Prior Authorization Protocol

Medicare Part D – 2018

Prior Authorization Group Description

ABSTRAL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 18 or greater.

Prescriber Restrictions:

Coverage Duration:

Through the end of the Plan contract year.

Other Criteria:

Patient is already taking and is tolerant to around-the-clock opioid therapy. Patients are considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Group Description

ACTEMRA IV

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Rheumatoid Arthritis, Juvenile Idiopathic Arthritis: 12 months. Cytokine Release Syndrome: 4 weeks.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to Remicade and one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description

ACTEMRA SC

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. GIANT CELL ARTERITIS: Failure or clinically significant adverse effects to methotrexate or azathioprine.

Prior Authorization Group Description

ACTHAR HP

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS: Prescribed by or in consultation with a neurologist.

Coverage Duration:

Infantile Spasms: 4 weeks, Multiple Sclerosis: 3 weeks

Other Criteria:

Multiple sclerosis: Patient is being treated with a relapsing remitting multiple sclerosis agent (e.g., Avonex, Betaseron, Copaxone, Gilenya) AND Failure or clinically significant adverse effects to corticosteroid therapy for acute exacerbations of multiple sclerosis.

Prior Authorization Group Description

ACTIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

16 years and older.

Prescriber Restrictions:

Coverage Duration:

Through the end of the Plan contract year.

Other Criteria:

Patient is already taking and is tolerant to around-the-clock opioid therapy. Patients are considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Group Description

ACYCLOVIR

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ADCIRCA

Covered Uses:

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

Exclusion Criteria:

Patients taking nitrates (e.g., Nitrodur, Nitrobid, Nitrostat, Isordil, Ismo). Patients taking a guanylate cyclase stimulator, such as riociguat (Adempas).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ADDYI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Reauthorization requests: Documentation that sexual desire has improved.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial: 8 weeks. Reauthorization: Through the end of the Plan contract year.

Other Criteria:

Prior Authorization Group Description

ADEMPAS

Covered Uses:

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

Exclusion Criteria:

Patients on concomitant phosphodiesterase (PDE) inhibitors (e.g., sildenafil, tadalafil, vardenafil, dipyridamole or theophylline) or nitrates (e.g., Nitrodur, Nitrobid, Nitrostat, Isordil, Ismo)

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

AFINITOR

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Renal Cell Carcinoma: Failure or clinically significant adverse effects to one of the following: Sutent, Nexavar, Votrient, Inlyta, Avastin in combination with Intron-A, Proleukin, Torisel. Breast Cancer: Prescribed in combination with exemestane AND Failure or clinically significant adverse effects to letrozole or anastrozole.

Prior Authorization Group Description

AIMOVIG

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Member experiences 4 or more migraine days per month for at least 3 months. CONTINUATION OF THERAPY: Member is responding positively to therapy as evidenced by a reduction in migraine days per month from baseline.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist, headache, or pain specialist.

Coverage Duration:

Initial: 3 months. Reauthorizations: 6 months

Other Criteria:

Failure of two of the following oral migraine preventative therapies, each from different therapeutic classes, unless contraindicated or clinically significant adverse effects are experienced: antiepileptic drugs (e.g., divalproex sodium, sodium valproate, topiramate), beta-blockers (e.g., metoprolol, propranolol, timolol), antidepressants (e.g., amitriptyline, venlafaxine).

Prior Authorization Group Description

ALECENSA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation that the patient does or does not have anaplastic lymphoma kinase (ALK)-positive disease.
CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ALUNBRIG

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Disease is ALK-positive and either metastatic or recurrent. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to crizotinib (Xalkori).

Prior Authorization Group Description

AMITRIPTYLINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Depression: Failure or clinically significant adverse effects to one of the following generic antidepressants: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine, or venlafaxine XR.

Prior Authorization Group Description

AMITRIPTYLINE/CHLORDIAZEPOXIDE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: duloxetine, escitalopram or venlafaxine XR.

Prior Authorization Group Description

AMITRIPTYLINE/PERPHENAZINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

AMPHOTERICIN B

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Abelcet only: failure or clinically significant adverse effects to conventional amphotericin B therapy. Ambisome when treating patients with Aspergillus species, Candida species and/or Cryptococcus species infections: failure or clinically significant adverse effects to conventional amphotericin B therapy.

Prior Authorization Group Description

AMPYRA

Covered Uses:

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

Exclusion Criteria:

Prior history of seizure.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ANTIHISTAMINE COMBINATIONS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Allergic rhinitis: Failure or clinically significant adverse effects to two of the following: levocetirizine, desloratadine, fluticasone propionate nasal suspension, flunisolide nasal solution or triamcinolone acetonide nasal inhaler. All other FDA approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

ANTIHISTAMINES (carbinoxamine, clemastine, cyproheptadine, diphenhydramine, promethazine)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Allergic rhinitis: Failure or clinically significant adverse effects to two of the following: levocetirizine, desloratadine, fluticasone propionate nasal suspension, flunisolide nasal solution or triamcinolone acetonide nasal inhaler. All other FDA approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

ARANESP

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Treatment of anemia due to myelodysplastic syndrome.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Procrit.

Prior Authorization Group Description

AUBAGIO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

AVASTIN

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Glioblastoma: Patient has progressive disease.

Age Restrictions:

Age 18 or older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Non-squamous non-small cell lung cancer: Use in combination with carboplatin and paclitaxel for first line treatment of unresectable, locally advanced, recurrent or metastatic disease. Metastatic renal cell carcinoma: Used in combination with interferon alfa.

Prior Authorization Group Description

BAXDELA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Current culture and sensitivity report shows isolated pathogen is a gram-positive or gram-negative organism susceptible to delafloxacin.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

14 days.

Other Criteria:

Failure of one fluoroquinolone, unless all are contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

BELEODAQ

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

BELSOMRA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

For patients 65 years of age and older: Failure or clinically significant adverse effects to one of the following: Rozerem, Silenor 6 mg/day or less, trazodone or temazepam. For patients under 65 years of age: Failure or clinically significant adverse effects to zolpidem or zolpidem CR.

Prior Authorization Group Description

BENLYSTA

Covered Uses:

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

Exclusion Criteria:

Previous anaphylaxis to Benlysta, severe active lupus nephritis or severe active central nervous system lupus.

Required Medical Information:

Documentation of systemic lupus erythematosus positive for anti-nuclear antibody (ANA) and/or anti-double-stranded DNA [anti-dsDNA])

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Currently receiving standard therapy for systemic lupus erythematosus that includes one or more of the following agents, unless all agents are contraindicated: glucocorticoids (e.g., prednisone), antimalarial (e.g., hydroxychloroquine or chloroquine), non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate).

Prior Authorization Group Description

BENZTROPINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Parkinsons disease/Parkinsonism: Failure or clinically significant adverse effects to two of the following: amantadine, levodopa/carbidopa, entacapone, pramipexole, ropinirole, selegiline. All other FDA-approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

BLEOMYCIN

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

BOSULIF

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

BOTOX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CHRONIC MIGRAINE HEADACHE: Patient has a persistent history of chronic, debilitating migraine headaches with frequent attacks on more than 15 days per month.

Age Restrictions:

Strabismus or blepharospasm associated with dystonia: 12 years of age or older.

Prescriber Restrictions:

Chronic migraine headache: Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Chronic migraine headache: Failure or clinically significant adverse effects to prophylactic treatment with one of the following: divalproex, topiramate, timolol or propranolol AND failure or clinically significant adverse effects to abortive therapy with one of the following: sumatriptan, rizatriptan, zolmitriptan, naratriptan, almotriptan, frovatriptan, Relpax, ergotamine/caffeine or dihydroergotamine.

Prior Authorization Group Description

BRAFTOVI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Positive for BRAF V600E or V600K mutation as detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with Mektovi.

Prior Authorization Group Description

BRIVIACT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Oral: Through the end of the Plan contract year.

Other Criteria:

Patient is receiving treatment with at least one other antiepileptic drug such as: Gabitril, levetiracetam, lamotrigine, Lyrica, gabapentin, Sabril, topiramate, oxcarbazepine, Fycompa, Potiga, carbamazepine, phenytoin, valproic acid or divalproex sodium.

Prior Authorization Group Description

BUPRENORPHINE/NALOXONE (Bunavail, Suboxone, Zubsolv)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

BUTABARBITAL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Insomnia: Failure or clinically significant adverse effects one of the following: Rozerem, Silenor, trazodone or temazepam. For use as a daytime sedative: patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

CABOMETYX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

CALQUENCE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Previously received at least one prior therapy (e.g., rituximab-containing regimen).

Prior Authorization Group Description

CAPRELSA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Non-small cell lung cancer.

Exclusion Criteria:

Required Medical Information:

Medullary Thyroid Cancer: Symptomatic or progressive disease that is unresectable locally advanced or metastatic.

Age Restrictions:

Prescriber Restrictions:

Medullary Thyroid Cancer: Prescribed by or in consultation with an oncologist or endocrinologist. Non-small cell lung cancer: Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

CARISOPRODOL/ASPIRIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

CARISOPRODOL/ASPIRIN/CODEINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

CAYSTON

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 7 or greater.

Prescriber Restrictions:

Coverage Duration:

28 days.

Other Criteria:

Prior Authorization Group Description

CERDELGA

Covered Uses:

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

Exclusion Criteria:

Extensive metabolizer (EM) or intermediate metabolizer (IM) taking a strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor AND IMs or poor metabolizer (PM) taking a strong CYP3A inhibitor.

Required Medical Information:

An FDA-cleared genotyping test has determined that this patient is a CYP2D6 extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM).

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

CEREZYME

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation of at least one of the following conditions resulting from Type I Gaucher disease: anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

CHLORPROPAMIDE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: glimepiride, glipizide or glipizide/metformin combination product.

Prior Authorization Group Description

CHORIONIC GONADOTROPIN

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Induction of ovulation and pregnancy in the anovulatory, infertile woman in whom the cause of anovulation is secondary and not due to primary ovarian failure. Treatment of obesity.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

CIALIS

Covered Uses:

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

Exclusion Criteria:

Patients taking nitrates (e.g., Nitrodur, Nitrobid, Nitrostat, Isordil, Ismo) or guanylate cyclase stimulators (e.g., Adempas (riociguat)).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to ONE alpha blocker (e.g., terazosin, doxazosin, tamsulosin, alfuzosin, Rapaflo) and ONE 5-alpha reductase inhibitor (finasteride, Jalyn or Avodart).

Prior Authorization Group Description

CIMZIA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

CROHN'S DISEASE: Prescribed by or in consultation with a GI specialist. PSORIATIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

Rheumatoid arthritis: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description

CINQAIR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient has a blood eosinophil count of greater than or equal to 400 cells/mcL within the past 3 months.
CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Patient is 18 years of age or older.

Prescriber Restrictions:

Prescribed by or in consultation with an allergist, pulmonologist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Must be used in combination with ONE inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide) AND must be used in combination with ONE long-acting beta-agonist (e.g., salmeterol, formoterol, vilanterol), unless contraindicated.

Prior Authorization Group Description

CINRYZE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial: 6 months. Reauthorization: 12 months.

Other Criteria:

Failure of danazol, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

CLADRIBINE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

CLOMIPRAMINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: fluoxetine, fluvoxamine or sertraline.

Prior Authorization Group Description

COMETRIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

COSENTYX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

PLAQUE PSORIASIS: Failure or clinically significant adverse effects to ONE of the following: methotrexate, cyclosporine, or acitretin.

Prior Authorization Group Description

COTELLIC

Covered Uses:

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

Exclusion Criteria:

Patients with wild-type BRAF melanoma.

Required Medical Information:

Lesion is positive for the BRAF V600E or V600K mutation as detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Used in combination with Zelboraf.

Prior Authorization Group Description

CRINONE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Progesterone supplementation or replacement as part of an Assisted Reproductive Technology (ART) treatment for infertile women with progesterone deficiency.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Crinone 8%: Failure or clinically significant adverse effects to Crinone 4%.

Prior Authorization Group Description

CROFELEMER (Fulyzaq, Mytesi)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Patient is on anti-retroviral therapy and failure or clinically significant adverse effects to loperamide or diphenoxylate/atropine.

Prior Authorization Group Description

CYCLOBENZAPRINE HCL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

CYTARABINE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

For acute non-lymphocytic leukemia: use in combination with other approved anti-cancer drugs.

Prior Authorization Group Description

DAKLINZA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. For the treatment of hepatitis C virus genotype 2 and 4.

Exclusion Criteria:

Required Medical Information:

Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

12 to 24 weeks based on genotype, prior treatment, or cirrhosis status.

Other Criteria:

Must be used in combination with Sovaldi. Genotype 1: Failure or clinically significant adverse effects to Harvoni (sofosbuvir/ledipasvir). Genotype 2: Failure or clinically significant adverse effects to sofosbuvir/ribavirin.

Prior Authorization Group Description

DIPYRIDAMOLE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

DOXEPIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

DUEXIS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to lansoprazole or omeprazole AND Failure or clinically significant adverse effects to one of the following: ibuprofen, diclofenac sodium or potassium, etodolac, fenoprofen, ketoprofen, meloxicam, naproxen, oxaprozin, piroxicam, salsalate, sulindac, tolmetin.

Prior Authorization Group Description

ELIDEL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of two medium to high potency topical corticosteroids (e.g., amcinonide, fluticasone propionate, triamcinolone acetonide, betamethasone valerate, fluocinolone acetonide, hydrocortisone butyrate, mometasone furoate, desoximetasone, fluocinonide or betamethasone dipropionate), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

EMEND 40 MG

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Four weeks.

Other Criteria:

Prior Authorization Group Description

EMFLAZA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by one of the following: Genetic testing (e.g., dystrophin deletion or duplication mutation found) OR if genetic studies are negative (i.e., no mutation identified), positive muscle biopsy (e.g., absence of dystrophin protein). CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

5 years of age or older

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of prednisone, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

ENBREL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist.HIDRADENITIS SUPPURATIVA: Prescribed by or in consultation with a rheumatologist, dermatologist or GI specialist.

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PLAQUE PSORIASIS: Failure or clinically significant adverse effects to one of the following: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

ENDARI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 5 or older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of hydroxyurea, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

ENTRESTO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Left ventricular ejection fraction less than 40%.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a cardiologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ENTYVIO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

MAINTENANCE REQUESTS: Documentation of partial or complete response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Humira or Remicade.

Prior Authorization Group Description

EPCLUSA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Treatment of HCV genotype 1, 2, 3, 4, 5, or 6 with decompensated cirrhosis and sofosbuvir or NS5A-based treatment failure.

Exclusion Criteria:

Required Medical Information:

Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

12 to 24 weeks based on cirrhosis status, genotype, prior treatment regimen.

Other Criteria:

Prior Authorization Group Description

EPOETIN (Epogen, Procrit)

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Treatment of anemia due to myelodyspastic syndrome.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ERGOLOID MESYLATES

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Alzheimer's dementia: Failure or clinically significant adverse effects to two of the following: donepezil, memantine, rivastigmine or galantamine. All other FDA-approved indications: Patient is continuing on the medication without adverse effects.

Prior Authorization Group Description

ERLEADA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Concurrent use of a gonadotropin-releasing hormone (GnRH) analog or past bilateral orchiectomy. Disease is not metastatic.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ESBRIET

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ESTROGENS (Activella, Alora, Amabelz, Climara, Climara Pro, Combipatch, Divigel, Duavee, Elestrin, Estrace, estropipate, Evamist, Femhrt, Fyavolv, Lopreeza, Menostar, Mimvey, Mimvey Lo, Minivelle, Premarin, Premphase, Prempro, Vivelle-Dot)

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Atrophic Vaginitis and Kraurosis Vulvae: Failure or clinically significant adverse effects to one of the following: Vagifem, Femring or Premarin vaginal cream. All other FDA approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

EVZIO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Narcan (naloxone nasal spray).

Prior Authorization Group Description

EXONDYS 51

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Duchenne muscular dystrophy with mutation amenable to exon 51 skipping confirmed by genetic testing. REAUTHORIZATION: Continued treatment will be approved with documentation of response to therapy such as improvement in 6 minute walk test (6MWT) distance or objective muscle strength exams (possibly evaluated on a scale of 0-5, with 0 being no motion and 5 being full strength).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

6 months.

Other Criteria:

Currently stable on an oral corticosteroid regimen (e.g., prednisone), unless contraindicated or member has experienced clinically significant adverse effects.

Prior Authorization Group Description

FARYDAK

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a hematologist or oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two prior regimens, including Velcade and an immunomodulatory agent (e.g., dexamethasone).

Prior Authorization Group Description

FASENRA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Blood eosinophil count of greater than or equal to 150 cells/mcL within the past 3 months.

Age Restrictions:

12 years of age or older.

Prescriber Restrictions:

Prescribed by or in consultation with an allergist, pulmonologist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with ONE inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide), unless contraindicated or clinically significant adverse effects are experienced AND Prescribed in combination with ONE long-acting beta-agonist (e.g., salmeterol, formoterol, vilanterol), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

FENTORA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 18 or greater.

Prescriber Restrictions:

Coverage Duration:

Through the end of the Plan contract year.

Other Criteria:

Patient is already taking and is tolerant to around-the-clock opioid therapy. Patients are considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Group Description

FERRIPROX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to deferoxamine, Exjade or Jadenu.

Prior Authorization Group Description

FIORICET WITH CODEINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to naproxen and ibuprofen.

Prior Authorization Group Description

FIORINAL WITH CODEINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to naproxen and ibuprofen.

Prior Authorization Group Description

FIRAZYR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 18 or greater.

Prescriber Restrictions:

Prescribed by or in consultation with an immunologist, allergist, hematologist or rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Medications known to cause angioedema (i.e., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate.

Prior Authorization Group Description

FLECTOR

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Cancer-related neuropathic pain.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Acute Pain: 4 weeks. Cancer-related neuropathic pain: Through the end of the Plan contract year.

Other Criteria:

Prior Authorization Group Description

FLUOROURACIL

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

FORTEO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to alendronate.

Prior Authorization Group Description

FURADANTIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Urinary tract infectious disease, Acute treament: Failure or clinically significant adverse effects to ONE of the following: sulfamethoxazole/trimethoprim or ciprofloxacin. Urinary tract infectious disease, Prophylaxis: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

GANCICLOVIR

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

GATTEX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

MAINTENANCE REQUESTS: Documentation of response to therapy.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

GILENYA

Covered Uses:

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

Exclusion Criteria:

History (in the last 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization or class III/IV heart failure. History or presence of Mobitz II second-degree or third-degree atrioventricular block or sick sinus syndrome, unless patient has a functioning pacemaker. Baseline QTc interval greater than or equal to 500 msec. Concurrent use of Class Ia or Class III anti-arrhythmic drugs.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

GILOTRIF

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Disease is positive for any of the following sensitizing EGFR mutations, as detected by an FDA-approved test, unless request is for second-line therapy in squamous non-small cell lung cancer: exon 19 deletion, exon 21 [L858R] substitution, L861Q, G719X, or S768I mutations.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

GLATIRAMER (Copaxone, Glatopa)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

GLYBURIDE (Diabeta, Glynase)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: glimepiride, glipizide or glipizide/metformin combination product.

Prior Authorization Group Description

GLYBURIDE/METFORMIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: glimepiride, glipizide or glipizide/metformin combination product.

Prior Authorization Group Description

GOCOVRI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Member is receiving levodopa-based therapy. Medical justification supports inability to use immediate-release amantadine.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of immediate-release amantadine unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

GRANIX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

HAEGARDA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial: 6 months. Reauthorization: 12 months.

Other Criteria:

Failure of danazol, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

HARVONI

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Treatment of HCV genotype 1, 4, 5, or 6 with decompensated cirrhosis and sofosbuvir-based treatment failure.

Exclusion Criteria:

Required Medical Information:

Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

8 to 24 weeks based on genotype and prior treatment, cirrhosis, or liver transplant status.

Other Criteria:

Prior Authorization Group Description

HERCEPTIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation that the patient has human epidermal growth factor receptor (HER2) positive cancer.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

HETLIOZ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

HUMAN GROWTH HORMONE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria:

Required Medical Information:

CHILDREN AND ADOLESCENTS WITH GROWTH HORMONE DEFICIENCY, SHOX DEFICIENCY IN CHILDREN: The patient's baseline height must be greater than 2 SD below the mean for gender and age. Growth rate is such that the patient is unlikely to attain an adult height in the normal range - 59 inches for girls and 63 inches for boys. TURNER SYNDROME: Confirmed by karyotype. PRADER-WILLI or NOONAN SYNDROME: The patient's baseline height must be less than the 5th percentile for gender and age or 2 or more SD below the mean measured paternal height. Growth rate is such that the patient is unlikely to attain an adult height in the normal range - 59 inches for girls and 63 inches for boys. REAUTHORIZATION: Continued treatment will be approved with documentation of response to therapy.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Adults: Through the end of the Plan contract year. Children: 6 months.

Other Criteria:

Prior Authorization Group Description

HUMIRA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist. CROHN'S DISEASE, ULCERATIVE COLITIS: Prescribed by or in consultation with a GI specialist. HIDRADENITIS SUPPURATIVA: Prescribed by or in consultation with a rheumatologist, dermatologist or GI specialist.

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PLAQUE PSORIASIS: Failure or clinically significant adverse effects to one of the following: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

HYDROCODONE (Hysingla ER, Zohydro ER)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Three months initial for non-malignant pain then one year. One year for cancer pain.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: MS Contin, Kadian, Duragesic, Opana ER, Avinza or Oxycontin.

Prior Authorization Group Description

HYDROXYZINE HCL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Oral formulations only: Pruritus: Failure or clinically significant adverse effects to one of the following topical agents: betamethasone, hydrocortisone, triamcinolone, fluticasone, clobetasol, fluocinonide or fluocinolone. Anxiety: Failure or clinically significant adverse effects to one of the following: venlafaxine, buspirone, duloxetine or escitalopram. Oral and injectable formulations: All other FDA approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

HYDROXYZINE PAMOATE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Pruritus: Failure or clinically significant adverse effects to one of the following topical agents: betamethasone, hydrocortisone, triamcinolone, fluticasone, clobetasol, fluocinonide or fluocinolone. Anxiety: Failure or clinically significant adverse effects to one of the following: venlafaxine, buspirone, duloxetine or escitalopram. All other FDA approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

ICLUSIG

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation of T315I mutation status. Acute Lymphoblastic Leukemia: Documentation of Philadelphia chromosome positive (Ph+) disease.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

T315I mutation-negative Chronic Myelogenous Leukemia: Failure of a trial of two tyrosine-kinase inhibitors (e.g., imatinib, nilotinib, dasatinib, bosutinib) used to treat CML, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

IDHIFA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Presence of an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test (e.g., Abbott RealTime IDH2 assay).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Disease has relapsed or is refractory following treatment with a first line chemotherapy regimen (e.g., cytarabine, idarubicin, daunorubicin, cladribine, midostaurin, fludarabine).

Prior Authorization Group Description

ILARIS

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Acute gouty arthritis.

Exclusion Criteria:

Required Medical Information:

Documentation of current weight.

Age Restrictions:

Cryopyrin-Associated Periodic Syndromes: 4 years and older. All other covered indications: 2 years and older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

IMATINIB

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Pediatric patients with Philadelphia chromosome positive (Ph+) acute lymphoblastic leukemia (ALL): Imatinib must be used in combination with chemotherapy.

Prior Authorization Group Description

IMBRUVICA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Chronic graft-versus-host disease: Prescribed by or in consultation with an oncologist, hematologist, or bone marrow transplant specialist. For all other indications: Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Mantle cell lymphoma: Failure or clinically significant adverse effects to one prior therapy [e.g., Rituxan (rituximab), vincristine, cytarabine, cisplatin, doxorubicin, Treanda (bendamustine)]. Marginal zone lymphoma: Patient has received at least one prior anti-CD20-based therapy.

Prior Authorization Group Description

IMIPRAMINE HCL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Depression: Failure or clinically significant adverse effects one of the following: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine or venlafaxine XR.

Prior Authorization Group Description

IMIPRAMINE PAMOATE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Depression: Failure or clinically significant adverse effects one of the following: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine or venlafaxine XR.

Prior Authorization Group Description

INDOMETHACIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to naproxen and sulindac.

Prior Authorization Group Description

INFLECTRA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: RHEUMATOID ARTHRITIS and PLAQUE PSORIASIS: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Psoriatic Arthritis/Plaque Psoriasis: Prescribed by or in consultation with a rheumatologist or dermatologist. Crohn's Disease/Ulcerative Colitis: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

12 months.

Other Criteria:

Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. Plaque Psoriasis: Failure or clinically significant adverse effects to one of the following: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

INGREZZA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Development of tardive dyskinesia is secondary to a centrally acting dopamine receptor blocking agent (neuroleptic) (e.g., first- or second-generation antipsychotics such as chlorpromazine or aripiprazole, antiemetics such as promethazine or metoclopramide, the tri-cyclic antidepressant amoxapine). CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a psychiatrist or neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

INLYTA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Thyroid carcinoma (i.e., Follicular carcinoma, Hurthle cell carcinoma, papillary carcinoma).

Exclusion Criteria:

Required Medical Information:

Follicular carcinoma, Hurthle cell carcinoma, papillary carcinoma: Disease is unresectable, recurrent/persistent or metastatic. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

INTERFERON BETA-1A (Avonex, Rebif)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

INTERFERON BETA-1B (Betaseron, Extavia)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

INTERMEZZO 1.75 MG

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Insomnia: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

INTERMEZZO 3.5 MG

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Insomnia: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

INTUNIV

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Attention Deficit Hyperactivity Disorder: Failure or clinically significant adverse effects to two of the following: dexmethylphenidate, methylphenidate or mixed amphetamine salts.

Prior Authorization Group Description

JAKAFI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation of current platelet count and complete blood count (CBC). CONTINUATION OF THERAPY: Documentation of reduction in spleen volume or symptom improvement.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

Initial: 6 months. Reauthorization: Through the end of the Plan contract year.

Other Criteria:

Prior Authorization Group Description

JUBLIA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to terbinafine tablets unless contraindicated.

Prior Authorization Group Description

JUXTAPID

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Repatha 420 mg (unless contraindicated).

Prior Authorization Group Description

JYNARQUE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a nephrologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

KADCYLA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Kadcyla will be used as a single-agent therapy. Documentation that the patient has either received prior therapy for metastatic disease or developed disease recurrence during or within six months of completing adjuvant therapy.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Previously received trastuzumab and a taxane (e.g., paclitaxel, docetaxel), either separately or in combination.

Prior Authorization Group Description

KADIAN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Medical justification as to why patient cannot take an equivalent daily dose of a generically available strength of Kadian.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

KALYDECO

Covered Uses:

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

Exclusion Criteria:

Patients with cystic fibrosis who are homozygous for the F508del mutation.

Required Medical Information:

Presence of one mutation in the CFTR gene that is responsive to ivacaftor as detected by an FDA-cleared cystic fibrosis mutation test.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

KAZANO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Tradjenta or Jentadueto AND Failure or clinically significant adverse effects to one of the following: Januvia, Janumet, Janumet XR.

Prior Authorization Group Description

KERYDIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to terbinafine tablets unless contraindicated.

Prior Authorization Group Description

KETOROLAC TROMETHAMINE

Covered Uses:

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

Exclusion Criteria:

Patients with active peptic ulcer disease. Advanced renal impairment or at risk for renal failure due to volume depletion. Suspected or confirmed cerebrovascular bleeding, hemorrhagic diathesis, incomplete hemostasis and those at high risk for bleeding. Patient currently receiving aspirin or NSAIDs (Non-steroidal anti-inflammatory drugs). Patient currently receiving Probenecid or pentoxifylline.

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

5 days

Other Criteria:

Prior Authorization Group Description

KEVEYIS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

KEVZARA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine, or auranofin.

Prior Authorization Group Description

KEYTRUDA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

KINERET

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin AND Failure or clinically significant adverse effects to one of the following: Enbrel, Humira, Remicade, Cimzia, Simponi or Simponi Aria.

Prior Authorization Group Description

KISQALI (includes Kisqali Femara Co-Pack)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Will be used in combination with an aromatase inhibitor (e.g., letrozole, anastrozole or exemestane) as initial endocrine-based therapy.

Prior Authorization Group Description

KOMBIGLYZE XR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Tradjenta or Jentadueto AND Failure or clinically significant adverse effects to one of the following: Januvia, Janumet, Janumet XR.

Prior Authorization Group Description

KORLYM

Covered Uses:

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

Exclusion Criteria:

Pregnancy.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

KUVAN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response, demonstrated by a reduction of blood phenylalanine levels from baseline.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial: 2 months. Reauthorization: Through the end of the Plan contract year.

Other Criteria:

Prior Authorization Group Description

KYNAMRO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Repatha 420 mg (unless contraindicated).

Prior Authorization Group Description

LATUDA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Schizophrenia: Failure or clinically significant adverse effects to two of the following generic atypical antipsychotics: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole.

Prior Authorization Group Description

LAZANDA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 18 or greater

Prescriber Restrictions:

Coverage Duration:

Through the end of the Plan contract year.

Other Criteria:

Patient is already taking and is tolerant to around-the-clock opioid therapy. Patients are considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Group Description

LEMTRADA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, Copaxone, Glatopa, Extavia or Rebif.

Prior Authorization Group Description

LENVIMA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Medullary thyroid carcinoma.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Renal Cell Carcinoma: Failure or clinically significant adverse effects to one of the following: Sutent, Nexavar, Votrient, Inlyta, Avastin in combination with Intron-A, Proleukin, Torisel AND Failure or clinically significant adverse effects to Opdivo or Cabometyx AND Must be used in combination with everolimus (Afinitor).

Prior Authorization Group Description

LEUKINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Use Following Induction Chemotherapy in Acute Myelogenous Leukemia, Use in Mobilization and Following Transplantation of Autologous Peripheral Blood Progentior Cells, Use in Myeloid Reconstitution After Autologous or Allogeneic Bone Marrow Transplantation: Failure or clinically significant adverse effects to Neupogen.

Prior Authorization Group Description

LIDODERM

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Diabetic peripheral neuropathy. Cancer-related neuropathic pain.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

LONSURF

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation that the patient does or does not have the KRAS wild type gene. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: 5-fluorouracil, capecitabine, oxaliplatin, irinotecan, Avastin, Cyramza, Zaltrap. If tumor expresses the KRAS wild type gene, failure or clinically significant adverse effects to Erbitux or Vectibix.

Prior Authorization Group Description

LOTRONEX

Covered Uses:

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

Exclusion Criteria:

Male patients.

Required Medical Information:

Female patient with irritable bowel symptoms persisting for at least 6 months.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

LUNESTA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: Rozerem, Silenor 6 mg/day or less, trazodone or temazepam.

Prior Authorization Group Description

LYNPARZA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Treatment of ovarian cancer: Mutations in the BRCA genes as detected by an FDA approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

LYNPARZA TABLET

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Treatment of ovarian cancer: Mutations in the BRCA genes as detected by an FDA approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

For maintenance therapy: Completed two or more platinum-based chemotherapy regimens and is in a complete or partial response.

Prior Authorization Group Description

MACRODANTIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Urinary tract infectious disease, Acute treament: Failure or clinically significant adverse effects to ONE of the following: sulfamethoxazole/trimethoprim or ciprofloxacin. Urinary tract infectious disease, Prophylaxis: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

MAVYRET

Covered Uses:

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

Exclusion Criteria:

Treatment-experienced patients with both NS3/4A protease inhibitor and NS5A inhibitor.

Required Medical Information:

If cirrhosis is present, confirmation of Child-Pugh A status. Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

8 to 16 weeks based on genotype, cirrhosis status, prior treatment regimen.

Other Criteria:

If patient has been previously treated with an HCV regimen containing NS5A inhibitor or an NS3/4A protease inhibitor, but not both, member has genotype 1.

Prior Authorization Group Description

MEGACE

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Cachexia associated with cystic fibrosis. Cachexia associated with cancer.

Exclusion Criteria:

Required Medical Information:

Breast Cancer: Megestrol acetate is being used for palliative treatment.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Anorexia and cachexia associated with AIDS: Failure or clinically significant adverse effects to oxandrolone and dronabinol.

Prior Authorization Group Description

MEGACE ES

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Cachexia associated with cystic fibrosis. Cachexia associated with cancer.

Exclusion Criteria:

Required Medical Information:

Breast Cancer: Megestrol acetate is being used for palliative treatment.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Anorexia and cachexia associated with AIDS: Failure or clinically significant adverse effects to oxandrolone and dronabinol.

Prior Authorization Group Description

MEKINIST

Covered Uses:

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

Exclusion Criteria:

MELANOMA: Monotherapy for patients who have disease progression on prior BRAF inhibitor therapy.

Required Medical Information:

MELANOMA: Positive for the BRAF V600E or V600K mutation detected by an FDA-approved test. NON-SMALL CELL LUNG CANCER, ANAPLASTIC THYROID CANCER: Positive for BRAF V600E mutation.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

NON-SMALL CELL LUNG CANCER, ANAPLASTIC THYROID CANCER: Used in combination with Tafinlar.

Prior Authorization Group Description

MEKTOVI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Positive for BRAF V600E or V600K mutation as detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with Braftovi.

Prior Authorization Group Description

MEPROBAMATE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: venlafaxine, buspirone, duloxetine or escitalopram.

Prior Authorization Group Description

METHOCARBAMOL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

METHOTREXATE INJ (Otrexup, Rasuvo)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to generic methotrexate injection.

Prior Authorization Group Description

METHYLDOPA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: amlodipine/benazepril, benazepril, benazepril/hydrochlorothiazide, captopril, captopril/hydrochlorothiazide, fosinopril, fosinopril/hydrochlorothiazide, lisinopril, lisinopril/hydrochlorothiazide, quinapril, quinapril/hydrochlorothiazide, losartan, losartan/hydrochlorothiazide, valsartan, valsartan/hydrochlorothiazide, irbesartan, irbesartan/hydrochlorothiazide, candesartan, candesartan/hydrochlorothiazide, carvedilol, labetalol, acebutolol, atenolol, bisoprolol, bisoprolol/hydrochlorothiazide, timolol, nadolol, propranolol, metoprolol, metoprolol/hydrochlorothiazide, pindolol, nifedipine SR, amlodipine, nicardipine.

Prior Authorization Group Description

MIRCERA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Procrit (epoetin alfa).

Prior Authorization Group Description

MIRVASO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Diagnosis of persistent facial erythema of rosacea with papules and pustules of rosacea: Failure or clinically significant adverse effects to topical metronidazole, Finacea or oral doxycycline.

Prior Authorization Group Description

MOZOBIL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation of patient's current weight and absolute neutrophil count (ANC dated within 30 days prior to the request.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Documented failure to reach and/or maintain a target absolute neutrophil count (ANC) with an adequate trial of Neupogen alone. Must be administered in combination with a granulocyte-colony stimulating factor (G-CSF) (i.e., filgrastim, filgrastim-sndz, or tbo-filgrastim).

Prior Authorization Group Description

NAMENDA (includes Namenda XR)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 59 years and younger. Prior authorization is not required for patients 60 years and older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NATPARA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NERLYNX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months total duration of therapy.

Other Criteria:

Documentation of previous treatment with Herceptin (trastuzumab) as adjuvant therapy.

Prior Authorization Group Description

NESINA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Tradjenta or Jentadueto AND Failure or clinically significant adverse effects to one of the following: Januvia, Janumet, Janumet XR.

Prior Authorization Group Description

NEULASTA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Mobilization of peripheral-blood progenitor cells prior to autologous transplantation.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NEUPOGEN

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Myelodysplastic syndrome. Neutropenia in patients with HIV/AIDS.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NINLARO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one prior therapy [e.g., Velcade (bortezomib), cyclophosphamide (Cytoxan), doxorubicin, Revlimid (lenalidomide), Thalomid (thalidomide), Alkeran (melphalan)]. Ninlaro must be used in combination with dexamethasone.

Prior Authorization Group Description

NORPACE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NORPACE CR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NORTHERA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NUCALA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient has a blood eosinophil count of greater than or equal to 150 cells/mcL within the past 3 months.
CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Patient is 12 years of age or older.

Prescriber Restrictions:

Prescribed by or in consultation with an allergist, pulmonologist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Must be used in combination with ONE inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide) AND must be used in combination with ONE long-acting beta-agonist (e.g., salmeterol, formoterol, vilanterol), unless contraindicated.

Prior Authorization Group Description

NUEDEXTA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NUPLAZID

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NUVIGIL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

OCALIVA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Must be used in combination with ursodeoxycholic acid unless patient is intolerant to ursodeoxycholic acid.

Prior Authorization Group Description

OCREVUS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Member will not use other disease modifying therapies for MS concurrently. CONTINUATION OF THERAPY: Member is maintained on therapy with positive response (e.g., improved or maintained disease control evidenced by decreased or stabilized Expanded Disability Status Scale (EDSS) score or reduction in relapses or MRI lesions).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a Neurologist.

Coverage Duration:

12 months.

Other Criteria:

Relapsing Forms Of Multiple Sclerosis: Failure or clinically significant adverse effects to one of the following: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, Copaxone, Glatopa, Extavia or Rebif.

Prior Authorization Group Description

ODOMZO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Basal cell carcinoma has recurred following surgery or radiation therapy, or member is not a candidate for surgery or radiation therapy.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

OFEV

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ONGLYZA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Tradjenta or Jentadueto AND Failure or clinically significant adverse effects to one of the following: Januvia, Janumet, Janumet XR.

Prior Authorization Group Description

OPSUMIT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ORALAIR

Covered Uses:

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

Exclusion Criteria:

Severe, unstable or uncontrolled asthma. History of any severe allergic reaction to sublingual allergen immunotherapy.

Required Medical Information:

Positive skin test or in vitro testing for pollen-specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy and Kentucky Blue Grass.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an allergist or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to 2 of the following: antihistamines, leukotriene modifiers or nasal steroids.

Prior Authorization Group Description

ORENCIA CLICKJECT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PSORIATIC ARTHRITIS: Failure or clinically significant adverse effects to methotrexate unless contraindicated.

Prior Authorization Group Description

ORENCIA IV

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to Remicade AND one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description

ORENCIA SC

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PSORIATIC ARTHRITIS: Failure or clinically significant adverse effects to methotrexate unless contraindicated.

Prior Authorization Group Description

ORENITRAM

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ORKAMBI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Presence of homozygous F508del mutation in an FDA-cleared cystic fibrosis mutation test.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ORPHENADRINE CITRATE ER

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

OSENI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Tradjenta or Jentadueto AND Failure or clinically significant adverse effects to one of the following: Januvia, Janumet, Janumet XR.

Prior Authorization Group Description

OSMOLEX ER

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Medical justification supports inability to use immediate-release amantadine.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of immediate-release amantadine unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

OTEZLA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

PLAQUE PSORIASIS: Failure or clinically significant adverse effects to ONE of the following: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

PARAFON FORTE DSC

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

PERSERIS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of TWO of the following atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: aripiprazole, ziprasidone, quetiapine, olanzapine, risperidone, asenapine, iloperidone, paliperidone.

Prior Authorization Group Description

PHENOBARBITAL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Partial seizures: Failure or clinically significant adverse effects to one of the following: carbamazepine, phenytoin, topiramate, tiagabine, levetiracetam, gabapentin, lamotrigine, oxcarbazepine, primidone or divalproex. Generalized seizures: Failure or clinically significant adverse effects to one of the following: carbamazepine, phenytoin, topiramate, levetiracetam, primidone or lamotrigine. Sedation: patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

PLEGRIDY

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

PRALUENT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Heterozygous Familial Hypercholesterolemia : Documentation (e.g., medical records, chart notes, laboratory values) of LDL level suggestive of a diagnosis of heterozygous familial hypercholesterolemia (e.g., Adults: LDL greater than 190 mg/dL). Hypercholesterolemia: Documentation of an LDL of 100 mg/dL or greater AND documented history of clinical atherosclerotic cardiovascular disease defined as one of the following: Acute coronary syndromes, Myocardial Infarction, Stable or unstable angina, Coronary or other arterial revascularization (e.g., percutaneous coronary intervention or coronary artery bypass graft surgery), Stroke, Peripheral artery disease presumed to be of atherosclerotic origin, Transient ischemic attack (TIA), Clinically significant coronary heart disease (CHD) diagnosed by invasive or noninvasive testing (such as coronary angiography, stress test using treadmill, stress echocardiography, or nuclear imaging), Carotid artery occlusion greater than 50% without symptoms, Renal artery stenosis or renal artery stent procedure. Reauthorization requests require documentation of LDL reduction while on Praluent therapy AND, if tolerated, confirmation of continued statin therapy at the maximally tolerated dose.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.

Coverage Duration:

6 months.

Other Criteria:

Clinically significant adverse effect(s), contraindication(s), intolerance or failure to two of the following at maximally tolerated doses: atorvastatin, rosuvastatin, simvastatin, Vytorin, pitavastatin, pravastatin, fluvastatin, or lovastatin.

Prior Authorization Group Description

PREVYMIS

Covered Uses:

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

Exclusion Criteria:

Member is receiving pimozide or ergot alkaloids. Member is receiving cyclosporine co-administered with pitavastatin or simvastatin.

Required Medical Information:

Intravenous (IV) Prevymis: Medical justification why the member cannot use oral therapy.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncology, hematology, infectious disease, or transplant specialist.

Coverage Duration:

Through day 100 post-transplantation.

Other Criteria:

Failure of generic valacyclovir or generic ganciclovir, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

PROCARDIA CAPSULES

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

CHRONIC STABLE ANGINA: Failure or clinically significant adverse effects to ONE of the following: nifedipine SR, amlodipine or nicardipine. VASOSPASTIC ANGINA: Failure or clinically significant adverse effects to ONE of the following: nifedipine SR or amlodipine.

Prior Authorization Group Description

PROLIA

Covered Uses:

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

Exclusion Criteria:

Hyopcalcemia (unless corrected prior to initiating therapy).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

For men with non-metastatic prostate cancer: Receiving or has received androgen deprivation therapy [i.e. leuprolide (Lupron), bicalutamide (Casodex) or Nilandron]. For women with breast cancer: Receiving or has received adjuvant aromatase inhibitor therapy [i.e. anastrozole (Arimidex), exemestane (Aromasin) or letrozole (Femara)].

Prior Authorization Group Description

PROMACTA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Thrombocytopenia in Chronic Hepatitis C: Documentation of current or planned interferon-based treatment of chronic hepatitis C.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Chronic Immune (Idiopathic) Thrombocytopenia: Failure of a corticosteroid (e.g., oral prednisone, intravenous methylprednisolone or oral dexamethasone), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

PROTOPIC

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Tacrolimus 0.1%: 16 years and older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of two medium to high potency topical corticosteroids (e.g., amcinonide, fluticasone propionate, triamcinolone acetonide, betamethasone valerate, fluocinolone acetonide, hydrocortisone butyrate, mometasone furoate, desoximetasone, fluocinonide or betamethasone dipropionate), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

PROVIGIL

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Multiple sclerosis-related fatigue.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

PURIXAN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Member has a documented swallowing disorder or an inability to swallow tablets or capsules. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to mercaptopurine tablets.

Prior Authorization Group Description

QUALAQUIN

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Babesiosis. Plasmodium vivax malaria.

Exclusion Criteria:

For the treatment or prevention of nocturnal leg cramps.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Malaria: 7 days. Babesiosis: 7-10 days

Other Criteria:

Plasmodium vivax malaria: Infection is chloroquine-resistant.

Prior Authorization Group Description

RADICAVA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Forced vital capacity greater than or equal to 80%, disease duration of less than or equal to 2 years, functionally retains most activities of daily living (defined as a baseline revised ALS Functional Rating Scale (ALSFRS-R) score with greater than or equal to 2 points in each of the 12 items, meets diagnostic criteria of definite or probable amyotrophic lateral sclerosis (ALS) based on El Escorial revised criteria. CONTINUATION OF THERAPY: Member continues to retain most activities of daily living, forced vital capacity greater than or equal to 80%, and ALSFRS-R score with greater than or equal to 2 points in each of the 12 items.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

6 months.

Other Criteria:

Prescribed in combination with riluzole unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

RANEXA

Covered Uses:

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

Exclusion Criteria:

Patients on strong CYP3A inhibitors (e.g., ketoconazole, HIV protease inhibitors, clarithromycin) or CYP3A inducers (e.g., rifampin, phenobarbital).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

RAYALDEE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient has stage 3 or 4 chronic kidney disease (CKD) and serum total 25-hydroxyvitamin D level less than 30 ng/mL.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

RELISTOR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Amitiza and Movantik.

Prior Authorization Group Description

REMICADE

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Wegener's Granulomatosis.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: RHEUMATOID ARTHRITIS and PLAQUE PSORIASIS: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Psoriatic Arthritis/Plaque Psoriasis: Prescribed by or in consultation with a rheumatologist or dermatologist. Crohn's Disease/Ulcerative Colitis: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

12 months.

Other Criteria:

Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. Plaque Psoriasis: Failure or clinically significant adverse effects to one of the following: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

REPATHA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Heterozygous or Homozygous Familial Hypercholesterolemia : Documentation (e.g., medical records, chart notes, laboratory values) of LDL level suggestive of a diagnosis of familial hypercholesterolemia (e.g., Adults: LDL greater than 190 mg/dL). Hypercholesterolemia: Documentation of an LDL of 100 mg/dL or greater AND documented history of clinical atherosclerotic cardiovascular disease defined as one of the following: Acute coronary syndromes, Myocardial Infarction, Stable or unstable angina, Coronary or other arterial revascularization (e.g., percutaneous coronary intervention or coronary artery bypass graft surgery), Stroke, Peripheral artery disease presumed to be of atherosclerotic origin, Transient ischemic attack (TIA), Clinically significant coronary heart disease (CHD) diagnosed by invasive or noninvasive testing (such as coronary angiography, stress test using treadmill, stress echocardiography, or nuclear imaging), Carotid artery occlusion greater than 50% without symptoms, Renal artery stenosis or renal artery stent procedure. Reauthorization requests require documentation of LDL reduction while on Repatha therapy AND, if tolerated, confirmation of continued statin therapy at the maximally tolerated dose.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.

Coverage Duration:

6 months.

Other Criteria:

Clinically significant adverse effect(s), contraindication(s), intolerance or failure to two of the following at maximally tolerated doses: atorvastatin, rosuvastatin, simvastatin, Vytorin, pitavastatin, pravastatin, fluvastatin, or lovastatin.

Prior Authorization Group Description

REVATIO

Covered Uses:

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

Exclusion Criteria:

Patients taking nitrates (e.g., Nitrodur, Nitrobid, Nitrostat, Isordil, Ismo). Patients taking a guanylate cyclase stimulator, such as riociguat (Adempas).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

REVLIMID

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Patients who are pregnant.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Mantle Cell Lymphoma: Failure of maximally tolerated doses of two prior chemo therapies (e.g., CHOP [cyclophosphamide, doxorubicin, vincristine, and prednisone], hyperCVAD [cyclophosphamide, vincristine, doxorubicin, and dexamethasone]) including Velcade unless contraindicated or clinically significant adverse effects are experienced. Multiple Myeloma: Must be used in combination with dexamethasone unless being used as maintenance therapy following autologous hematopoietic stem cell transplantation or as maintenance therapy for active (symptomatic) myeloma responding to primary myeloma therapy.

Prior Authorization Group Description

REXULTI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Schizophrenia: Failure or clinically significant adverse effects to two of the following generic atypical antipsychotics: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole.

Prior Authorization Group Description

RITUXAN

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Mantle Cell Lymphoma. Waldenstrom macroglobulinemia.

Exclusion Criteria:

Current or prior hepatitis B virus infection. Rheumatoid arthritis, Granulomatosis with polyangiitis, Microscopic polyangiitis: Concurrent use with biologic agents and DMARDs other than methotrexate.

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response. RHEUMATOID ARTHRITIS: At least 16 weeks have elapsed since the last course of therapy.

Age Restrictions:

Prescriber Restrictions:

Non-Hodgkin's lymphoma, Chronic lymphocytic leukemia, Mantle cell lymphoma, Waldenstrom macroglobulinemia: Prescribed by or in consultation with an oncologist. Rheumatoid arthritis, Granulomatosis with polyangiitis, Microscopic polyangiitis: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

RA: 3 months. Other indications: 6 months. Renewals: To end of Plan contract year.

Other Criteria:

Rheumatoid Arthritis: Used in combination with methotrexate, unless contraindicated or clinically significant adverse effects were experienced with prior methotrexate therapy AND Failure of Enbrel or Humira, unless contraindicated or clinically significant adverse effects are experienced. Granulomatosis with polyangiitis, Microscopic polyangiitis: Used in combination with a glucocorticoid (e.g. prednisone, prednisolone, dexamethasone). Mantle cell lymphoma: Used in combination with anthracycline-based regimens (e.g., CHOP, hyperCVAD [cyclophosphamide, vincristine, doxorubicin and dexamethasone]).

Prior Authorization Group Description

RUBRACA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Mutations in the BRCA genes as detected by an FDA-approved test or member has a complete or partial response to two or more platinum-based chemotherapy regimens.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

RYDAPT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Acute Myeloid Leukemia: Positive for the FLT3 mutation as detected by an FDA-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay). CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Acute Myeloid Leukemia: Prescribed by or in consultation with an oncologist. Advanced Systemic Mastocytosis: Prescribed by or in consultation with an oncologist, allergist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Acute Myeloid Leukemia: Prescribed in combination with daunorubicin for induction therapy AND in combination with cytarabine for induction and consolidation therapy.

Prior Authorization Group Description

SAVELLA

Covered Uses:

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

Exclusion Criteria:

Use of monoamine oxidase inhibitors concomitantly or in close temporal proximity.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Fibromyalgia: Failure or clinically significant adverse effects to duloxetine or Lyrica. Depression: Failure of one of the following generic antidepressants: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine, or venlafaxine XR, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

SEROQUEL XR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Schizophrenia: Failure or clinically significant adverse effects to two of the following generic atypical antipsychotics: risperidone, olanzapine, quetiapine immediate release, ziprasidone, aripiprazole.

Prior Authorization Group Description

SEROSTIM

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

REAUTHORIZATION: Continued treatment will be approved with documentation of response to therapy.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

6 months.

Other Criteria:

Patient is being treated with concomitant antiretroviral therapy

Prior Authorization Group Description

SILIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following as recommended by the American Academy of Dermatology: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

SIMPONI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist or dermatologist. ULCERATIVE COLITIS: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description

SIMPONI ARIA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description

SKELAXIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

SOMA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

SOMAVERT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Inadequate response to surgery or radiation therapy, unless surgery or radiation therapy is not appropriate for the patient.

Prior Authorization Group Description

SONATA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: Rozerem, Silenor 6 mg/day or less, trazodone or temazepam.

Prior Authorization Group Description

SOVALDI

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. For the treatment of hepatitis C virus genotypes 5 and 6.

Exclusion Criteria:

Required Medical Information:

Diagnosis of chronic hepatitis C (CHC) and genotype 1, 2, 3, 4, 5 or 6 confirmed by detectable serum hepatitis C virus RNA by quantitative assay OR For treatment of CHC in patients with hepatocellular carcinoma (HCC) meeting Milan criteria (awaiting liver transplantation). Milan criteria is defined as the presence of a tumor 5 cm or less in diameter in patients with single hepatocellular carcinomas and no more than three tumor nodules, each 3 cm or less in diameter in patients with multiple tumors and no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor. Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

GT 1 to 6: 12 to 24 weeks or HCC with CHC: up to 48 weeks or until liver transplantation

Other Criteria:

For Sovaldi in combination with Daklinza for genotype 1: Failure or clinically significant adverse effects to Harvoni (sofosbuvir/ledipasvir). For Sovaldi in combination with Daklinza for genotype 2: Failure or clinically significant adverse effects to sofosbuvir/ribavirin. For patients with hepatocellular carcinoma (HCC) meeting Milan criteria (awaiting liver transplantation): must be used in combination with ribavirin.

Prior Authorization Group Description

SPRITAM

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Medical justification must be provided why patient cannot take generic levetiracetam tablets or liquid.

Prior Authorization Group Description

SPRYCEL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome-positive chronic myeloid leukemia (CML) or Philadelphia chromosome-positive acute lymphoblastic leukemia (ALL): Failure of imatinib, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

STELARA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist. CROHN'S DISEASE: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

12 months.

Other Criteria:

PLAQUE PSORIASIS: Failure or clinically significant adverse effects to ONE of the following: methotrexate, cyclosporine, or acitretin. PSORIATIC ARTHRITIS: Failure or clinically significant adverse effects to methotrexate unless contraindicated.

Prior Authorization Group Description

STELARA IV

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

4 weeks.

Other Criteria:

Prior Authorization Group Description

STIVARGA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

METASTATIC COLORECTAL CANCER: Documentation that the patient does or does not have the RAS wild type gene. Documentation that the patient does or does not have the BRAF V600E mutation. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

METASTATIC COLORECTAL CANCER: If tumor does not have the RAS wild type gene, failure or clinically significant adverse effects to one of the following: 5-fluorouracil, capecitabine, oxaliplatin, irinotecan, Cyramza, Avastin, Zaltrap OR If tumor expresses the RAS wild type gene without the BRAF V600E mutation, failure or clinically significant adverse effects to Erbitux or Vectibix. GASTROINTESTINAL STROMAL TUMOR: Failure or clinically significant adverse effects to one of the following: Gleevec or Sutent.

Prior Authorization Group Description

STRENSIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

SUBSYS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 18 or greater

Prescriber Restrictions:

Coverage Duration:

Through the end of the Plan contract year.

Other Criteria:

Patient is already taking and is tolerant to around-the-clock opioid therapy. Patients are considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Group Description

SUBUTEX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is pregnant OR Written documentation of intolerance to naloxone.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Non pregnant: 3 months initial. Pregnant patients: 9 months.

Other Criteria:

Prior Authorization Group Description

SURMONTIL

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Irritable bowel syndrome.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Depression: Failure or clinically significant adverse effects to one of the following: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine, or venlafaxine XR.

Prior Authorization Group Description

SYMDEKO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Presence of homozygous F508del mutation or at least one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor.

Age Restrictions:

Age greater than or equal to 12 years.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

SYMLINPEN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation that the current HbA1c level is greater than 7%.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Diabetes Type 2: Failure of a metformin-containing regimen, unless contraindicated or clinically significant adverse effects are experienced. Diabetes Type 1: Failure of an insulin-containing regimen, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

TAGRISSO

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Disease is positive for any of the following, as detected by an FDA-approved test: exon 19 deletions, exon 21 L858R mutations, or T790M mutation with progression on or after an EGFR TKI therapy (e.g., Tarceva, Iressa, or Gilotrif).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

TALTZ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

TARCEVA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Non-small cell lung cancer: Documentation that the patient has EGFR exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Pancreatic cancer: Tarceva is being prescribed in combination with gemcitabine.

Prior Authorization Group Description

TASIGNA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Patients with hypokalemia, hypomagnesemia, or long QT syndrome.

Required Medical Information:

Chronic Myelogenous Leukemia (CML), Acute Lymphoblastic Leukemia (ALL): Documentation that the patient has Philadelphia chromosome positive disease.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Soft Tissue Sarcoma Gastrointestinal Stromal Tumor: Failure to imatinib, sunitinib, or regorafenib, unless contraindicated or clinically significant adverse effects are experienced

Prior Authorization Group Description

TAVALISSE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of a corticosteroid (e.g., prednisone, methylprednisolone, or dexamethasone), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

TECENTRIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of platinum-containing chemotherapy (e.g., cisplatin or carboplatin), OR the patient is not eligible for cisplatin-containing chemotherapy. Non-small cell lung cancer: If a known epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberration exists, then for ALK+ disease: prior trial of Xalkori or Alecensa OR for EGFR+ disease: prior trial of Tarceva, Gilotrif or Iressa.

Prior Authorization Group Description

TECFIDERA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

TENEX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: amlodipine/benazepril, benazepril, benazepril/hydrochlorothiazide, captopril, captopril/hydrochlorothiazide, fosinopril, fosinopril/hydrochlorothiazide, lisinopril, lisinopril/hydrochlorothiazide, quinapril, quinapril/hydrochlorothiazide, losartan, losartan/hydrochlorothiazide, valsartan, valsartan/hydrochlorothiazide, irbesartan, irbesartan/hydrochlorothiazide, candesartan, candesartan/hydrochlorothiazide, carvedilol, labetalol, acebutolol, atenolol, bisoprolol, bisoprolol/hydrochlorothiazide, timolol, nadolol, propranolol, metoprolol, metoprolol/hydrochlorothiazide, pindolol, nifedipine SR, amlodipine, nicardipine.

Prior Authorization Group Description

TETRABENAZINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

TIBSOVO

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Presence of an isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test (e.g., Abbott RealTime IDH1 Assay).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

For age less than 60 years, disease has relapsed or is refractory following treatment with a first-line chemotherapy regimen (e.g., cytarabine, idarubicin, daunorubicin, cladribine, midostaurin).

Prior Authorization Group Description

TREMFYA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to ONE of the following as recommended by the American Academy of Dermatology: methotrexate, cyclosporine, or acitretin.

Prior Authorization Group Description

TRIHEXYPHENIDYL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Parkinsons disease/Parkinsonism: Failure or clinically significant adverse effects to two of the following: amantadine, levodopa/carbidopa, entacapone, pramipexole, ropinirole, selegiline. All other FDA-approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

TYMLOS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response. Tymlos has not been used for more than two years.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of a bisphosphonate (e.g., alendronate) unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

TYSABRI

Covered Uses:

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

Exclusion Criteria:

Patients who have or have had progressive multifocal leukoencephalopathy.

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS: Prescribed by or in consultation with a neurologist. CROHN'S DISEASE: Prescribed by or in consultation with a GI specialist.

Coverage Duration:

12 months.

Other Criteria:

RELAPSING FORMS OF MULTIPLE SCLEROSIS: Failure or clinically significant adverse effects to one of the following: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, Copaxone, Glatopa, Extavia or Rebif. CROHN'S DISEASE: Failure or clinically significant adverse effects to Humira or Remicade.

Prior Authorization Group Description

ULTRAVATE LOTION

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to generic halobetasol propionate and generic clobetasol propionate.

Prior Authorization Group Description

UPTRAVI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

VALCHLOR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following skin-directed therapies: topical corticosteroids (e.g., clobetasol, triamcinolone), Targretin gel, Tazorac, or imiquimod. FOR CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Prior Authorization Group Description

VANCOCIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, infectious disease specialist or hospitalist.

Coverage Duration:

C. Diff diarrhea: 14 days. Staph enterocolitis: 10 days. Recurrent C. Diff: 10 weeks

Other Criteria:

Prior Authorization Group Description

VENCLEXTA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of clinically significant adverse effects to one previous therapy (e.g., Imbruvica, Campath, high-dose methylprednisolone with Rituxan).

Prior Authorization Group Description

VERSACLOZ

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Psychotic disorder associated with Parkinson's disease.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of or clinically significant adverse effects to clozapine (Clozaril) or FazaClo.

Prior Authorization Group Description

VERZENIO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

VIBERZI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to loperamide and either diphenoxylate-atropine or dicyclomine, unless patient is 65 years or older.

Prior Authorization Group Description

VIMOVO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to pantoprazole, lansoprazole or omeprazole AND For osteoarthritis or rheumatoid arthritis, failure or clinically significant adverse effects to one of the following: ibuprofen, diclofenac sodium or potassium, etodolac, fenoprofen, ketoprofen, meloxicam, naproxen, oxaprozin, piroxicam, salsalate, sulindac, tolmetin OR For ankylosing spondylitis: Failure or clinically significant adverse effects to one of the following: diclofenac sodium, naproxen or sulindac.

Prior Authorization Group Description

VINBLASTINE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Documentation that vinblastine is being used as palliative therapy.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

VINCRISTINE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Patients with the demyelinating form of Charcot-Marie-Tooth syndrome.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Hodgkin's disease, non-Hodgkin's malignant lymphomas, rhabdomyosarcoma, neuroblastoma, Wilms' tumor: use in combination with other oncolytic agents.

Prior Authorization Group Description

VOSEVI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

For members with cirrhosis, documentation of Child-Pugh A status. Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

12 weeks.

Other Criteria:

If HCV genotype 1, 2, 3, 4, 5 or 6, member has previously been treated with an HCV regimen containing one of the following NS5A inhibitors: daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir. Alternatively, if HCV genotype is 1a or 3, member has previously been treated with an HCV regimen containing sofosbuvir.

Prior Authorization Group Description

VOTRIENT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

SOFT TISSUE SARCOMA: Member has received prior chemotherapy (e.g., regimens containing doxorubicin or epirubicin).

Prior Authorization Group Description

VRAYLAR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to TWO of the following atypical antipsychotics: aripiprazole, ziprasidone, quetiapine, olanzapine, risperidone.

Prior Authorization Group Description

VYTORIN 10/80 MG

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Patient has been taking ezetimibe 10 mg/simvastatin 80 mg for 12 months or longer.

Prior Authorization Group Description

XALKORI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation that the patient is ALK-positive as detected by an FDA-approved test or that the patient is ROS-1 positive as confirmed by a laboratory-developed break-apart FISH or RT-PCR clinical trial assay.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

XATMEP

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Less than 18 years of age.

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist (for acute lymphoblastic leukemia) or rheumatologist (for polyarticular juvenile idiopathic arthritis).

Coverage Duration:

12 months.

Other Criteria:

Medical justification as to why member cannot use methotrexate tablets.

Prior Authorization Group Description

XELJANZ (includes Xeljanz XR)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description

XEOMIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

XERMELO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Prescribed in combination with a somatostatin analog (e.g., octreotide, lanreotide) unless contraindicated or clinically significant adverse effects are experienced. CONTINUATION OF THERAPY: Maintained on therapy with positive response (e.g., reduction in bowel movement frequency, reduction in urinary 5-HIAA levels).

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure to a trial of a somatostatin analog (e.g., octreotide, lanreotide) unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

XOLAIR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Moderate to severe persistent asthma: Patient has a positive skin test or in vitro reactivity to a perennial aeroallergen AND Patient has a confirmed total serum IgE level greater than 30 IU/ml. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Asthma: Patient is 6 years of age or older. Chronic Idiopathic Urticaria: Patient is 12 years of age or older.

Prescriber Restrictions:

Asthma: Prescribed by or in consultation with a pulmonologist, immunologist, or allergist. Urticaria: Prescribed by or in consultation with an allergist, dermatologist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Moderate to severe persistent asthma: Failure or clinically significant adverse effects to one inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide). Chronic Idiopathic Urticaria: Failure or clinically significant adverse effects to one H1 Antihistamine (e.g., levocetirizine or desloratadine).

Prior Authorization Group Description

XTANDI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

For patients without visceral metastases: failure or clinically significant adverse effects to Zytiga.

Prior Authorization Group Description

YERVOY

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Small cell lung cancer.

Exclusion Criteria:

Required Medical Information:

Small cell lung cancer: Disease relapse within 6 months following complete or partial response or stable disease.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Small cell lung cancer: Disease relapse with initial treatment (e.g., cisplatin, carboplatin containing regimen).

Prior Authorization Group Description

YONSA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with methylprednisolone. Member has previously had bilateral orchiectomy, failed androgen deprivation therapy (ADT) or will use ADT concurrently with Yonsa.

Prior Authorization Group Description

ZALTRAP

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Colorectal cancer is resistant or has progressed following an oxaliplatin-containing regimen AND Zaltrap will be used in combination with 5-fluorouracil, leucovorin, and irinotecan (FOLFIRI).

Prior Authorization Group Description

ZARXIO

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Myelodysplastic syndrome. Neutropenia in patients with HIV/AIDS. Hematopoietic syndrome of acute radiation syndrome.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ZEJULA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Completed two or more platinum-based chemotherapy regimens and are in a complete or partial response.

Prior Authorization Group Description

ZELBORAF

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Non-small cell lung cancer. Hairy Cell Leukemia.

Exclusion Criteria:

MELANOMA: Patients with wild-type BRAF melanoma.

Required Medical Information:

MELANOMA, NON-SMALL CELL LUNG CANCER: Positive for the BRAF V600E mutation detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

HAIRY CELL LEUKEMIA: Condition is non-responsive to purine analog therapy (e.g., pentostatin, cladribine).

Prior Authorization Group Description

ZEPATIER

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

12 to 16 wks based on genotype,presence of NS5A resistance-associated polymorphisms,prior treatment.

Other Criteria:

Prior Authorization Group Description

ZINPLAVA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation of positive Clostridium difficile test.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

4 weeks.

Other Criteria:

Will receive or is currently receiving antibacterial drug treatment for Clostridium difficile infection (e.g., metronidazole, vancomycin, fidaxomicin) concomitantly with Zinplava. Has received appropriate treatment for past CDI recurrences, including a pulsed vancomycin regimen.

Prior Authorization Group Description

ZOLPIDEM (Ambien, Ambien CR, Edluar, Zolpimist)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: Rozerem, Silenor 6 mg/day or less, trazodone or temazepam.

Prior Authorization Group Description

ZURAMPIC

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to allopurinol or Uloric AND Must be used in combination with allopurinol or Uloric.

Prior Authorization Group Description

ZYDELIG

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. MALT lymphoma (gastric and nongastric). Splenic Marginal Zone Lymphoma. Primary Cutaneous Marginal Zone B-Cell Lymphoma. Nodal Marginal Zone Lymphoma.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a hematologist or oncologist.

Coverage Duration:

12 months.

Other Criteria:

For relapsed follicular B-cell non-Hodgkin lymphoma (FL) or relapsed small lymphocytic lymphoma (SLL): failure or clinically significant adverse effects to two prior systemic therapies (e.g., For FL: Leukeran, Rituxan, Treanda, R-CHOP, R-CVP, FCMR or for SL: Leukeran, Gazyva, FCR, FR, BR or PCR).

Prior Authorization Group Description

ZYKADIA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Soft tissue sarcoma - inflammatory myofibroblastic tumor.

Exclusion Criteria:

Required Medical Information:

Documentation that the patient does or does not have anaplastic lymphoma kinase (ALK)-positive disease. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ZYTIGA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Must be used in combination with prednisone.