LEON MEDICAL CENTERS

HEALTH PLANS®

Cigna HealthSpring®

Prior Authorization

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Prior Authorization Criteria
Approved: MAY 2017
Version 14

ABILIFY MAINTENA

Products Affected

- Abilify Maintena

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient must have failure, contraindication or intolerance to Aristada before Abilify Maintena is authorized.

ACTEMRA

Products Affected

- Actemra INJ 162MG/0.9ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ACTIMMUNE

Products Affected

- Actimmune

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Afinitor is considered medically necessary for the treatment of patients with advanced renal cell carcinoma after failure of treatment with Sutent (sunitinib) OR Nexavar (sorafenib).

ALCOHOL DEPENDENCE AGENTS

Products Affected

- Acamprosate Calcium Dr

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of alcohol dependence
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ALDARA

Products Affected

- Zyclara
- Zyclara Pump CREA 2.5%

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ANTIANGIOGENIC AGENTS

Products Affected

- Votrient

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Votrient is considered medically necessary for the treatment of patients with a diagnosis of 1.) advanced renal cell carcinoma or 2.)advanced soft tissue sarcoma who have received prior chemotherapy

ANTIEMETICS

Products Affected

- Akynzeo
- Anzemet
- Granisetron Hcl TABS
- Sancuso

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ANTIFUNGALS, AZOLE

Products Affected

- Voriconazole INJ
- Voriconazole ORAL TABS
- Voriconazole SUSR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented fungal culture and or notes from medical record suggestive of a serious fungal infection
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 to 6 months, depending on indication
Other Criteria	N/A

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)
Age Restrictions	12 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient must have a positive autoantibody test (i.e., anti-nuclear antibody [ANA] greater than or equal to 1:80 and/or anti-double-stranded DNA [anti-dsDNA] greater than or equal to 30 IU/ml) AND active disease state as documented by a SELENA-SLEDAI score of 6 or greater on the current treatment regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The patient must be receiving one standard therapy for SLE with any of the following: corticosteroids, hydroxychloroquine, immunosuppressives (cyclophosphamide, azathioprine, mycophenolate, methotrexate, cyclosporine) or nonsteroidal anti-inflammatory drugs AND there must be an absence of severe active lupus nephritis or severe active central nervous system lupus before Benlysta is authorized. B vs D coverage determination.

BOTULINUM TOXIN

Products Affected

- Botox
- Dysport
- Xeomin

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Exclude when used for cosmetic purposes.
Required Medical Information	Documentation of diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

CESAMET

Products Affected

- Cesamet

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

COLONY STIMULATING FACTORS

Products Affected

- Leukine INJ 250MCG
- Neulasta
- Neulasta Onpro Kit
- Neupogen
- Zarxio

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

CRINONE

Products Affected

- Crinone

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

EMPLICITI

Products Affected

- Empliciti

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and current medication regimen
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Empliciti is approved with concurrent use of dexamethasone and lenalidomide. B vs D coverage determination.

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis including genotype, current medication regimen, HCV-RNA levels, history of previous HCV therapies and presence/absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks, based on indication and established treatment guidelines
Other Criteria	For genotype 1, 4, 5 and 6, clinical information must be provided confirming the patient is not a candidate for Harvoni before Epclusa will be authorized.

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

FORTEO

Products Affected

- Forteo INJ 600MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	1.) Pediatric patients or young adults with open epiphyses. 2.) History of prior external beam or implant radiation involving the skeleton
Required Medical Information	1.) Bone mineral density (BMD) by DEXA at hip and spine. 2.) Confirmation of normal serum alkaline phosphatase or provider statement that Paget's disease has been excluded. 3.) Treatment history related to bisphosphonates and Prolia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Up to 1 year. Total lifetime Forteo therapy not to exceed 24 months.

Other Criteria	For the diagnoses of treatment of postmenopausal osteoporosis and treatment of primary or hypogonadal male osteoporosis, patient must have 1.) failure, contraindication, or intolerance to one oral bisphosphonate with failure or contraindication defined as any one of the following: a.) creatinine clearance less than 35 mL/min, b.) inability to remain upright for 30 minutes after dose, c.) clinical suggestion of structural esophageal disease (e.g., known stricture, dysphagia), d.) significant fall in BMD after at least one year on therapy, or e.) new fracture while on bisphosphonate therapy AND 2.) failure, contraindication, or intolerance to Prolia with failure or contraindication defined by either of the following: a.) significant fall in BMD after at least one year on therapy or b.) new fracture while on Prolia therapy, before Forteo will be approved. For the diagnosis of corticosteroid induced osteoporosis, patient must have failure, contraindication, or intolerance to one oral bisphosphonate with failure or contraindication defined as any one of the following: a.) creatinine clearance less than 35 mL/min, b.) inability to remain upright for 30 minutes after dose, c.) clinical suggestion of structural esophageal disease (e.g., known stricture, dysphagia), d.) significant fall in BMD after at least one year on therapy, or e.) new fracture while on bisphosphonate therapy before Forteo will be approved. For patients with a T-score less than or equal to -3.5, failure of oral bisphosphonates and Prolia are not required.

GILENYA

Products Affected

- Gilenya

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

GRANIX

Products Affected

- Granix

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

GROWTH HORMONE

Products Affected

- Genotropin
- Genotropin Miniquick
- Humatrope
- Humatrope Combo Pack
- Norditropin Flexpro
- Nutropin Aq Nuspin 5
- Nutropin Aq Pen
- Omnitrope
- Saizen
- Saizen Click.easy
- Serostim INJ 4MG, 5MG, 6MG
- Tev-tropin
- Zomacton
- Zorbtive

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Growth hormone stimulation test required for adult-onset pituitary disease, hypothalamic disease, surgery, radiation therapy, trauma, childhood-onset GH deficiency
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis including genotype, HCV RNA viral levels prior to treatment, history of previous HCV therapies, and presence/absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 to 24 weeks based on indication and established treatment guidelines
Other Criteria	N/A

HEMATOPOIETICS

Products Affected

- Aranesp Albumin Free INJ 100MCG/0.5ML, 100MCG/ML, 10MCG/0.4ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 25MCG/0.42ML, 25MCG/ML, 300MCG/0.6ML, 300MCG/ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML
- Epogen INJ 10000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML
- Mircera INJ 100MCG/0.3ML, 200MCG/0.3ML, 50MCG/0.3ML, 75MCG/0.3ML
- Procrit

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial treatment of anemia, documentation of Hemoglobin less than 10, transferrin saturation greater than 20%, and ferritin levels greater than 100 obtained over the last 3 months. For reauthorizations, approvals granted if Hemoglobin does not exceed 10-12g/dL or approvals granted if Hemoglobin does not exceed 10-13g/dL for the indication of reduction of allogeneic red cell transfusions in patients undergoing elective, noncardiac, nonvascular surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	B vs D coverage determination

HEPATITIS B AGENTS

Products Affected

- Adefovir Dipivoxil

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that patient is totally blind and lacks light perception
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HORMONAL AGENTS, GONADOTROPINS

Products Affected

- Chorionic Gonadotropin INJ
- Novarel
- Pregnyl W/diluent Benzyl Alcohol/nacl

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HORMONAL AGENTS, SOMATOSTATIN ANALOGS

Products Affected

- Octreotide Acetate
- Sandostatin Lar Depot
- Signifor Lar
- Somatuline Depot

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

HRM - SKELETAL MUSCLE RELAXANTS

Products Affected

- Carisoprodol ORAL TABS
- Carisoprodol/aspirin
- Carisoprodol/aspirin/codeine
- Cyclobenzaprine Hcl ORAL TABS
- Soma TABS 250MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	Approval duration is through the end of the plan year.
Other Criteria	N/A

IDIOPATHIC PULMONARY FIBROSIS

Products Affected

- Esbriet
- Ofev

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from part D.
Exclusion Criteria	Other known causes of interstitial lung disease e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity.
Required Medical Information	Diagnosis confirmed by 1.) in patients without surgical lung biopsy: Usual interstitial pneumonia (UIP) pattern on high resolution computed tomography (HRCT) is indicative of IPF or 2.) in patients with surgical lung biopsy: The combination of HRCT and biopsy pattern is indicative of IPF. Documented forced vital capacity (% FVC) greater than or equal to 50% performed within the last 6 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Esbriet and Ofev will each be used as monotherapy.

IMMUNE STIMULANTS, NON-VACCINE

Products Affected

- Pegasys
- Pegasys Proclick
- Pegintron
- Peg-intron Redipen
- Peg-intron Redipen Pak 4

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of genotype to determine length of therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 to 48 weeks based on indication and established treatment guidelines.
Other Criteria	N/A

IMMUNE SUPPRESSANTS

Products Affected

- Cimzia
- Cosentyx
- Cosentyx Sensoready Pen
- Enbrel
- Enbrel Sureclick
- Humira
- Humira Pediatric Crohns Disease Starter Pack
- Humira Pen
- Humira Pen-crohns Diseasestarter
- Humira Pen-psoriasis Starter
- Orencia
- Orencia Clickject
- Remicade
- Simponi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months

Other Criteria	1.)Use of Humira, Enbrel, Cimzia, Orencia, Simponi and Remicade is considered medically necessary for the treatment of Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least 2 alternative disease modifying antirheumatic drugs (DMARDs). 2.)Use of Humira, Enbrel, and Remicade is considered medically necessary for the treatment of Juvenile Rheumatoid Arthritis in patients that have tried and failed at least 2 DMARDs. 3.)Use of Humira, Enbrel, Cimzia, Simponi and Remicade is considered medically necessary for the treatment Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine. 4.)Use of Humira, Enbrel, Cimzia,Simponi and Remicade is considered medically necessary for the treatment of Psoriatic Arthritis in patients with active disease. 5.)Use of Humira, Remicade and Cimzia is considered medically necessary for the treatment of Moderate to severe Crohn's Disease in patients that have tried and failed at least 2 of the following: immunomodulators, corticosteroids, or aminosalicylates. 6.)Use of Humira, Simponi and Remicade is considered medically necessary for treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 2 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine. 7.)Use of Humira, Enbrel, and Remicade is considered medically necessary for the treatment of Plaque Psoriasis in patients that have: a) moderate to severe chronic disease, b) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, c) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) , AND d) tried and failed at least 1 systemic therapy (cyclosporine, methotrexate, or acitretin) OR phototherapy 8.) Use of Humira will also be considered medically necessary for the treatment of hidradenitis suppurativa and uveitis. 9.)Use of Remicade will be considered medically necessary for the treatment of fistulizing Crohn's disease. B vs D coverage determination required for Remicade.

IMMUNE SUPPRESSANTS - TRANSPLANT RELATED

Products Affected

- Astagraf XL
- Atgam
- Azasan
- Azathioprine INJ
- Azathioprine TABS
- Cellcept Intravenous
- Cyclosporine INJ
- Cyclosporine ORAL CAPS
- Cyclosporine Modified
- Envarsus Xr
- Gengraf
- Hecoria
- Mycophenolate Mofetil
- Mycophenolic Acid Dr
- Nulojix
- Prograf INJ
- Rapamune SOLN
- Sandimmune SOLN
- Sirolimus ORAL TABS
- Tacrolimus ORAL CAPS
- Zortress

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

IMMUNOMODULATORS

Products Affected

- Avonex
- Avonex Pen
- Betaseron
- Copaxone INJ 20MG/ML, 40MG/ML
- Tecfidera
- Tecfidera Starter Pack

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

INTRON-A

Products Affected

- Intron A
- Intron A W/diluent

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Hepatitis C: Patient has no documented failure or intolerance to pegylated interferons

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	1.) Patient treated with an apolipoprotein B synthesis inhibitor (e.g. Kynamro). 2.) Patient with moderate or severe hepatic impairment (based on Child-Pugh category B or C), active liver disease or unexplained persistent abnormal liver function tests.
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia (HoFH) as demonstrated by 1.) genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9 or ARH adaptor protein gene locus OR 2.) an untreated LDL-cholesterol concentration greater than 500 mg/dL OR 3.) total LDL greater than or equal to 300mg/dl while on a maximum tolerated dose of a high-intensity statin (high-intensity statins include atorvastatin 40 to 80mg and rosuvastatin 20 to 40mg) taken in combination with any of the following: ezetimibe, a bile acid sequestrant, or niacin AND one of the following: a.) cutaneous or tendinous xanthoma before the age of 10 years OR b.) untreated LDL cholesterol levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190mg/dl).
Age Restrictions	18 years and older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For approval, patient must meet all of the following criteria: 1.) Failure, contraindication, or intolerance to Repatha (requires prior authorization), 2.) Juxtapid will be taken in combination with a maximum tolerated dose of atorvastatin OR rosuvastatin and with any one of the following: ezetimibe, a bile acid sequestrant, or niacin. (For patients intolerant to statins, no concurrent statin use required.)

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with cystic fibrosis (CF) who are homozygous for the F508del mutation in the CFTR gene.
Required Medical Information	CF mutation test documenting a G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, or S549R mutation in the CFTR gene.
Age Restrictions	2 years of age and older for packets. 6 years of age and older for tablets.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For RA: 18 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Treatment of rheumatoid arthritis (RA) in adults and when the following criteria are met: inadequate response, intolerance, or contraindication to at least one disease-modifying anti-rheumatic drug (DMARD) (i.e., methotrexate (MTX), azathioprine, gold, hydroxychloroquine, penicillamine, sulfasalazine) AND the patient has had failure, contraindication, or intolerance to Enbrel or Humira.

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

KYNAMRO

Products Affected

- Kynamro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	1.) Patient receiving LDL apheresis. 2.) Patient treated with an MTP inhibitor (e.g. Juxtapid). 3.) Patient with moderate or severe hepatic impairment (based on Child-Pugh category B or C), active liver disease or unexplained persistent abnormal liver function tests.
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia (HoFH) as demonstrated by 1.) genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9 or ARH adaptor protein gene locus OR 2.) an untreated LDL-cholesterol concentration greater than 500 mg/dL OR 3.) total LDL greater than or equal to 300mg/dl while on a maximum tolerated dose of a high-intensity statin (high-intensity statins include atorvastatin 40 to 80mg and rosuvastatin 20 to 40mg) taken in combination with any of the following: ezetimibe, a bile acid sequestrant, or niacin AND one of the following: a.) cutaneous or tendinous xanthoma before the age of 10 years OR b.) untreated LDL cholesterol levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190mg/dl).
Age Restrictions	18 years and older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For approval, patient must meet all of the following criteria: 1.) Failure, contraindication, or intolerance to Repatha (requires prior authorization), 2.) Kynamro will be taken in combination with a maximum tolerated dose of atorvastatin OR rosuvastatin and with any one of the following: ezetimibe, a bile acid sequestrant, or niacin.

LETAIRIS

Products Affected

- Letairis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

LIDOCAINE PATCH

Products Affected

- Lidocaine PTCH

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For the FDA-labeled indication of post-herpetic neuralgia, no additional criteria are required to be met. For diabetic neuropathic pain: the patient must have previous use and inadequate response or intolerance to any ONE medication that is FDA-labeled for diabetic peripheral neuropathy, including (but not limited to) duloxetine and Lyrica.

LIPASE INHIBITORS

Products Affected

- Xenical

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage for weight loss is excluded under Part D.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

LONG-ACTING OPIOID ANALGESICS

Products Affected

- Zohydro Er ORAL C12A

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

MEMANTINE IR

Products Affected

- Memantine Hcl
- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Automatic approval if member is greater than 26 years of age. Prior Authorization is required for age 26 or younger.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

METABOLIC BONE DISEASE AGENTS

Products Affected

- Ibandronate Sodium INJ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Intolerance to oral bisphosphonates or is unable to tolerate oral bisphosphonates due to gastrointestinal conmorbidities or is unable to adhere to dosing requirements.

METHAMPHETAMINE HCL

Products Affected

- Methamphetamine Hcl

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient must have failure, contraindication or intolerance to one formulary alternative such as dextroamphetamine, amphetamine/dextroamphetamine, methylphenidate or dexmethylphenidate before methamphetamine hcl is authorized.

MOLECULAR TARGET INHIBITORS

Products Affected

- Alecensa
- Bosulif
- Cabometyx
- Caprelsa
- Cometriq
- Cotellic
- Farydak
- Gilotrif
- Ibrance
- Iclusig
- Imatinib Mesylate
- Imbruvica
- Inlyta
- Iressa
- Jakafi
- Kisqali
- Lenvima 10 Mg Daily Dose
- Lenvima 14 Mg Daily Dose
- Lenvima 18 Mg Daily Dose
- Lenvima 20 Mg Daily Dose
- Lenvima 24 Mg Daily Dose
- Lenvima 8 Mg Daily Dose
- Lynparza
- Mekinist
- Nexavar
- Pomalyst
- Rubraca
- Sprycel
- Stivarga
- Sutent
- Synribo
- Tafinlar
- Tarceva
- Tasigna
- Tykerb
- Xalkori
- Zydelig
- Zykadia

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

MONOCLONAL ANTIBODIES

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For the diagnosis of asthma: Laboratory data reflecting IgE levels greater than 30 but less than 1500 IU/mL , medical history documenting previous trial and response to inhaled corticosteroids and a leukotriene receptor antagonist. For the diagnosis of chronic idiopathic urticaria (CIU): Documentation that the patient has remained symptomatic despite at least 2 weeks of one H1 antihistamine therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

MUCOLYTICS

Products Affected

- Pulmozyme

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patient has a known hypersensitivity to dornase-alfa or to chinese Hamster ovary cell products.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

MYALEPT

Products Affected

- Myalept

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and current medication regimen
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Ninlaro is approved with concurrent use of dexamethasone and lenalidomide.

NON AMPHETAMINE CENTRAL NERVOUS SYSTEM AGENTS

Products Affected

- Armodafinil
- Modafinil
- Nuvigil

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and sleep study for the diagnosis of sleep apnea or narcolepsy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis and prior medication history
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The patient must have failure, contraindication or intolerance to fludrocortisone acetate or midodrine.

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

OLYSIO

Products Affected

- Olysio

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Previous failure of Olysio, Incivek or Victrelis.
Required Medical Information	Documentation from the medical record of diagnosis including genotype, current medication regimen, HCV-RNA levels, history of previous HCV therapies and presence/absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 to 24 weeks based on indication and treatment guidelines.
Other Criteria	Olysio must be used with other concurrent therapy based on indication and established treatment guidelines. For genotype 1, clinical information must be provided confirming the patient is not a candidate for Harvoni before combination therapy with Olysio and Sovaldi will be authorized.

ONIVYDE

Products Affected

- Onivyde

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

ORAL TRETINOINS

Products Affected

- Absorica
- Amnesteem
- Claravis
- Myorisan
- Zenatane

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

OTEZLA

Products Affected

- Otezla

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

OTREXUP

Products Affected

- Otrexup

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

PROCYSBI

Products Affected

- Procysbi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The patient must have failure, contraindication or intolerance to Cystagon before Procysbi will be authorized.

RASUVO

Products Affected

- Rasuvo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of wound type and wound care therapy provided.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Regranex must be used as adjunctive therapy to clinically appropriate ulcer wound care including debridement, infection control, and/or pressure relief.

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: Clinical atherosclerotic cardiovascular disease OR Heterozygous familial hypercholesterolemia (HeFH) (confirmed by genetic testing or WHO/Dutch Lipid Group criteria or Simon-Broome criteria) OR Homozygous Familial Hypercholesterolemia (HoFH) (confirmed by either: Genetic testing or History of untreated low-density lipoprotein cholesterol (LDL-C) greater than 500mg/dl or treated LDL greater than 300mg/dl with either: presence of xanthomas before the age of 10 years or evidence of heterozygous familial hypercholesterolemia in both parents.)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial:6 mo. Reauthorization for 12 mo requires documented evidence of clinical beneficial response
Other Criteria	For atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemia (HeFH): Patient is on high-intensity statin therapy or maximally tolerated statin therapy, is not at LDL-C level goal, and will be continued on high intensity or maximally tolerated statin therapy while on Repatha. (For patients intolerant to statins, no concurrent statin use required.) For Homozygous Familial Hypercholesterolemia (HoFH): Patient is on high-intensity or maximally tolerated lipid-lowering therapy (such as statins and/or ezetimibe), and is not at LDL-C level goal, and will be continued on high intensity or maximally tolerated lipid-lowering therapy while on Repatha. (For patients intolerant to statins, no concurrent statin use required.)

RETINOIDS TOPICAL

Products Affected

- Adapalene
- Avita
- Clindamycin Phosphate/tretinoin
- Differin LOTN
- Retin-a Micro Pump GEL 0.08%
- Tretinoin EXTERNAL CREA
- Tretinoin EXTERNAL GEL
- Tretinoin Microsphere
- Tretinoin Microsphere Pump
- Veltin
- Ziana

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

RUCONEST

Products Affected

- Ruconest

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

SIVEXTRO

Products Affected

- Sivextro TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis, site of infection, recent culture and sensitivity data, current or previous treatment for infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	Use of Sivextro is considered medically necessary for use in infections resulting from MRSA. Sivextro is also considered medically accepted for other clinically appropriate infections when drug allergies prevent the use of clinically appropriate 1st-line agents in other infections.

SOVALDI

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis including genotype, current medication regimen, HCV-RNA levels, history of previous HCV therapies and presence/absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 to 48 weeks based on indication and established treatment guidelines.
Other Criteria	Must be used with other concurrent therapy based on indication and established treatment guidelines. For genotype 1, clinical information must be provided confirming the patient is not a candidate for Harvoni before combination therapy with Olysio and Sovaldi will be authorized.

SYLATRON

Products Affected

- Sylatron

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis of chorea associated with Huntington's Disease. CYP 2D6 genotype must be provided for doses greater than 50mg/day.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

THALIDOMIDE (THALOMID)

Products Affected

- Thalomid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

THROMBOPOIETIN RECEPTOR AGONIST

Products Affected

- Promacta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis of: a.) thrombocytopenia in patients with chronic hepatitis C b.) chronic immune (idiopathic) thrombocytopenic purpura (ITP) with documentation of previous therapy with corticosteroids OR intravenous immune globulin (IVIG) therapy over a period of at least 30 days OR insufficient response to a splenectomy, or c.) severe aplastic anemia with documentation of inadequate response to previous immunosuppressive therapy (e.g. Atgam, Thymoglobulin, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Use of Promacta for the treatment of thrombocytopenia is considered medically necessary in: a) patients with chronic hepatitis C, or b) patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP) that have failed corticosteroid OR intravenous immune globulin (IVIG) therapy OR have had an insufficient response to a splenectomy.

TOPICAL ANTI-INFLAMMATORIES

Products Affected

- Diclofenac Sodium GEL 3%
- Flector

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Diclofenac Gel: 3 months. Flector Patch: 6 months.
Other Criteria	N/A

TOPICAL IMMUNOMODULATORS

Products Affected

- Elidel
- Tacrolimus EXTERNAL OINT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 months for tacrolimus ointment and 6 months for Elidel
Other Criteria	N/A

TRANSMUCOSAL FENTANYL CITRATE

Products Affected

- Abstral
- Fentanyl Citrate Oral Transmucosal
- Fentora BUCCAL TABS 100MCG, 200MCG, 400MCG, 600MCG, 800MCG
- Lazanda
- Subsys

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis.
Age Restrictions	16 years of age and older for fentanyl citrate (lozenge/troche). 18 years of age and older for Lazanda, Abstral and Fentora
Prescriber Restrictions	Enrollment in the Transmucosal Immediate-Release Fentanyl (TIRF) REMS Access program
Coverage Duration	12 months
Other Criteria	Transmucosal fentanyl products will only be covered with documentation of breakthrough cancer pain. The patient must be currently receiving and be tolerant to opioid therapy for persistent cancer pain.The patient must be enrolled in the TIRF REMS Access program.

TRIMETHOBENZAMIDE

Products Affected

- Trimethobenzamide Hcl CAPS 300MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

VALCHLOR GEL

Products Affected

- Valchlor

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medical history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Valchlor Topical Gel is considered medically necessary for the treatment of patients with Stage 1A and 1B mycosis fungoides-type cutaneous T-cell lymphoma who have received prior skin-directed therapy.

VASODILATORS

Products Affected

- Adcirca
- Opsumit
- Orenitram
- Sildenafil
- Tracleer

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

XELJANZ

Products Affected

- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from medical record of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Xtandi is considered medically necessary in patients who have a diagnosis of metastatic castration-resistant prostate cancer. The patient must have a history of failure, intolerance or contraindication to Zytiga before Xtandi is authorized.

YONDELIS

Products Affected

- Yondelis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of BRAF V600E mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ZYTIGA

Products Affected

- Zytiga TABS 250MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from medical record of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Zytiga is approved for use in combination with prednisone.

PART B VERSUS PART D

Products Affected

- Acetylcysteine INHALATION SOLN
- Actemra INJ 200MG/10ML, 400MG/20ML, 80MG/4ML
- Acyclovir Sodium INJ 50MG/ML
- Adagen
- Albuterol Sulfate INHALATION NEBU
- Aldurazyme
- Amiodarone Hcl INJ
- Apokyn INJ 30MG/3ML
- Aprepitant
- Aralast Np INJ 1000MG, 500MG, 800MG
- Argatroban INJ 125MG/125ML; 0.9%, 250MG/2.5ML, 250MG/250ML; 0.9%
- Arzerra
- Atropine Sulfate INJ 0.4MG/0.5ML, 1MG/ML, 8MG/20ML
- Bcg Vaccine
- Berinert
- Bethkis
- Bivigam
- Brovana
- Budesonide INHALATION SUSP 0.25MG/2ML, 0.5MG/2ML, 1MG/2ML
- Buprenorphine Hcl INJ
- Capastat Sulfate
- Cardene IV INJ 5%; 40MG/200ML
- Carimune Nanofiltered INJ 6GM
- Cerezyme
- Cidofovir
- Cinryze
- Cosmegen
- Cromolyn Sodium NEBU
- Cyclophosphamide ORAL CAPS
- Cyramza
- Depo-provera INJ 400MG/ML
- Diltiazem Hcl INJ 100MG, 125MG/25ML, 25MG/5ML, 50MG/10ML
- Docefrez INJ 20MG
- Docetaxel
- Doxercalciferol INJ
- Doxorubicin Hcl Liposome
- Elelyso
- Eligard
- Emend ORAL CAPS
- Emend SUSR
- Engerix-b
- Erwinaze
- Esomeprazole Sodium
- Fabrazyme
- Faslodex INJ 250MG/5ML
- Fentanyl Citrate INJ 1000MCG/20ML, 100MCG/2ML, 2500MCG/50ML, 250MCG/5ML, 500MCG/10ML
- Firmagon
- Flebogamma Dif
- Folotyn
- Fomepizole
- Fusilev
- Gablofen
- Gamastan S/d
- Gammagard Liquid INJ 2.5GM/25ML, 30GM/300ML
- Gammaked
- Gammaplex INJ 10GM/200ML
- Gamunex-c
- Ganciclovir INJ 500MG
- Gazyva
- Glassia
- H.p. Acthar
- Halaven
- Hizentra
- Hydralazine Hcl INJ
- Hydromorphone Hcl INJ 10MG/ML, 1MG/ML, 2MG/ML, 4MG/ML, 50MG/5ML

- Hydromorphone Hcl Dosette
- Ilaris
- Imovax Rabies (h.d.c.v.)
- Infumorph 200
- Infumorph 500
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Jevtana
- Kabiven
- Kadcyla
- Kepivance
- Ketorolac Tromethamine INJ
- Kyprolis
- Labetalol Hcl INJ
- Lartruvo
- Leuprolide Acetate INJ
- Levalbuterol NEBU
- Levalbuterol Hcl INHALATION NEBU
- Levetiracetam INJ 500MG/5ML
- Levoleucovorin INJ 175MG/17.5ML, 250MG/25ML, 50MG
- Levoleucovorin Calcium
- Levothyroxine Sodium INJ 200MCG, 500MCG
- Lidocaine Hcl INJ
- Lioresal Intrathecal
- Lipodox
- Lipodox 50
- Lumizyme
- Lupaneta Pack
- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)
- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)
- Magnesium Sulfate INJ
- Meperidine Hcl INJ 100MG/ML, 10MG/ML, 25MG/ML, 50MG/ML
- Methadone Hcl INJ
- Methocarbamol INJ 1000MG/10ML
- Methyldopate Hcl
- Metoprolol Tartrate INJ
- Mozobil
- Myozyme
- Naglazyme
- Nalbuphine Hcl INJ 10MG/ML, 20MG/ML
- Nebupent
- Neumega
- Nitroglycerin INJ 5MG/ML
- Octagam
- Oncaspar
- Ondansetron Hcl INJ
- Ondansetron Hcl ORAL SOLN
- Ondansetron Hcl ORAL TABS
- Ondansetron Odt
- Opdivo
- Orphenadrine Citrate INJ
- Pamidronate Disodium
- Pantoprazole Sodium INJ
- Paricalcitol INJ
- Pentam 300
- Perforomist
- Perikabiven
- Perjeta
- Portrazza
- Privigen INJ 20GM/200ML, 5GM/50ML
- Procainamide Hcl INJ 100MG/ML
- Prolastin-c
- Prolia
- Propranolol Hcl INJ
- Rabavert
- Recombivax Hb
- Regonol INJ 10MG/2ML
- Remodulin
- Rheumatrex
- Ribavirin SOLR
- Rifampin INJ
- Simponi Aria
- Simulect
- Sodium Bicarbonate INJ 4.2%, 7.5%, 8.4%
- Sodium Bicarbonate Partial Fill

- Somavert
- Stelara
- Synagis INJ 100MG/ML, 50MG/0.5ML
- Tecentriq
- Thymoglobulin
- Tobramycin NEBU
- Trelstar
- Trelstar Mixject
- Trexall
- Trisenox
- Tysabri
- Tyvaso
- Tyvaso Refill
- Tyvaso Starter
- Unituxin
- Uvadex
- Ventavis
- Verapamil Hcl INJ
- Virazole
- Vivitrol
- Vpriv
- Xgeva
- Yervoy
- Zaltrap
- Zanosar
- Zemaira
- Zoledronic Acid
- Zuplenz

Details

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

INDEX

D

E

F

G

H

I

J

K

L

R

S

T