PHIP PROVIDENCE MEDICARE ADVANTAGE PLANS AND PHIP PROVIDENCE HEALTH PLAN

2018 PRIOR AUTHORIZATION CRITERIA

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For the most recent list of drugs or for any other questions, please contact Providence Medicare Advantage Plans Customer Service at 503-574-8000 or 1-800-603-2340 (TTY: 711). Service is available seven days a week, between 8 a.m. and 8 p.m. (Pacific Time). You may also visit www.ProvidenceHealthPlan.com/PHIP.

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H9047_2018GRAM21
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
ACTINIC KERATOSIS AGENTS

MEDICATION(S)
FLUOROURACIL 0.5% CREAM, PICATO, TOLAK

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 dermatologist.

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

OTHER CRITERIA
Documentation of trial, failure, contraindication or intolerance to the following formulary, generic topical agents: a. 5-fluorouracil (2% or 5% cream/solution) AND b. imiquimod 5% cream. Reauthorization requires documentation of a reduction in the number and/or size of lesions of actinic keratosis and medical rationale for continuing therapy beyond recommended treatment course.
MEDICATION(S)
ADCIRCA, SILDENAFIL, SILDENAFIL 10 MG/12.5 ML VIAL, TADALAFIL 20 MG TABLET

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.

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: Catheterization-proven diagnosis of Pulmonary Arterial Hypertension as defined by: 1. Mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg at rest or greater than 30 mmHg with exercise. AND 2. Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg. 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 within three months of therapy is needed.
**ADEMPAS**

**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**
N/A

**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 or equal to 25 mmHg at rest or greater than 30 mmHg with exercise, AND b. Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg.
MEDICATION(S)
ALBENDAZOLE 200 MG TABLET, ALBENZA, EMVERM

COVERED USES
All FDA-approved indications not otherwise excluded from Part D. The following off-label uses will be covered: pinworm (Enterobius vermicularis) (off-label for Albenza®).

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

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

OTHER CRITERIA
N/A
**ALLERGENS**

**MEDICATION(S)**
ORALAIR

**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**
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 16 weeks 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. For reauthorization: Consistent use during treatment period for allergy season previously approved for coverage.
MEDICATION(S)
AMPYRA, DALFAMPRIDINE ER

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 of improved 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.
ANTIDEPRESSANTS

MEDICATION(S)
DESVENLAFAXINE ER, DESVENLAFAXINE FUMARATE ER, FETZIMA, TRINTELLIX, 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 and reauthorization will be approved for one year.

OTHER CRITERIA
Documented trial, failure, intolerance or contraindication to two formulary, generic SSRIs or SNRIs (e.g., citalopram, sertraline, paroxetine, venlafaxine, duloxetine)
**ANTIPSYCHOTICS**

**MEDICATION(S)**
LATUDA, REXULTI, SAPHRIS, 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 authorization and reauthorization will be approved for one year.

**OTHER CRITERIA**
For adjunctive treatment of major depressive disorder (brexipiprazole only): 1) Documentation of current use of an antidepressant (e.g., citalopram, sertraline, paroxetine, duloxetine) AND 2) Documented trial, failure, intolerance or contraindication to two formulary antipsychotics used for this indication (e.g., quetiapine extended-release, aripiprazole). For schizophrenia or bipolar disorder: Documented trial, failure, intolerance or contraindication to two formulary, generic antipsychotics (e.g., quetiapine immediate-release, olanzapine, ziprasidone, risperidone).
**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. Documentation that patient has significant off episodes AND 2. Documentation of trial and failure, intolerance or contraindication to maximally tolerated dose of 1) levodopa, AND 2) 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.
AUSTEDO

MEDICATION(S)
AUSTEDO

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, reserpine, or tetrabenazine.

REQUIRED MEDICAL INFORMATION
Abnormal Involuntary Movement Scale (AIMS) score or Extrapyramidal Symptom Rating Scale (ESRI) 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
N/A

PRESCRIBER RESTRICTION
For Huntington's disease: prescribed by, or in consultation with, a neurologist
For tardive dyskinesia: prescribed by, or in consultation with, a psychiatrist or neurologist.

COVERAGE DURATION
Initial auth will be approved for 3 months and reauth will be approved for 12 months.

OTHER CRITERIA
For chorea associated with Huntington's disease, diagnosis of Huntington's disease as defined by:
a. DNA testing showing CAG expansion of 36 or more AND b. Family History (if known) AND c. Classic presentation (choreiform movements, psychiatric problems, and dementia). For reauthorization: documentation must be provided showing benefit of therapy with improved function through reduction of choreiform movements. For Tardive Dyskinesia, documentation of tardive dyskinesia secondary to at least 3 months of therapy with a dopamine receptor blocking agent (such as haloperidol) or 1 month in patients 60 years of age and older. Reauthorization requires documentation of successful response to the medication.
BARBITURATES

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.
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 mofetil, Hydroxychloroquine, Chloroquine,
Cyclophosphamide. Reauthorization: 1. Documentation of response to Benlysta. AND 2. Documentation that oral corticosteroid use is stable or decreased.


**BUTALBITAL**

**MEDICATION(S)**

**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. Member is less than 65 years of age. OR 2. 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 3. 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.
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.
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 geneticist, hepatologist, gastroenterologist or metabolic specialist.

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

OTHER CRITERIA
N/A
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 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)
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)**
CRESEMBA

**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, hematologist, oncologist, or pulmonologist.

**COVERAGE DURATION**
Initial authorization will be approved for 3 months. Reauthorization for one year.

**OTHER CRITERIA**
1. For the treatment of invasive aspergillus infections: documented failure, intolerance, or contraindication to voriconazole and posaconazole. 2. For the treatment of invasive mucormycosis, isavuconazonium is covered.
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. Johns wort.

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 24 weeks based on indication and established treatment guidelines

OTHER CRITERIA
1. Criteria will be applied consistent with current AASLD/IDSA guidance AND 2. One of the following:
   a. For genotype 1 infection, documentation of FDA labeled contraindication to ledipasvir-sofosbuvir (Harvoni), OR
   b. For genotype 3 infection, documentation of FDA labeled contraindication to velpatasvir-sofosbuvir (Epclusa)
**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**
N/A

**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**
Roflumilast (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 maximally tolerated dose.
**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)**
DUPIXENT 300 MG/2 ML SAFE SYRG

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

**EXCLUSION CRITERIA**
Use in combination with other therapeutic immunomodulators used for the treatment of skin disorders (e.g., Xolair®, Taltz®).

**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**
Must be 18 years of age or older.

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

**COVERAGE DURATION**
Initial auth will be approved for 3 months, up to 6 months. Re-auth will be approved for 1 year.

**OTHER CRITERIA**
All of the following criteria must be met: 1) Diagnosis of chronic moderate to severe atopic dermatitis despite the use of therapies outlined in criterion number 2 and 3 below. 2) Documented trial and failure of a topical high-potency topical corticosteroid (e.g., clobetasol 0.05%, betamethasone dipropionate 0.05%, triamcinolone 0.5%) applied once daily for at least two (2) weeks or a topical calcineurin inhibitor (e.g., tacrolimus ointment) applied twice daily for at least one (1) month. 3) Documented trial and failure of an adequate treatment course with a systemic immunomodulatory agents (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate) for at least two (2) months unless contraindicated. Reauthorization requires documentation of reduction from baseline of flares, pruritus, and affected BSA.
MEDICATION(S)
DUZALLO

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

EXCLUSION CRITERIA
Monotherapy for the treatment of hyperuricemia associated with gout.

REQUIRED MEDICAL INFORMATION
Serum uric acid 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
N/A

COVERAGE DURATION
Initial authorization for 6 months. Reauthorization for 12 months.

OTHER CRITERIA
1) Documented clinical diagnosis of gout, AND 2) Documented serum uric acid levels greater than 6 mg/dL after at least 3 months of therapy with a xanthine oxidase inhibitor (e.g., allopurinol or febuxostat (Uloric®)), AND 3) Documented trial, failure, contraindication or intolerance to probenecid in combination with a xanthine oxidase inhibitor. Clinical failure is defined as the inability to achieve serum uric acid levels of less than 6 mg/dL after at least three months of combination therapy. Reauthorization requires documented response to therapy as defined by a reduction in occurrence of gout flares, tophi reduction, or serum uric acid levels maintained below 6 mg/dL.
EGRIFTA

**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**
N/A

**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.
**EMFLAZA**

**MEDICATION(S)**
EMFLAZA

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

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Genetic test confirmation of Duchenne muscular dystrophy. 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**
Ages 5 and up.

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

**COVERAGE DURATION**
Initial authorization for 6 months. Reauthorization for 12 months.

**OTHER CRITERIA**
A diagnosis of Duchenne muscular dystrophy with genetic test confirmation AND intolerable side effects to 1) prednisone daily regimen (0.75mg/kg/day) and 2) prednisone weekend regimen (10mg/kg/weekend).
MEDICATION(S)
EPCLUSA

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 specific HCV genotype, baseline HCV RNA count, complete blood count, liver panel, and renal function status are required.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
12 weeks.

OTHER CRITERIA
1. Criteria will be applied consistent with current AASLD/IDSA guidance AND 2. For genotype 1, 4, 5, and 6 infection, documentation of FDA labeled contraindication to ledipasvir-sofosbuvir (Harvoni)
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)
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: interferon-beta 1a (Avonex, Rebi, or Plegridy), interferon-beta 1b (Betaseron), dimethyl fumarate (Tecfidera), glatiramer acetate (Copaxone), teriflunomide (Aubagio) or fingolimod (Gilenya).
FASLODEX

MEDICATION(S)
FASLODEX

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
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
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 16 years or older.

PRESCRIBER RESTRICTION
N/A

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)
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
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 12 years and older.

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 agents used for the treatment of seizure disorder (e.g. carbamazepine, oxcarbazepine, phenytoin, levetiracetam, valproic acid, divalproex).
MEDICATION(S)
BIVIGAM, CARIMUNE NF NANOFILTERED, FLEBOGAMMA DIF, GAMMAGARD LIQUID,
GAMMAGARD S-D, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PRIVIGEN

COVERED USES
All FDA-approved indications not otherwise excluded from Part D. Primary Immune Deficiency Disorders (e.g., agammaglobulinemia, hypogammaglobulinemia, common variable immunodeficiency, HyperIgM, or Wiskott-Aldrich syndrome) are covered by Medicare Part B only. The following off-label uses will be covered, according to criteria outlined below: Hematopoietic Stem Cell Transplant Recipients, Acute Guillian Barre Syndrome, Dermatomyositis, Chronic inflammatory demyelinating polyneuropathy, Multifocal motor neuropathy, Relapsing-remitting type multiple sclerosis, Exacerbation of Myasthenia gravis, Autoimmune Hemolytic Anemia.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
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 Kawasaki syndrome: 1. At least 5 days of fever AND 2) Presence of principal clinical features (e.g., bilateral conjunctival infection without exudate, polymorphous rash, edema of extremities, erythema of palms and soles, changes in oral cavity, cervical lymphadenopathy). For ITP: 1) Documented trial, failure, intolerance or contraindication to systemic corticosteroids (i.e. prednisone or dexamethasone) AND 2) Documentation of active bleeding, high-risk of bleeding, or a platelet count less than 30 cells.
per microliter. Reauthorization: 1) Documentation of platelet count less than 30 cells per microliter AND 2) Active bleeding or high risk of bleeding. For prevention of infections in patients with chronic B cell lymphocytic leukemia: 1) Documented IgG less than 500 mg/dL OR 2) History of recurrent, severe infections. For dermatomyositis: 1) Documented trial, failure, intolerance or contraindication to: a) systemic corticosteroids (i.e. prednisone or methylprednisolone) AND b) immunosuppressant therapy (e.g., methotrexate, azathioprine) AND 2) Documentation of severe symptoms despite previous therapy with above agents. Reauthorization: 1) Documented response to therapy AND 2) Reduction in chronic corticosteroid use. For multifocal motor neuropathy: 1) Motor involvement of at least two nerves for more than one month, without symptoms of sensory abnormalities AND 2) Documentation of severe disease/disability. Reauthorization: Documented response to therapy. For relapsing-remitting type multiple sclerosis: Documentation of trial, failure, intolerance or contraindication to at least two standard therapies (e.g., glatiramer, interferon beta, dimethyl fumarate). For Hematopoietic Stem Cell Transplant (HSCT) Recipients: Documentation of IgG less than 400 mg/dL within 100 days post-transplant. For acute Guillain Barre Syndrome: 1) Documentation of symptom onset within 2 weeks or symptoms are severe (e.g. unable to ambulate independently) For chronic inflammatory demyelinating polyneuropathy: 1) Documented severe disability and 2) One of the following: a) Documented trial, failure, intolerance or contraindication to systemic corticosteroids (i.e. prednisone or methylprednisolone), b) Documentation of pure motor CIDP. For Autoimmune Hemolytic Anemia: 1) Documented trial, failure, intolerance or contraindication to systemic corticosteroids (i.e. prednisone or methylprednisolone) AND 2) Documented trial, failure, intolerance or contraindication to another conventional therapy for autoimmune hemolytic anemia (e.g., cyclophosphamide, azathioprine, cyclosporine)
MEDICATION(S)
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
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**
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 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.
HAEGARDA

MEDICATION(S)
HAEGARDA

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 authorization will be approved for 3 months. Reauthorization 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 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 recommended dose 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.
HARVONI

MEDICATION(S)
HARVONI

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 specific HCV genotype, baseline HCV RNA count, complete blood count, liver panel, and renal function status are required.

AGE RESTRICTION
Approved for 12 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
Criteria will be applied consistent with current AASLD/IDSA guidance.
HEMATOLOGY

MEDICATION(S)
ARANESP, EPOGEN, 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 Crohn's 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 or neurologist.

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
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 1. Ability to ingest solid food. Authorization will be given for a maximum of 4 weeks. Efficacy beyond 4 weeks has not been established.
MEDICATION(S)
ILARIS

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 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
N/A

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. Diagnosis of Familial Mediterranean Fever (FMF) and the following: 1. Documented trial and failure, contraindication or intolerance to colchicin 2. Classic symptoms associated with FMF (febrile episodes, pain in the abdomen, chest or arthritis of large joints Diagnosis of Hyperimmunoglobulin D
(Hyper-IgD) Syndrome (HIDS)/Mevalonate Kinase Deficiency confirmed by: 1. Laboratory evidence of genetic mutation MVK (mevalonate kinase), a 2. Classic symptoms associated with HIDs (abdominal pain:lymphadenopathy, aphthous ulcers). Diagnosis of Tumor Necrosis Factor (TNF) receptor Associated Periodic Syndrome (TRAPS) confirmed by: 1. Laboratory evidence of genetic mutation TNFRSF1A (tumor necrosis factor receptor super family) and 2. Classic symptoms associated with TRAPs (abdominal pain, skin rash, musculoskeletal pain, eye manifestations).
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
For initial authorization: 1. Height standard deviation score of less than or equal to -3.0 AND 2. Basal IGF-1 standard deviation score of less than or equal to -3.0 AND 3. Normal or elevated growth hormone (GH) based on at least one elevated growth hormone stimulation test AND 4. X-Ray confirmation of open epiphyses. Reauthorization will require evidence that the medication remains effective and X-ray confirmation of open epiphyses.
INGREZZA

MEDICATION(S)
INGREZZA

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Abnormal Involuntary Movement Scale (AIMS) score or Extrapyramidal Symptom Rating Scale (ESRI) 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
18 years of age or older

PRESCRIBER RESTRICTION
For tardive dyskinesia: prescribed by, or in consultation with, a psychiatrist or neurologist.

COVERAGE DURATION
Initial authorization will be approved for 3 months and re-auth will be approved for 12 months.

OTHER CRITERIA
Documentation of tardive dyskinesia secondary to therapy with a dopamine receptor blocking agent (such as haloperidol). Reauthorization requires documentation of successful response to the medication.
**MEDICATION(S)**
JUXTAPID, KYNAMRO

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

**EXCLUSION CRITERIA**
N/A

**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**
N/A

**PRESCRIBER RESTRICTION**
N/A

**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)**
JYNARQUE

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

**EXCLUSION CRITERIA**
Hepatic Impairment, Anuria, Hypovolemia

**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**
May be covered for patients aged 18 years and older

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

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

**OTHER CRITERIA**
For autosomal dominant polycystic kidney disease (ADPKD), all of the following criteria must be met:
1. Diagnosis of ADPKD confirmed by the following: a. Patient has family history of known or suspected ADPKD: at least two cysts per kidney b. Patient without family history of known or suspected ADPKD: genetic confirmation or bilaterally enlarged kidneys with presence of cysts
2. Patient does not have significant renal disease other than ADPKD (e.g., renal cancer, acute kidney injury)
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**
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 ages 6 years and older

**PRESCRIBER RESTRICTION**
N/A

**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
N/A

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

OTHER CRITERIA
N/A
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
Must be prescribed by or in consultation with a metabolic specialist or geneticist.

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

OTHER CRITERIA
For initial authorization, documentation of the diagnosis of phenylketonuria (PKU) by a metabolic specialist. For reauthorization, documentation that average blood Phe levels have decreased by at least 30% and remain 30% below pretreatment baseline.
**MEDICATION(S)**
LAZANDA

**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 18 years or older.

**PRESCRIBER RESTRICTION**
N/A

**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)
LIDOCAINE 5% PATCH

COVERED USES
All FDA-approved indications not otherwise excluded from Part D, diabetic peripheral neuropathy and cancer-related neuropathic pain.

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 gabapentin. Reauthorization will require documentation submitted showing adequate response to therapy.
LUMIZYME

MEDICATION(S)
LUMIZYME

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
MEDICATION(S)
Mavyret

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

EXCLUSION CRITERIA
Coadministration with atazanavir and rifampin. Patients with severe hepatic impairment (Child-Pugh 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, renal function status, prior therapy and response are required.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
8 to 16 weeks based on indication and established treatment guidelines

OTHER CRITERIA
1. Criteria will be applied consistent with current AASLD/IDSA guidance AND 2. Documentation of FDA labeled contraindication to ledipasvir-sofosbuvir (Harvoni) in genotypes 1, 4, 5 and 6 or sofosbuvir/velpatasvir (Epclusa) in genotypes 2 and 3.
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
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. 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
N/A

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

COVERAGE DURATION
Initial authorization 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)**
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.
NOCTIVA

**MEDICATION(S)**
NOCTIVA

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

**EXCLUSION CRITERIA**
Co-administration with loop diuretic or systemic or inhaled glucocorticoids

**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. Serum sodium levels.

**AGE RESTRICTION**
50 years of age and older

**PRESCRIBER RESTRICTION**
N/A

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

**OTHER CRITERIA**
Initial Authorization: 1. Diagnosis of nocturnal polyuria has been confirmed with a 24-hour urine collection 2. Patient has a 6 month history of awaking at least two times per night to void 3. All other causes of nocturia have been ruled out or adequately treated [e.g., benign prostatic hyperplasia (BPH), overactive bladder (OAB), obstructive sleep apnea (OSA), medications] 4. Documentation of trial and failure of desmopressin tablets 5. Documentation of a normal serum sodium level based on laboratory reference range within the previous 60 days Reauthorization 1. Documentation of a normal serum sodium level 2. Documentation that the member has had a decrease in nighttime wakening
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
Reauthorization: requires documentation of response to therapy, defined as a reduction in episodes of laughing, crying, and/or emotional lability.
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
AND 2. Mini-mental status examination (MMSE) score of 21 or greater, to indicate ability to self-report symptoms.
**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 ACETATE, SANDOSTATIN LAR, SANDOSTATIN LAR DEPOT

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

EXCLUSION CRITERIA
N/A

REQUIREDMEDICAL 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.

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

PRESCRIBERRESTRICTION
N/A

COVERAGEDURATION
Initial authorization for 3 months, up to 12 months. Reauthorization for 12 months.

OTHERCRITERIA
N/A
OLYSIO

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 relapsers to protease inhibitors (PIs).

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 24 weeks based on indication and established treatment guidelines.

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

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
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
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 ANTI-CANCER AGENTS**

**MEDICATION(S)**
AFINITOR, AFINITOR DISPERZ, ALECENSA, ALUNBRIG, BOSULIF, BRAFTOVI, CABOMETYX, CALQUENCE, CAPRELSA, COMETRIQ, COTELLC, ERIVEDGE, ERLEADA, FARYDAK, GILOTRIF, IBRANCE, ICLUSIG, IDHIFA, IMATINIB MESYLATE, IMBRUVICA, INLYTA, IRESSA, JAKAFI, KISQALI, KISQALI FEMARA CO-PACK, LENVIMA, LONSURF, LYNPARZA, MEKINIST, MEKTOVI, NERLYNX, NEXAVAR, NINLARO, ODOMZO, POMALYST, REVLIMID, RUBRACA, RYDAPT, SPRYCEL, STIVARGA, SUTENT, TAFINLAR, TAGRISSO, TARCEVA, TASNIA, TYKERB, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VOTRIENT, XALKORI, XTANDI, YONSA, ZEJULA, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA, ZYTIGA

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D and those indications supported by National Comprehensive Cancer Network guidelines with recommendation 2A or higher.

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

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

EXCLUSION CRITERIA
N/A

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
N/A

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

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)
NOXAFIL 40 MG/ML SUSPENSION, NOXAFIL DR 100 MG TABLET, VORICONAZOLE 200 MG TABLET, VORICONAZOLE 200 MG VIAL, VORICONAZOLE 40 MG/ML SUSP, VORICONAZOLE 50 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
Must be prescribed by, or in consultation with, an infectious disease specialist, hematologist or oncologist

COVERAGE DURATION
Initial authorization will be approved for 3 months. Reauthorization for one year.

OTHER CRITERIA
1. For oropharyngeal candidiasis: Documented failure, intolerance, or contraindication to two generic, formulary alternatives (e.g., fluconazole, itraconazole) 2. For esophageal candidiasis (voriconazole solution only): Documented failure, intolerance, or contraindication to two generic, formulary alternatives (e.g., fluconazole, itraconazole) 3. For the treatment of invasive Aspergillus or Candida infections, both voriconazole and posaconazole are covered 4. For prophylaxis of invasive Aspergillus or Candida infections (posaconazole only): Patient is immunocompromised due to one of the following: a. Hematopoietic stem cell transplant recipients with graft-versus-host disease b. Current diagnosis of cancer currently undergoing chemotherapy or radiation c. HIV/AIDS
ORENCIA

MEDICATION(S)
ORENCIA 125 MG/ML SYRINGE, ORENCIA 50 MG/0.4 ML SYRINGE, ORENCIA 87.5 MG/0.7 ML SYRINGE, ORENCIA CLICKJECT

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 Rheumatologist.

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

OTHER CRITERIA
Documentation of trial, failure, intolerance, or contraindication to two of the following targeted immune modulators: Enbrel, Humira, Remicade, Simponi 50mg or Simponi Aria.
MEDICATION(S)
ORKAMBI

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 6 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.
OSTEOPOROSIS

MEDICATION(S)
Forteo, Miacalcin 400 Unit/2 mL Vial, Prolia, Tymlos

COVERED USES
All medically accepted 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: 1. Documentation of trial and failure of bisphosphonate therapy or contraindication/intolerance to both oral and IV 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, femoral neck or hip bone mineral density (BMD) T-score less than or equal to -2.5]. OR B. Documented risk of osteoporosis (defined as BMD T-score between -1.0 and –2.5) AND meeting one of two risk assessments a) one of the following risk factors: i. previous fracture, ii. history of hip or spine fracture in first degree relative, iii. low body weight (less than 127 lbs. for women), iv. smoking, excess alcohol intake, v. secondary osteoporosis (e.g. rheumatoid arthritis), vi. 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 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
OTEZLA

MEDICATION(S)
OTEZLA

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 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.
**PART D VS PART B**

**MEDICATION(S)**
ABELCET, ACETYLCYSTEINE 10% VIAL, ACETYLCYSTEINE 20% VIAL, ACYCLOVIR SODIUM, 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, AMBISOME, AMINOSYN II 15% IV SOLUTION, AMPHOTERICIN B 50 MG VIAL, ASTAGRAF XL, AZATHIOPRINE 50 MG TABLET, AZATHIOPRINE SODIUM, BONIVA 3 MG/3 ML SYRINGE, BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, CALCITONIN-SALMON, 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 25 MG CAPSULE, CYCLOSPORINE 50 MG/ML AMPUL, CYCLOSPORINE MODIFIED, DERMACINRX EMPRICAINE, DERMACINRX PRIZOPAK, DOXERCALCIFEROL, ENGERIX-B ADULT, ENGERIX-B PEDIATRIC-adolescent, ENVARSUS XR, GANCICLOVIR 500 MG VIAL, GENGRAF, HEPARIN 10,000 UNIT/10 ML VIAL, HEPARIN 2,000 UNIT/2 ML VIAL, HEPARIN 30,000 UNIT/30 ML VIAL, HEPARIN SOD 1,000 UNIT/ML VIAL, HEPLISAV-B, HIZENTRA, IBANDRONATE 3 MG/3 ML SYRINGE, IBANDRONATE 3 MG/3 ML VIAL, INTRALIPID, IPRATROPIUM BR 0.02% SOLN, IPRATROPIUM-ALBUTEROL, LEVOCARNITINE 200 MG/ML VIAL, LEVOCARNITINE 330 MG TABLET, LIDO-PRILo CAINE PACK, LIDOCAINE 5% OINTMENT, LIDOCAINE-PRILoCAINE, LIDOPRIL, LIDOPRIL XR, LIpROZONEPAK, LP LITE PAK, MEDOLOR PAK, MYCOPHENOLATE 200 MG/ML SUSP, MYCOPHENOLATE 250 MG CAPSULE, MYCOPHENOLATE 500 MG TABLET, MYCOPHENOLIC ACID, NEBUPENT, NULOJIX, NUTRILIPID, PAMIDRONATE DISODIUM, PARICALCITOL, PRILOLID, PROGRAF 5 MG/ML AMPULE, PULMOZYME, RAPAMUNE 1 MG/ML ORAL SOLN, RECOMBIVAX HB, RELADOR PAK, RELADOR PAK PLUS, SENSIPAR, 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, 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, ZOLEDRONIC ACID 5 MG/100 ML, ZOMETA 4 MG/100 ML INJECTION, ZORTRESS 0.25 MG TABLET, ZORTRESS 0.5 MG TABLET, ZORTRESS 0.75 MG TABLET

**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 80 mg daily or rosuvastatin 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. LDLC 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 signification 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.
PREVYMIS

MEDICATION(S)
PREVYMIS

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 18 years and older

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a hematologist, oncologist, or infectious disease specialist

COVERAGE DURATION
Initial authorization will be approved for 3 months, up to 100 days post-transplant.

OTHER CRITERIA
ALL of the following must be met: 1) Patient is within 100 days post- allogeneic transplant, and 2) CMV Recipient positive, and 3) Member has ONE of the following: a) GVHD requiring more than or equal to 1 mg/kg/day use of prednisone [or equivalent] b) Receipt of lymphocyte depleting therapy (eg. antithymocyte globulin [ATG], antithymocyte globulin equine [ATGAM], antithymocyte globulin rabbit [thymoglobulin], alemtuzumab, fludarabine) within the previous 6 months c) Transplant was a cord blood allograft d) History of CMV drug resistance within the past 6 months 4) If IV letermovir is being requested, rationale for not using oral letermovir must be provided (eg. patient is unable to swallow).
MEDICATION(S)
PROCYSBI

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 Cystagon immediate release tablets.
MEDICATION(S)
PROMACTA

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

EXCLUSION CRITERIA
N/A

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
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with an Oncologist, Hematologist, or Hepatologist.

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

OTHER CRITERIA
For chronic immune thrombocytopenia (ITP): 1. Patient is at risk for bleeding with a platelet count of less than 30,000 per microliter. 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. For severe aplastic anemia: 1. Patient is at risk for bleeding with a platelet count of less than or equal to 30,000 per microliter. AND 2. Documented trial, failure, intolerance or contraindication to an immunosuppressive therapy (e.g. cyclosporine). For reauthorization: Patient continues to be at risk for bleeding with a platelet count of less than or equal to 50,000 per microliter.
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
N/A

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
Catheterization-proven diagnosis of Pulmonary Arterial Hypertension as defined by: 1. Mean pulmonary artery pressure (mPAP) greater than or equal to 25 mmHg at rest or greater than 30 mmHg with exercise, AND 2. Pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg
MEDICATION(S)
RADICAVA

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. FVC and ALSFRS-R score.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Initial approval and re-authorization: 6 months

OTHER CRITERIA
Initial criteria: Documentation of all of the following: a. Diagnosis of definite or probable amyotrophic lateral sclerosis (ALS) per the El Escorial Criteria b. Disease duration of 2 years or less c. Baseline ALS Functional Rating Scale-Revised (ALSFRS-R) with greater than or equal to 2 points in each individual item d. Forced vital capacity (FVC) greater than or equal to 80% (taken within the past 3 months). Reauthorization criteria: 1. Documentation of a clinical benefit from therapy such as stabilization of functional ability and maintenance of activities of daily living (ADLs).
**MEDICATION(S)**
REGRANEX

**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 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.
RESPIRATORY

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
**MEDICATION(S)**
RITUXAN, RITUXAN HYCELA

**COVERED USES**
All medically accepted 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 or Rheumatologist.

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

**OTHER CRITERIA**
For Rheumatoid Arthritis: 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. For polyarteritis or vasculitis: Documentation of trial, failure, intolerance, or contraindication to systemic corticosteroid therapy, plus one of the following to induce remission: a. Immunosuppressant therapy (e.g., methotrexate, azathioprine, leflunamide) OR b. cyclophosphamide. For Immune Thrombocytopenia (ITP): 1. Documentation of trial, failure, intolerance, or contraindication to systemic corticosteroid therapy AND 2. Documentation of active bleeding, or high-risk of bleeding, or a platelet count less than 30 thousand per microliter.
MEDIcATION(S)
SIGNIFOR

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
1. Confirmation of Cushing’s disease with 2 of the 3 following tests: a. 24 hr urine cortisol (UFC) (normal range can vary per laboratory: usually a positive test is above 10 mcg/24h) b. Overnight dexamethasone suppression test (1 mg dexamethasone is given at 11 PM, cortisol next day should be less than 1.8 mcg/dl). c. Three midnight salivary cortisol specimens (depending on test utilized, a positive test would be above 145 ng/dl), AND 2. Documentation that the patient’s condition has failed to respond to pituitary surgery, or that the patient is not eligible for pituitary surgery.
**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)
SOMAVER

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 endocrinologist.

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

OTHER CRITERIA
All of the criteria below must be met: 1. Documentation that the patient has persistent, moderate-to-severe symptoms of disease (e.g., impaired glucose tolerance, hypertension, elevated triglycerides, arrhythmias) following surgical resection, or patient is ineligible for surgery AND 2. Documentation of trial and failure, intolerance or contraindication to octreotide injection therapy.
MEDICATION(S)
SOVALDI

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 specific HCV genotype, baseline HCV RNA count, complete blood count, liver panel, and renal function status are required.

AGE RESTRICTION
Approved for 12 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. Criteria will be applied consistent with current AASLD/IDSA guidance AND 2. One of the following:
   a. For genotype 1 and 4 infection, documentation of FDA labeled contraindication to ledipasvir-sofosbuvir (Harvoni), OR b. For genotype 2 and 3 infection, documentation of FDA labeled contraindication to velpatasvir-sofosbuvir (Epclusa)
**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.
STIMULANTS

MEDICATION(S)
DAYTRANA, 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 HCL ER, METHYLPHENIDATE LA, RELEXXII, RITALIN LA 10 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
N/A

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
N/A

PRESCRIBER RESTRICTION
N/A

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. 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.
STRENSIQ

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
Must be prescribed by, or in consultation with, an endocrinologist, geneticist or metabolic specialist.

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, or skeletal manifestations.
**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 one year.

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

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 one year.

OTHER CRITERIA
MEDICATION(S)
SYMDEKO

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 may be necessary.

AGE RESTRICTION
Approved for patients 12 years or older

PRESCRIBER RESTRICTION
Must be prescribed by or in consultation with a pulmonologist or provider at a Cystic Fibrosis Center

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

OTHER CRITERIA
Diagnosis of cystic fibrosis with documentation of homozygous F508del mutation or at least one copy of a responsive mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene (as indicated by the package insert) 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.
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
N/A

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%. Reauthorization requires that the HbA1c remains less than or equal to 9%.
**MEDICATION(S)**
SYNRIBO

**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
**MEDICATION(S)**
SYPRINE, TRIENTINE HCL

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

**EXCLUSION CRITERIA**
Cystinuria AND rheumatoid arthritis

**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 or hepatologist.

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

**OTHER CRITERIA**
Documentation of trial and failure, intolerance, or contraindication to penicillamine (Depen®)
**MEDICATION(S)**
BEXAROTENE, TARGRETIN 1% GEL

**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**
For oral bexarotene capsule - 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. For 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).
TECHNIVIE

MEDICATION(S)
TECHNIVIE

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 weeks

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)
ANDRODERM, ANDROGEL 1.62% GEL PUMP, ANDROGEL 1.62%(1.25G) GEL PCKT, ANDROGEL 1.62%(2.5G) GEL PCKT, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 25 MG/2.5 GM PCKT, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PCKT

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Testosterone 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
Approved for adults 18 years of age and older.

PRESCRIBERRESTRICTION
N/A

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

OTHER CRITERIA
Diagnosis of primary or secondary (hypogonadatropic) hypogonadism, confirmed by: At least two (2) serum total testosterone levels (samples taken before 11 am on different days) that are less than 300 ng/dL and taken without acute illness/stress. For shift-workers, levels should be measured within 3 hours of waking.
MEDICATION(S)
THIOLA

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
24-hour urine collection with urinary cysteine 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
Must be prescribed by, or in consultation with, a nephrologist or urologist.

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

OTHER CRITERIA
All of the following criteria must be met: 1. Confirmation of cystinuria by at least one 24-hour urine collection with measurement of urinary cysteine levels greater than 500 mg/day, 2. Documented failure to conservative treatment with increased fluid intake (at least 2.5 liters/day), a diet restricted in sodium and protein, and urine alkalization with potassium citrate (to achieve pH greater than 7). Failure is defined by: a. Failure to lower the urine cystine concentration to below 243 mg/L and to raise the urine pH to above 7 in a 24 urine (or, if available, failure to lower the urinary supersaturation of cystine to below 1), b. Persistence of cystine crystals visualized by urinalys, 3. Documented trial, failure, intolerance or contraindication to penicillamine (Depen®). Reauthorization requires documentation of urine cystine concentration less than 300 mg/L or reduction in production of cystine stones.
MEDICATION(S)
THIORIDAZINE 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 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.
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 or in consultation with an oncologist.

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

OTHER CRITERIA
N/A
TYSABRI

**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**
N/A

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consultation with 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 at least two of the following disease modifying therapies, or medical rationale why these therapies cannot be tried: 1) interferon beta-1a (Avonex, Rebif), 2) peginterferon beta-1a (Plegridy), 3) Interferon-beta 1b (Betaseron), 4) dimethyl fumarate (Tecfidera), 5) glatiramer acetate (Copaxone), 6) Teriflunomide (Aubagio), or 7) Fingolimod (Gilenya) AND 3. Negative anti-JCV antibody status. If anti-JCV antibody positive, the patient must meet the following criteria: a. Confirmation patient has no prior history of cytotoxic or chemotherapy use (excluding steroids) AND b. Medical rationale is provided for continued use despite increased risk of developing progressive multifocal leukoencephalopathy (PML). 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 status. If anti-JCV antibody positive, the patient must meet the following
criteria: a. Confirmation patient has no prior history of cytotoxic or chemotherapy use (excluding
steroids) AND b. Medical rationale is provided for continued use despite increased risk of developing
progressive multifocal leukoencephalopathy (PML).
MEDICATION(S)
BUDESONIDE ER, UCERIS 9 MG ER 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
Approved for patients 18 years and older.

PRESCRIBER RESTRICTION
N/A

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 budesonide 9 mg extended-release oral tablet (Uceris) will allow for an 8-week treatment course. Further approval for budesonide 9 mg extended-release oral tablet (Uceris) requires medical rationale why standard maintenance therapy with generic budesonide delayed-release capsule (Entocort EC) or other medication for ulcerative colitis is not appropriate.
MEDICATION(S)
VASCEPA

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

EXCLUSION CRITERIA
N/A

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
N/A

PRESCRIBER RESTRICTION
N/A

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 fenofibrate. AND 2. A triglyceride level within the past 6 months that is greater than 500 mg/dl.
VIBERZI

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 y

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 eluxadoline (Viberzi).
MEDICATION(S)
VIEKIRA PAK, VIEKIRA XR

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 24 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)
VOSEVI

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

EXCLUSION CRITERIA
Coadministration with rifampin.

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, renal function status, prior therapy and response are required.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
12 weeks

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance
MEDICATION(S)
COLESEVELAM HCL, 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
N/A

PRESCRIBER RESTRICTION
N/A

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). 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)
TETRABENAZINE

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). 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)**
XERMELO

**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 one year

**OTHER CRITERIA**
All of the following criteria must be met: 1. Diagnosis of carcinoid syndrome diarrhea 2. Patient is experiencing four (4) or more bowel movements per day, despite use of long-acting octreotide therapy (e.g., Sandostatin LAR, octreotide infusion pump) for at least three (3) months 3. Documentation of failure to short-acting octreotide (Sandostatin) for breakthrough symptoms. Failure is defined as continuing to experience four (4) or more bowel movements per day despite daily use of these agents 4. Documentation that long-acting octreotide therapy will be used in combination with the requested medication. Reauthorization will require documentation of response to therapy.
**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**
N/A

**PRESCRIBER RESTRICTION**
N/A

**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.
XIFAXAN

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
For irritable bowel syndrome with diarrhea (IBS-D): Must be prescribed by, or in consultation with, a gastroenterologist.

COVERAGE DURATION
Hepatic encephalopathy: 1 year; Traveler’s diarrhea: 3 days; IBS-D: 14 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 only: IgE. For initiation, Asthma Control Test (ACT) or Asthma Control Questionnaire (ACQ) scores. For initiation of treatment, 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**
N/A

**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 2. IgE baseline levels greater than 30 IU/ml 3. Positive skin test to common perennial aeroallergens 4. Documentation of a 90-day trial of a combination of a high-dose inhaled corticosteroids and a long-acting inhaled beta2-agonist unless there is intolerance or contraindication to the medications. 5. Documentation of inadequate asthma control defined as one of the following: a. Asthma Control Test (ACT) score less than 20 or Asthma Control Questionnaire (ACQ) score greater than 1.5, b. At least 2 exacerbations requiring oral systemic corticosteroids in the last 12 months or c. At least 1 exacerbation requiring hospitalization. Initial reauthorization for asthma will require documentation of response to therapy with at least one of the following: 1. Improvement in ACT or ACQ score 2. Reduction in number of asthma exacerbations requiring oral systemic corticosteroids or hospitalization 3. Decrease in utilization of rescue medications (This may be verified by pharmacy...
claims information). 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 and 3. Trial and failure of one of the following: montelukast, famotidine or ranitidine. Reauthorization will require objective documentation of response to therapy (e.g. reduction in flares).
MEDICATION(S)
XYREM

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). 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 or neurologist.

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. 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. Documentation of trial and failure, contraindication, or intolerance to modafinil AND armodafinil, unless the patient is diagnosed with cataplexy. Ongoing approval will require documentation that Xyrem treatment has been effective.
ZEPATIER

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 established treatment guidelines.

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

MEDICATION(S)
ZURAMPIC

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

EXCLUSION CRITERIA
Monotherapy for the treatment of hyperuricemia associated with gout.

REQUIRED MEDICAL INFORMATION
Serum uric acid 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
N/A

COVERAGE DURATION
Initial authorization for 6 months. Reauthorization for 12 months.

OTHER CRITERIA
1) Documented clinical diagnosis of gout, AND 2) Documented serum uric acid levels greater than 6 mg/dL after at least 3 months of therapy with a xanthine oxidase inhibitor (e.g., allopurinol or febuxostat (Uloric®)) AND 3) Documentation that medication will be used in combination with a xanthine oxidase inhibitor, AND 4) Documented trial, failure, contraindication or intolerance to probenecid in combination with a xanthine oxidase inhibitor. Clinical failure is defined as the inability to achieve serum uric acid levels of less than 6 mg/dL after at least three months of combination therapy. Reauthorization requires documented response to therapy as defined by a reduction in occurrence of gout flares, tophi reduction, or serum uric acid levels maintained below 6 mg/dL.