAMINE SULFATE ER, DEXTROAMPHETAMINE-AMPHET ER, DEXTROAMPHETAMINE-AMPHETAMINE, METADATE ER, METHYLPHENIDATE ER, METHYLPHENIDATE 10 MG TABLET, METHYLPHENIDATE 20 MG TABLET, METHYLPHENIDATE 5 MG TABLET, METHYLPHENIDATE HCL CD, METHYLPHENIDATE ER 30 MG CAP, METHYLPHENIDATE ER 40 MG CAP, METHYLPHENIDATE LA, METHYLPHENIDATE SR, RITALIN LA 10 MG CAPSULE, RITALIN LA 60 MG CAPSULE, VYVANSE, ZENZEDI 10 MG TABLET, ZENZEDI 5 MG TABLET

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale is required. For continuation of therapy documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
1. Member is under 65 years old OR 2. Documentation that medical benefits exceed the risks (e.g., dependence, hypertension, myocardial ischemia, agitation, insomnia, and seizures) associated with these medications is needed.
MEDICATION(S)
STIVARGA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist.

COVERAGE DURATION
Initial authorization for 3 months, up to 6 months. Reauthorization for 6 months.

OTHER CRITERIA
N/A
MEDICATION(S)
STRENSIQ

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for one year.

OTHER CRITERIA
Initial Authorization: 1) Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia confirmed by all of the following criteria: a) Patient less than or equal to 18 at age of onset of disease, and b) Total serum alkaline phosphatase (ALP) below the lower limit of normal for age, 2) One or more of the following HPP-related findings: a) Radiographic evidence of HPP, b) History or presence of non-traumatic fracture or delayed fracture healing, c) Nephrocalcinosis or history of elevated serum calcium, d) Functional craniosynostosis, e) Respiratory compromise or rachitic chest deformity, f) Vitamin B6-responsive seizures, or g) Failure to thrive.
Reauthorization: Response to therapy with either improvement in respiratory status, growth or radiographic findings
MEDICATION(S)
BUPRENORPHINE-NALOXONE

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Treatment of chronic pain.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization for 3 months, up to 6 months. Reauthorization for 6 months.

OTHER CRITERIA
Must meet all of the following criteria: 1. an opioid dependence treatment plan is in place including psychosocial counseling AND 2. a dosing and tapering plan is in place AND 3. patient is abstaining from opioids (verified by claims) unless medically necessary for acute pain. Reauthorization will require evidence of compliance (consistent fill history) abstinence from use of opioids (verified by claims) and documentation of tapering plan or rationale to continue maintenance dosing.
**SUTENT**

**MEDICATION(S)**
SUTENT

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by an oncologist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for 6 months.

**OTHER CRITERIA**
For all indications, documentation of response to Sutent must be submitted for continued authorization.
**SYLATRON**

**MEDICATION(S)**
SYLATRON, SYLATRON 4-PACK

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation with a Hematologist/Oncologist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for 6 months.

**OTHER CRITERIA**
Reauthorization will only be approved up to 5 years of therapy within patient's lifetime.
MEDICATION(S)
SYLVANT 100 MG VIAL

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist or hematologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
**MEDICATION(S)**
SYMLINPEN 120, SYMLINPEN 60

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
Patients that require the use of drugs known to alter gastrointestinal motility (i.e. GI anticholinergics, metoclopramide). Patients with a confirmed diagnosis of gastroparesis.

**REQUIRED MEDICAL INFORMATION**
HbA1c. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Prescribed by an endocrinologist or in consultation with an endocrinologist or credentialed diabetic specialist.

**COVERAGE DURATION**
Initial auth for 6 months and reauth approved 1 yr subject to effective response criteria.

**OTHER CRITERIA**
All of the following criteria must be met: Patient is an insulin dependent diabetic AND Patient's HbA1c is greater than or equal to 7% and is less than or equal to 9% AND documentation of the failure of achieving optimal glycemic control despite multiple titrations and adjustments with various basal and bolus insulin dosing regimens. Optimal glycemic control is defined as HbA1c is less than 7%. Criteria for evaluation of effective response: - Reauthorization requires that the HbA1c remains less than or equal to 9%.
SYNRIBO

MEDICATION(S)
SYNRIBO

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for six months.

OTHER CRITERIA
NA
MEDICATION(S)
TAGRISSO

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with an oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
N/A
MEDICATION(S)
TARCEVA

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for six months.

OTHER CRITERIA
For all indications, documentation of response to Tarceva must be submitted in order for continued authorization.
**MEDICATION(S)**
BEXAROTENE, TARGRETIN

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by an Oncologist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for one year.

**OTHER CRITERIA**
Oral Targretin - Trial, failure, intolerance or contraindication to one conventional therapy including, but not be limited to: Extracorporeal photopheresis, isotretinoin, interferon, vorinostat, denileukin diftitox, low-dose methotrexate Topical Targretin Gel - Trial, failure, intolerance or contraindication to one conventional therapy including, but not be limited to: Corticosteroids, mechlorethamine HCl, carmustine, phototherapy (UVB or PUVA) For all indications, documentation of response to Targretin must be submitted in order for continued authorization.
MEDICATION(S)
TASIGNA

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for six months.

OTHER CRITERIA
N/A
TECHNIVIE

MEDICATION(S)
TECHNIVIE

COVERED USES
All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
In patients with liver cirrhosis or decompensated liver disease

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting specific HCV genotype, pathology report demonstrating chronic HCV infection, baseline HCV RNA count, complete blood count, and renal function status are required.

AGE RESTRICTION
Approved for 18 years and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist

COVERAGE DURATION
12 weeks

OTHER CRITERIA
MEDICATION(S)
ANDRODERM, ANDROGEL, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 25 MG/2.5 GM PKT, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for adults 18 years of age and older.

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for lifetime approval.

OTHER CRITERIA
Diagnosis of primary or secondary (hypogonadatropic) hypogonadism when documentation of at least ONE low testosterone level (total testosterone less than 300 ng/mL or free testosterone less than 9 ng/dL) drawn prior to 10 AM.
MEDICATION(S)
THIORIDAZINE HCL

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 1 year.

OTHER CRITERIA
1. Member is under 65 years old OR 2. Documented trial, failure, contraindication or intolerance to at least two formulary agents used in the treatment of schizophrenia such as olanzapine, ziprasidone, risperidone, or haloperidol. AND For all FDA approved indications, prescribing provider indicates that medical benefits exceed the risks associated with these medications (increased risk of anticholinergic adverse effects and QT-interval prolongation).
MEDICATION(S)
TOPIRAMATE ER

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for 2 years and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documentation of trial and failure, intolerance or contraindication to topiramate immediate release and one additional formulary anti-epileptic medication: e.g. valproic acid, clonazepam or lamotrigine. OR, Prescriber is a neurologist.
TRETINOIN ORAL

MEDICATION(S)
TRETINOIN 10 MG CAPSULE

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist.

COVERAGE DURATION
Authorization will be approved for 3 months only.

OTHER CRITERIA
N/A


MEDICATION(S)
TRINTELLIX

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
Documented trial, failure, intolerance or contraindication to at least two formulary antidepressants for the treatment of Major Depressive Disorder (e.g. citalopram, fluoxetine, sertraline, paroxetine).
MEDICATION(S)
TYKERB

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
For all indications, documentation of response to Tykerb must be submitted in order for continued authorization.
**MEDICATION(S)**

TYSABRI

**COVERED USES**

All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**

Use of Tysabri in combination with other disease modifying therapy to treat patients with multiple sclerosis will not be covered. In Crohn's disease, the use of Tysabri in combination with immunosuppressants or inhibitors of TNF-alpha will not be covered.

**REQUIRED MEDICAL INFORMATION**

Anti-JCV antibody, Antibody Index. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**

NA

**PRESCRIBER RESTRICTION**

Prescribed by either a neurologist or gastroenterologist.

**COVERAGE DURATION**

Initial authorization for six months and reauthorization will be approved for one year.

**OTHER CRITERIA**

For Multiple sclerosis: 1. Diagnosis of relapsing remitting multiple sclerosis AND 2. Documentation of trial, failure, or intolerance to primary therapy with other disease modifying therapies: one beta-interferon (Avonex, Rebif or Betaseron), Dimethyl fumarate (Tecfidera), or glatiramer acetate (Copaxone), or medical rationale why primary therapies cannot be tried. AND 3. Negative Anti-JCV antibody OR If positive Anti-JCV antibody, must meet the following criteria: a. Confirmation patient has no prior history of cytotoxic or chemotherapy use (excluding steroids) and b. Anti-JCV index is less than or equal to 0.9. For Crohn's disease: 1. Diagnosis of moderate to severe Crohn's disease AND 2. Documentation of trial, failure, intolerance, or lack of response to a formulary TNF-alpha inhibitor (Remicade and/or Humira) indicated for Crohn's. AND 3. Negative Anti-JCV antibody OR If positive Anti-JCV antibody, must meet the following criteria: a. Confirmation patient has no prior history of cytotoxic or chemotherapy use (excluding steroids) and b. Anti-JCV index is less than 0.9.
reauthorization, documentation of response to the medication must be provided.
MEDICATION(S)
UCERIS 9 MG ER TABLET

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for patients 18 years and older.

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 8 weeks.

OTHER CRITERIA
All the following criteria must be met: Trial and failure of or contraindication to a topical AND an oral formulary agent indicated for the treatment of ulcerative colitis (e.g. mesalamine enema or suppositories, Delzicol, Asacol HD). The initial approval of Uceris will allow for an 8-week treatment course. Further approval for Uceris requires medical rationale why standard maintenance therapy with generic budesonide or other medication for ulcerative colitis is not appropriate.
MEDICATION(S)
ULORIC

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
1) Documented clinical diagnosis of gout, and 2) Failed attempt of or contraindications to an adequate treatment course of allopurinol unless renal impairment or hypersensitivity. Failed attempt is defined as having more than one gout flare in a year despite having a documented uric acid level of less than 6 mg/dl.
MEDICATION(S)
VASCEPA 1 GM CAPSULE

COVERED USES
All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
Triglyceride level. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
1. Trial (defined as 2 months of therapy), failure, or contraindication to a formulary agent to treat very high triglycerides such as a fenofibrate. AND 2. A triglyceride level within the past 6 months that is greater than 500 mg/dl.
MEDICATION(S)
VELCADE

COVERED USES
All FDA-approved indications not otherwise excluded from part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an oncologist.

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
N/A
**MEDICATION(S)**
VENCLEXTA, VENCLEXTA STARTING PACK

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by, or in consultation with, an oncologist

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for six months.

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

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by, or in consultation with a Gastroenterologist

COVERAGE DURATION
Initial authorization will be approved for 6 months. Reauthorization will be approved for up to 1 year.

OTHER CRITERIA
Initial authorization: 1. Diagnosis of IBS-D by a gastroenterologist using ROME III Criteria: Recurrent abdominal pain or discomfort (uncomfortable sensation not described as pain) at least 3 days/month in the last 2 months associated with two or more of the following: a. Improvement with defecation b. Onset associated with a change in frequency of stool c. Onset associated with a change in form (appearance) of stool AND 2. Documentation of trial and failure, contraindication, or intolerance to loperamide. Reauthorization requires documentation of response to treatment with Viberzi.
**MEDICATION(S)**
AZACITIDINE

**COVERED USES**
All FDA-approved indications not otherwise excluded from part D.

**EXCLUSION CRITERIA**
NA

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
NA

**PRESCRIBER RESTRICTION**
NA

**COVERAGE DURATION**
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

**OTHER CRITERIA**
NA
MEDICATION(S)
VIEKIRA PAK, VIEKIRA XR

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HCV genotype and subtype, HCV RNA, CrCl. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist.

COVERAGE DURATION
12 weeks. 24 weeks for Genotype 1a with cirrhosis and for liver transplant recipients.

OTHER CRITERIA
1. Documentation of genotype and subtype (e.g. 1a vs. 1b) to determine treatment duration. AND
2. Documentation of any prior chronic hepatitis C treatment history and response to therapy (null responder, partial-responder or relapser) to guide treatment duration. AND
3. Documentation of liver fibrosis status to guide treatment duration. AND
4. Documentation that patient will be monitored for adherence.
MEDICATION(S)
VIIBRYD

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHER CRITERIA
Documented trial and failure of two formulary generic SSRI antidepressants (e.g. citalopram, fluoxetine, sertraline, paroxetine).
**VOTRIENT**

**MEDICATION(S)**
VOTRIENT

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by an oncologist.

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for 6 months.

**OTHER CRITERIA**
For all indications, documentation of response to Votrient must be submitted for continued authorization.
**MEDICATION(S)**
VRAYLAR

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Initial auth for 3 months, up to 12 months. Reauthorization for 12 months.

**OTHER CRITERIA**
Documented trial, failure, or contraindication of two of the following: aripiprazole, olanzapine, risperidone, quetiapine, or ziprasidone.
MEDICATION(S)
WELCHOL

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Monotherapy for the treatment of type 2 diabetes.

REQUIRED MEDICAL INFORMATION
HbA1c, TG. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial: Hyperlipidemia 3 mo up to 12 mo, Diabetes 3 mo up to 6 mo. Reauthorization: 12 months.

OTHER CRITERIA
Primary Hyperlipidemia: 1. Documented intolerance or contraindication to a generic, high-intensity statin (i.e. atorvastatin 80mg) AND 2. Documented trial, intolerance or contraindication to cholestyramine AND 3. TG less than 500mg/dL (absolute contraindication if over 500mg/dL). AND 3. TG less than 500mg/dL (absolute contraindication if over 500mg/dL). Type 2 diabetes 1. Documentation of trial and failure, contraindication or intolerance to metformin therapy, up to a maximum effective dose of 2000 mg/day AND 2. Documented trial and failure of a sulfonylurea or pioglitazone therapy OR contraindications exist to both of these therapies that precludes trial of a sulfonylurea (e.g., known hypersensitivity reactions to components of product) OR pioglitazone e.g., Class III or IV heart failure). AND 3. A documented HbA1c, obtained within the last six months, that is greater than or equal to 7% and less than or equal to 10%. Criteria for evaluation of effective response: Reauthorization requires that the HbA1c remains less than or equal to 9%.
MEDICATION(S)
XALKORI

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form, relevant chart notes documenting medical rationale, and NSCLC that is ALK-positive are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
Verified positive tumor status for the ALK-positive mutation identified by an FDA approved test such as the Vysis ALK Break Apart FISH Probe test. Documentation of response to Xalkori must be submitted in order for continued authorization.
MEDICATION(S)
TETRABENAZINE, XENAZINE

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Active suicidality and/or untreated or inadequately treated depression. Hepatic Impairment. Use in combination with monoamine oxidase inhibitors or reserpine.

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a Neurologist.

COVERAGE DURATION
Initial prior auth will be approved for 3 months. Reauth may be approved for 1 yr.

OTHER CRITERIA
All of the following must be met: 1. Diagnosis of Huntington Disease as defined by: a. DNA testing showing CAG expansion of more than 37 AND b. Family History (if known) AND c. Classic Presentation (choreiform movements, psychiatric problems, and dementia). AND 2. Documentation that chorea is causing functional impairment. After initial 3 month authorization and at least annually, documentation must be provided showing benefit of therapy with improved function through reduction of choreiform movements.
MEDICATION(S)
XGEVA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
For the prevention of skeletal-related events in patients with multiple myeloma.

REQUIRED MEDICAL INFORMATION
For prevention of skeletal-related events in patients with bone metastases from solid tumors: documentation confirming bone metastasis. For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization and reauthorization will be approved for one year.

OTHER CRITERIA
For prevention of skeletal-related events in patients with bone metastases from solid tumors: documented trial and failure of, intolerance to, or contraindication to zoledronic acid or pamidronate therapy.
MEDICATION(S)
XIFAXAN

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Traveler's diarrhea: approved for 12 years of age and older. Hepatic Encephalopathy: approved for 18 years of age and older. Irritable bowel syndrome with diarrhea: approved for adults 18 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
HE (prevention) and IBS without constipation: approved for 1 year. Traveler's diarrhea: 30 days.

OTHER CRITERIA
Traveler's diarrhea (200 mg tablets): 1. Diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli. Xifaxan is not covered if documentation shows diarrhea that is complicated by fever or blood in stool. Hepatic Encephalopathy (HE) (550 mg tablets): 1. Use for the prevention of recurrence of overt HE. AND 2. Documentation of trial and failure, contraindication or intolerance to lactulose. Irritable Bowel Syndrome with diarrhea (IBS-D) (550 mg tablets) with or without small intestinal bacterial growth (SIBO): 1. Documentation of trial and failure, contraindication, or intolerance to opioid mu receptor agonists [e.g. loperamide(Imodium)], AND 2. Diagnosis of IBS-D by a gastroenterologist using ROME III criteria: Recurrent abdominal pain or discomfort (uncomfortable sensation not described as pain) at least 3 days/month in the last 2 months associated with two or more of the following: a) Improvement with defecation b) Onset associated with a change in frequency of stool c) Onset associated with a change in form (appearance) of stool. Reauthorization in IBS-D
requires documentation of initial response to treatment with rifaximin and recurrence of IBS-D symptoms.
MEDICATION(S)
XOLAIR

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For asthma: IgE For initiation, a prior authorization form and relevant chart notes documenting drug rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
Approved for 12 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Initial authorization will be for six months. Reauthorization will be for one year.

OTHER CRITERIA
For asthma, must meet all of the following criteria: 1. Diagnosis of moderate or severe persistent allergic asthma who remain symptomatic on inhaled corticosteroids 2. IgE baseline levels greater than 30 IU/ml 3. Positive skin test to a common perennial aeroallergens. For chronic idiopathic urticaria, must meet all of the following criteria: 1. Documentation that the condition is idiopathic and that secondary causes of urticaria (e.g. offending allergens, physical contact, etc.) have been ruled out 2. Trial and failure of levocetirizine Reauthorization will require objective documentation of response to therapy (e.g. reduction in flares or oral steroid dose).
MEDICATION(S)
XTANDI

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist.

COVERAGE DURATION
Initial authorization for 3 months, up to 6 months. Reauthorization for 6 months.

OTHER CRITERIA
N/A
XYREM

MEDICATION(S)
XYREM

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
Full nocturnal polysomnogram and a multiple sleep latency test (for diagnosis of narcolepsy). For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
NA

COVERAGE DURATION
Initial authorization: 6 months. Reauthorization for 1 year subject to effective response criteria.

OTHER CRITERIA
Xyrem will be approved for Narcolepsy (when all of the following conditions are met): a. Established diagnosis of narcolepsy from a sleep specialist. b. Full nocturnal polysomnogram and a multiple sleep latency test showing mean onset to sleep less than 10 minutes c. No other polysomnographic reasons to explain sleepiness. Ongoing approval will require documentation that Xyrem treatment has been effective.
MEDICATION(S)
ZEPATIER

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
In patients with moderate or severe hepatic impairment (Child-Pugh B or C).

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting specific HCV genotype, baseline HCV RNA count, complete blood count, liver panel, and renal function status are required.

AGE RESTRICTION
Approved for 18 years and older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist.

COVERAGE DURATION
12 to 16 weeks based on indication and consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
1. Criteria will be applied consistent with current AASLD/IDSA guidance AND 2. Documentation of FDA labeled contraindication to ledipasvir-sofosbuvir (Harvoni)
**MEDICATION(S)**
ZETIA

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required.

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
Initial authorization and reauthorization will be approved for one year.

**OTHER CRITERIA**
Documented intolerance or contraindication to two formulary high-intensity statin medications (i.e. atorvastatin 80 mg and Crestor® (rosuvastatin) 40 mg).
MEDICATION(S)
ZOLINZA

COVERED USES
All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
N/A.
**MEDICATION(S)**
ZYDELIG

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consultation with an oncologist or a hematologist.

**COVERAGE DURATION**
Initial authorization for 3 months, up to 6 months. Reauthorization will be approved for 6 mo.

**OTHER CRITERIA**
1. For the diagnosis of relapsed chronic lymphocytic leukemia (CLL), both a and b must be met:
   a. Documentation that idelalisib will be given in combination with rituximab, AND b. Documentation of co-morbidities (e.g. CrCl less than 60 ml/min, severe neutropenia or thrombocytopenia from prior chemotherapies) that would prevent the patient from receiving standard chemotherapy.  

OR 2. For the diagnosis of relapsed follicular B-cell non-Hodgkin lymphoma (FL), documentation that the member has received at least two prior systemic therapies (e.g. rituximab + bendamustine, RCHOP, RCVP).

OR 3. For the diagnosis of relapsed small lymphocytic lymphoma (SLL), documentation of at least two prior systemic therapies (e.g. rituximab +/- chlorambucil, rituximab +/- bendamustine).
**ZYKADIA**

**MEDICATION(S)**
ZYKADIA

**COVERED USES**
All FDA approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA**
NA

**REQUIRED MEDICAL INFORMATION**
For initiation of treatment, a prior authorization form, relevant chart notes documenting medical rationale, NSCLC that is ALK-positive and documentation of progression following or intolerance to treatment with crizotinib are required. For continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

**AGE RESTRICTION**
NA

**PRESCRIBER RESTRICTION**
Must be prescribed by an Oncologist.

**COVERAGE DURATION**
Initial authorization for 3 months, up to 6 months. Reauthorization for 6 months.

**OTHER CRITERIA**
Verified positive tumor status for the ALK-positive mutation identified by an FDA approved test such as the Vysis ALK Break Apart FISH Probe test. Documentation of response to Zykadia must be submitted in order for continued authorization.
MEDICATION(S)
ZYTIGA

COVERED USES
All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
NA

REQUIRED MEDICAL INFORMATION
For initiation of treatment, a prior authorization form and relevant chart notes documenting medical rationale are required and for continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
NA

PRESCRIBER RESTRICTION
Must be prescribed by an Oncologist.

COVERAGE DURATION
Initial authorization and reauthorization will be approved for 6 months.

OTHER CRITERIA
For all indications, documentation of response to Zytiga must be submitted in order for continued authorization.