2022 Medicare Part D
Prior Authorization Requirements

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ACTEMRA

MEDICATION(S)
ACTEMRA 162 MG/0.9 ML SYRINGE, ACTEMRA ACTPEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE ACTEMRA CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) GIANT CELL ARTERITIS IN COMBINATION WITH TAPERING COURSE OF CORTICOSTEROIDS OR AS SINGLE AGENT FOLLOWING DISCONTINUATION OF CORTICOSTEROIDS, OR (2) SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS, OR (3) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, AND RINVOQ, OR (4) POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL AND HUMIRA, OR (5) SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD) (EARLY DIFFUSE SSC AND ILD, AND EARLY EVIDENCE OF ILD PROGRESSION) WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO MYCOPHENOLATE. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY OR PULMONOLOGY.

COVERAGE DURATION
12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ACTIMMUNE

MEDICATION(S)
ACTIMMUNE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A MAXIMUM DOSE OF 50 MCG PER SQUARE METER 3 TIMES WEEKLY.

AJOVY

MEDICATION(S)
AJOVY AUTOINJECTOR, AJOVY SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE CONCURRENTLY WITH BOTULINUM TOXIN.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PATIENT HAS GREATER THAN OR EQUAL TO 4 MIGRAINE DAYS PER MONTH, AND (2) PATIENT HAS A DOCUMENTED INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO AT LEAST TWO STANDARD PROPHYLACTIC PHARMACOLOGIC THERAPIES (AT LEAST ONE DRUG EACH FROM A DIFFERENT PHARMACOLOGIC CLASS SUCH AS ANTICONVULSANT, BETA-BLOCKER, CALCIUM CHANNEL BLOCKER, ANTIDEPRESSANT). RENEWAL CRITERIA: DOCUMENTATION OF A POSITIVE RESPONSE.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
INITIAL CRITERIA: RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH A NEUROLOGIST, A HEADACHE SPECIALIST OR A PAIN SPECIALIST.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ANDROGEN THERAPY

MEDICATION(S)
TESTOSTERONE 1% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 10 MG GEL PUMP, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT, TESTOSTERONE CYPIONATE, TESTOSTERONE ENANTHATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTED TESTOSTERONE DEFICIENCY OF LESS THAN 300 NG/DL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

ANTICONVULSANTS - SELECT AGENTS

MEDICATION(S)
APTIOM, DIACOMIT, FINTEPLA, FYCOMPA, RUFINAMIDE, ZONISADE, ZTALMY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGY.

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

ANTIDEPRESSANTS - NON-PREFERRED AGENTS

MEDICATION(S)
AUVELITY, DRIZALMA SPRINKLE, FETZIMA, TRINTELLIX, VIIBRYD, VILAZODONE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO TWO PREFERRED ALTERNATIVE ANTIDEPRESSANTS, SUCH AS: CITALOPRAM, ESCITALOPRAM, FLUOXETINE, PAROXETINE, SERTRALINE, VENLAFAXINE, OR DULOXETINE, OR (3) FOR DRIZALMA, FOR THE DIAGNOSES OF DIABETIC PERIPHERAL NEUROPATHY AND CHRONIC MUSCULOSKELETAL PAIN, DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO DULOXETINE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

ANTINEOPLASTIC INJECTABLES

MEDICATION(S)
BESREMI, DARZALEX FASPRO, FULVESTRANT, LUPRON DEPOT, LUPRON DEPOT (LUPANETA), LUPRON DEPOT-PED 11.25 MG 3MO, LUPRON DEPOT-PED 7.5 MG KIT, MVASI, POLIVY, TRELSTAR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL: FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, OR (2) DOCUMENTATION THAT A PATIENT IS CURRENTLY RECEIVING OR HAS PREVIOUSLY RECEIVED AND BENEFITED FROM THE USE OF THIS MEDICATION FOR THE TREATMENT OF CANCER. RENEWAL: DOCUMENTATION OF A BENEFICIAL RESPONSE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
N/A

ARCALYST

MEDICATION(S)
ARCALYST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS) OR DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA) WITH GENETIC TESTING CONFIRMING MUTATION IN THE IL1RN GENE, AND DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO KINERET OR (2) DIAGNOSIS OF RECURRENT PERICARDITIS, AND DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO TWO OF THE FOLLOWING THERAPIES: NON-STEROIDAL ANTI-INFLAMMATORY DRUGS, COLCHICINE OR CORTICOSTEROIDS. RENEWAL CRITERIA: (1) REAUTHORIZATIONS WILL REQUIRE MEDICAL CHART DOCUMENTATION THAT THE PATIENT HAS BEEN SEEN WITHIN THE PAST 12 MONTHS, AND (2) PROVIDER ATTESTATION OF CLINICAL IMPROVEMENT AND THAT THE MEDICATION CONTINUES TO BE EFFECTIVE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH A SPECIALIST.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF POSITIVE RESPONSE.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ATYPICAL ANTIPSYCHOTIC AGENTS

MEDICATION(S)
ASENAPINE MALEATE, CAPLYTA, FANAPT, LYBALVI, PALIPERIDONE ER, REXULTI, SECUADO, VRAYLAR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO TWO OF THE FOLLOWING ALTERNATIVES: RISPERIDONE, ZIPRASIDONE, OLANZAPINE, QUETIAPINE REGULAR RELEASE, QUETIAPINE EXTENDED RELEASE OR ARIPIPRAZOLE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

AUSTEDO

MEDICATION(S)
AUSTEDO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGY OR PSYCHIATRY.

COVERAGE DURATION
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF POSITIVE RESPONSE.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

BRIVIACT

MEDICATION(S)
BRIVIACT 10 MG TABLET, BRIVIACT 10 MG/ML ORAL SOLN, BRIVIACT 100 MG TABLET, BRIVIACT 25 MG TABLET, BRIVIACT 50 MG TABLET, BRIVIACT 75 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO LEVETIRACETAM AND ONE ADDITIONAL PREFERRED SEIZURE MEDICATION, SUCH AS LAMOTRIGINE, CARBAMAZEPINE, DIVALPROEX, PHENYTOIN, TOPIRAMATE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

CABLIVI

MEDICATION(S)
CABLIVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
THROMBOCYTOPENIA DUE TO ANOTHER CAUSE, INCLUDING SEPSIS, INFECTION WITH E. COLI 0157, ATYPICAL HEMOLYTIC UREMIC SYNDROME, DISSEMINATED INTRAVASCULAR COAGULATION, OR CONGENITAL THROMBOTIC THROMBOCYTOPENIC PURPURA.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PATIENT IS AN ADULT DIAGNOSED WITH ACQUIRED THROMBOTIC THROMBOCYTOPENIC PURPURA (ATTP) INCLUDING THE FOLLOWING: (A) THROMBOCYTOPENIA WITH PLATELET COUNT LESS THAN 100,000/MICROL (100X10E9/L), AND (B) INCLUDES MICROSCOPIC EVIDENCE OF RED BLOOD CELL FRAGMENTATION (E.G., SCHISTOCYTES) (2) DOCUMENTATION OF ONE OF THE FOLLOWING RELATED TO ADAMTS13: (A) SEVERE ADAMTS13 DEFICIENCY (ACTIVITY LEVELS OF LESS THAN 10%), OR (B) ADAMTS DEFICIENCY (ACTIVITY LEVELS OF GREATER THAN 10% BUT LESS THAN 30%), WITH CLINICAL RATIONALE SUPPORTING THE DIAGNOSIS OF ATTP, OR (C) ADAMTS13 HAS BEEN ORDERED BUT LAB RESULTS ARE NOT YET AVAILABLE, AND (4) PRESCRIBED IN COMBINATION WITH PLASMA EXCHANGE AND IMMUNOSUPPRESSIVE THERAPY (SUCH AS HIGH-DOSE GLUCOCORTICOIDS AND/OR RITUXIMAB, AND (5) CABLIVI WILL BE DISCONTINUED IF PATIENT EXPERIENCES MORE THAN 2 RECURRENCES OF ATTP WHILE ON CABLIVI. RENEWAL CRITERIA: PATIENT WAS PREVOIUSLY TREATED SUCCESSFULLY WITH CABLIVI AND CONTINUES TO MEET INITIAL CRITERIA FOR A SUBSEQUENT EPISODE.

AGE RESTRICTION
LIMITED TO ADULTS AGE 18 YEARS AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY HEMATOLOGY/ONCOLOGY

COVERAGE DURATION

12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

CENEGERMIN

MEDICATION(S)
OXERVATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF NEUROTROPHIC KERATITIS AND (2) PROVIDER ATTESTATION THAT PATIENT HAS BEEN EDUCATED ON ADMINISTRATION TECHNIQUE, DRUG STORAGE, AND DRUG PREPARATION REQUIREMENTS.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 2 YEARS AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH AN OPHTHALMOLOGIST

COVERAGE DURATION
8 WKS PER FDA LABELING.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

CIMZIA

MEDICATION(S)
CIMZIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE CIMZIA CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ACTEMRA AND ORENCIA, OR (2) PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG ORENCIA, OR (3) PLAQUE PSORIASIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, COSENTYX, OTEZLA AND SKYRIZI, OR (4) ANKYLOSING SPONDYLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, RINVOQ, AND COSENTYX, OR (5) CROHN'S DISEASE WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG. PREFERRED DRUGS ARE HUMIRA OR SKYRIZI, OR (6) DIAGNOSIS OF NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS WITH SIGNS OF INFLAMMATION WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG COSENTYX. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY, DERMATOLOGY, OR

GASTROENTEROLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

COVERAGE DURATION

12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

CINRYZE

MEDICATION(S)
CINRYZE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE CINRYZE CONCURRENTLY WITH OTHER BIOLOGIC PROPHYLACTIC THERAPY.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: RESERVED FOR PATIENTS WHO HAVE (1) A DIAGNOSIS OF HEREDITARY ANGIOEDEMA (HAE) WITH LABORATORY CONFIRMATION INCLUDING ONE OF THE FOLLOWING: (A) TYPE I DEFINED AS SERUM C4 LESS THAN 14 MG/DL AND C1 INHIBITOR (C1INH) LESS THAN 19.9 MG/DL, OR (B) TYPE II DEFINED AS A FUNCTIONAL C1INH LESS THAN 72%, OR (C) A KNOWN HAE-CAUSING C1INH MUTATION, AND (2) DOCUMENTATION OF FAILURE OR MEDICAL CONTRAINDICATION TO TAKHZYRO, AND (3) DOCUMENTATION OF FAILURE OR MEDICAL CONTRAINDICATION TO ANDROGEN THERAPY (DANAZOL) FOR HAE PROPHYLAXIS, AND (4) DOCUMENTATION OF A HAE MANAGEMENT PLAN AND USE OF THIS THERAPY IS IN ACCORDANCE WITH THAT PLAN. RENEWAL CRITERIA: (1) MEDICAL CHART DOCUMENTATION OF THE NUMBER AND SEVERITY OF HAE ATTACKS OCCURRING IN THE PREVIOUS 6 MONTHS, AND (2) PATIENT HAS EXPERIENCED A REDUCTION IN THE NUMBER OF HAE ATTACKS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY A HEMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST.

COVERAGE DURATION
SIX MONTHS, THEN EVERY SIX MONTHS IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

COSENTYX

MEDICATION(S)
COSENTYX (2 SYRINGES), COSENTYX PEN, COSENTYX PEN (2 PENS), COSENTYX SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE COSENTYX CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) PSORIATIC ARTHRITIS WITH MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO BOTH OF THE FOLLOWING FOR 1 MONTH: CONTINUOUS TREATMENT WITH ONE NSAID AND METHOTREXATE, OR (2) ANKYLOSING SPONDYLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO CONTINUOUS TREATMENT WITH ONE NSAID FOR 1 MONTH, AND FOR PERIPHERAL DISEASE ONLY, DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE WITH ONE OF THE FOLLOWING: CONTINUOUS LOCAL CORTICOSTEROID INJECTION THERAPY (WHEN DISEASE PROCESS PERMITS), METHOTREXATE, OR SULFASALAZINE, OR (3) PLAQUE PSORIASIS WITH AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP, AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS, WITH MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO 2 OF THE FOLLOWING FOR 3 MONTHS: TOPICAL CORTICOSTEROID THERAPY, PHOTOTHERAPY, METHOTREXATE, CYCLOSPORINE, ACITRETIN, OR (4) DIAGNOSIS OF NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS WITH SIGNS OF INFLAMMATION, OR (5) DIAGNOSIS OF ACTIVE ENTHESITIS-RELATED ARTHRITIS. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY DERMATOLOGY AND RHEUMATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY

COVERAGE DURATION

12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

CROMOLYN

MEDICATION(S)
CROMOLYN 100 MG/5 ML ORAL CONC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: PATIENT HAS TRIED AND FAILED ONE OF THE FOLLOWING: (A) CONCURRENT USE OF BOTH H1 AND H2 ANTIHISTAMINE THERAPIES (SUCH AS HYDROXYZINE WITH FAMOTIDINE), OR (B) ANTILEUKOTRIENE THERAPY (SUCH AS MONTELUKAST). RENEWAL CRITERIA: DOCUMENTATION OF SYMPTOMATIC IMPROVEMENT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH AN ALLERGIST OR SPECIALIST.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

CYSTARAN

MEDICATION(S)
CYSTADROPS, CYSTARAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF CYSTINOSIS. RENEWAL CRITERIA: DOCUMENTATION OF CLINICAL TREATMENT EFFECT (SUCH AS DOCUMENTATION OF SLIT LAMP EXAM RESULTS)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PROVIDERS SPECIALIZING IN GENETICS AND METABOLISM, OR FOR OPHTHALMOLOGY SPECIALISTS.

COVERAGE DURATION
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

DALFAMPRIDINE ER

MEDICATION(S)
DALFAMPRIDINE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, (2) DOCUMENTATION THAT THE PATIENT IS CURRENTLY ABLE TO WALK 25 FEET, AND (3) PHYSICIAN ATTESTATION THAT PATIENT HAS DIFFICULTY WALKING. RENEWAL CRITERIA: DOCUMENTATION OF A POSITIVE RESPONSE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF POSITIVE RESPONSE.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

DALIRESP

MEDICATION(S)
DALIRESP, ROFLUMILAST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF SEVERE COPD CONFIRMED WITH AN FEV-1 LESS THAN 50 PERCENT OF PREDICTED, AND (2) ASSOCIATED CHRONIC BRONCHITIS AS DEFINED BY THE PRESENCE OF COUGH AND SPUTUM PRODUCTION FOR AT LEAST 3 MONTHS IN EACH OF TWO CONSECUTIVE YEARS, AND (3) DOCUMENTATION OF INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATIONS TO TWO OF THE FOLLOWING: LONG-ACTING BETA-AGONIST (SUCH AS FORMOTEROL OR SALMETEROL), ANTICHOLINERGIC (SUCH AS IPRATROPIUM) OR ORAL INHALED STEROID (SUCH AS BECLOMETHASONE, BUDESONIDE, FLUTICASONE OR MOMETASONE).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

DIFICID

MEDICATION(S)
DIFICID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF CLOSTRIDIUM DIFFICILE INFECTION, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO A COURSE OF ORAL VANCOMYCIN.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

DIGOXIN

MEDICATION(S)
DIGITEK 250 MCG TABLET, DIGOX 250 MCG TABLET, DIGOXIN 0.25 MG TABLET, DIGOXIN 250 MCG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) THE PATIENT IS CURRENTLY STABLE ON DIGOXIN 0.25 MG AND IS MONITORED FOR ADVERSE DRUG EVENTS, OR (2) FOR PATIENTS WITH ATRIAL FIBRILLATION AND CONTRAINDICATIONS OR INADEQUATE RESPONSE TO COMBINATION THERAPY WITH A LOWER DOSE OF DIGOXIN AND EITHER A BETA BLOCKER OR A NON DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKER (SUCH AS DILTIAZEM OR VERAPAMIL), OR (3) FOR PATIENTS WITH HEART FAILURE AND CONTRAINDICATIONS OR INADEQUATE RESPONSE TO COMBINATION THERAPY WITH A LOWER DOSE OF DIGOXIN AND A BETA BLOCKER.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

DIHYDROERGOTAMINE

MEDICATION(S)
DIHYDROERGOTAMINE MESYLATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH TWO TRIPTAN MEDICATIONS SUCH AS SUMATRIPTAN, NARATRIPTAN OR RIZATRIPTAN.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

DUPIXENT

MEDICATION(S)
DUPIXENT PEN, DUPIXENT SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ATOPIC DERMATITIS: (1) MEDICAL CHART DOCUMENTATION OF MODERATE TO SEVERE ATOPIC DERMATITIS WITH AT LEAST 10% BODY SURFACE AREA (BSA) OR INVOLVEMENT WITH THE FACE, NECK, HANDS, FEET, OR GENITALS, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO ONE PRESCRIPTION-STRENGTH TOPICAL CORTICOSTEROID. ASTHMA: (1) MEDICAL CHART DOCUMENTATION OF EOSINOPHILIC OR ORAL CORTICOSTEROID DEPENDENT MODERATE TO SEVERE ASTHMA, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO ONE INHALED CORTICOSTEROID AND ONE LONG ACTING BETA-AGONIST (LABA). CHRONIC RHINOSINUSITIS: (1) MEDICAL CHART DOCUMENTATION OF CHRONIC RHINOSINUSITIS WITH NASAL POLIPOSIS AND (2) PATIENT IS CURRENTLY RECEIVING THERAPY WITH AN INTRANASAL CORTICOSTEROID AND EXPERIENCING MODERATE TO SEVERE RHINOSINUSITIS SYMPTOMS OR HAS MEDICAL CONTRAINDICATIONS TO INTRANASAL CORTICOSTEROIDS, OR (3) PATIENT HAS A DOCUMENTED REOCCURRENCE OF NASAL POLYPS AFTER SURGERY TO TREAT NASAL POLYPS.

AGE RESTRICTION
ASTHMA - RESERVED FOR PATIENTS AGE 6 AND OLDER. ATOPIC DERMATITIS - RESERVED FOR PATIENTS AGE 6 AND OLDER. CHRONIC RHINOSINUSITIS - RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
ASTHMA -RESERVED FOR PRESCRIBING BY AN ASTHMA SPECIALIST, ALLERGIST OR PULMONOLOGIST. ATOPIC DERMATITIS-RESERVED FOR PRESCRIBING BY AN ALLERGIST,

IMMUNOLOGIST, OR DERMATOLOGIST. CHRONIC RHINOSINUSITIS - RESERVED FOR PRESCRIBING BY AN ALLERGIST, PULMONOLOGIST OR OTOLARYNGOLOGIST.

COVERAGE DURATION

12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

EMGALITY

MEDICATION(S)
EMGALITY PEN, EMGALITY SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE EMGALITY CONCURRENTLY WITH BOTULINUM TOXIN.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) FOR THE DIAGNOSIS OF CHRONIC AND EPISODIC MIGRAINE, THE PATIENT HAS GREATER THAN OR EQUAL TO 4 MIGRAINE DAYS PER MONTH, AND THE PATIENT HAS A DOCUMENTED INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO AT LEAST TWO STANDARD PROPHYLACTIC PHARMACOLOGIC THERAPIES (AT LEAST ONE DRUG EACH FROM A DIFFERENT PHARMACOLOGIC CLASS SUCH AS ANTICONVULSANT, BETA-BLOCKER, ANTIDEPRESSANT, CALCIUM CHANNEL BLOCKER), OR (2) FOR PATIENTS DIAGNOSED WITH EPISODIC CLUSTER HEADACHES, THE PATIENT HAS A DOCUMENTED INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO AT LEAST TWO OTHER PROPHYLAXIS AGENTS (EX. VERAPAMIL AND LITHIUM). RENEWAL CRITERIA: DOCUMENTATION OF A POSITIVE RESPONSE.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
INITIAL CRITERIA: RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH A NEUROLOGIST, A HEADACHE SPECIALIST OR A PAIN SPECIALIST.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

EMSAM

MEDICATION(S)
EMSAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO ONE PREFERRED DRUG FROM EACH OF THE FOLLOWING TWO ANTIDEPRESSANT SUB-CLASSES: (A) SSRI'S SUCH AS CITALOPRAM, ESCITALOPRAM, FLUOXETINE, PAROXETINE, SERTRALINE, AND (B) SNRI'S SUCH AS VENLAFAXINE OR DULOXETINE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

ENBREL

MEDICATION(S)
ENBREL, ENBREL MINI, ENBREL SURECLICK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE ENBREL CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE WITH CONCURRENT USE OF 2 OF THE FOLLOWING FOR 3 MONTHS: METHOTREXATE, HYDROXYCHLOROQUINE, LEFLUNOMIDE, OR SULFASALAZINE, OR (2) JUVENILE IDIOPATHIC ARTHRITIS OR PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO BOTH OF THE FOLLOWING FOR 1 MONTH: CONTINUOUS TREATMENT WITH ONE NSAID AND METHOTREXATE, OR (3) ANKYLOSING SPONDYLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO CONTINUOUS TREATMENT WITH ONE NSAID FOR 1 MONTH, AND FOR PERIPHERAL DISEASE ONLY, DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE WITH ONE OF THE FOLLOWING: CONTINUOUS LOCAL CORTICOSTEROID INJECTION THERAPY (WHEN DISEASE PROCESS PERMITS), METHOTREXATE, OR SULFASALAZINE, OR (4) PLAQUE PSORIASIS WITH AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP, AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS, WITH MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO 2 OF THE FOLLOWING FOR 3 MONTHS: TOPICAL CORTICOSTEROID THERAPY, PHOTOTHERAPY, METHOTREXATE, CYCLOSPORINE, ACITRETIN. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

RESERVED FOR PRESCRIBING BY DERMATOLOGY AND RHEUMATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

COVERAGE DURATION

12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ENSPRYNG

MEDICATION(S)
ENSPRYNG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE ENSPRYNG CONCURRENTLY WITH UPLINZA OR SOLIRIS.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: RESERVED FOR PATIENTS WITH: (1) A DIAGNOSIS OF NEUROMYELITIS OPTICA SPECTRUM DISORDER AND (2) LABS DOCUMENTING POSITIVE ANTI-AQUAPORIN-4 ANTIBODIES, AND (3) FAILURE TO RESPOND TO TREATMENT WITH OR CONTRAINDICATION TO ORAL STEROIDS. RENEWAL CRITERIA: DOCUMENTATION OF (1) THE PATIENT HAS BEEN SEEN WITHIN THE LAST 12 MONTHS, AND (2) THE PATIENT HAS A CLINICALLY MEANINGFUL RESPONSE TO THERAPY AS DOCUMENTED BY THE PRESCRIBER.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 YEARS AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH A SPECIALIST (FOR EXAMPLE NEUROLOGIST OR OPHTHALMOLOGIST).

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ENZYME REPLACEMENT

MEDICATION(S)
CERDELGA, CHOLBAM, NITISINONE, ORFADIN 20 MG CAPSULE, ORFADIN 4 MG/ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PROVIDERS SPECIALIZING IN GENETICS AND METABOLISM, GASTROENTEROLOGY, HEMATOLOGY, AND NEPHROLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

EPCLUSA

MEDICATION(S)
EPCLUSA 150-37.5 MG PELLET PKT, EPCLUSA 200 MG-50 MG TABLET, EPCLUSA 200-50 MG PELLET PACK, SOFOSBUVIR-VELPATASVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF HEPATITIS C GENOTYPE AND BASELINE VIRAL LOAD, PROVIDER ATTESTATION OF READINESS TO TREAT, PATIENT ATTESTATION OF READINESS FOR TREATMENT, AND SUBMISSION OF VIROLOGIC RESPONSE UPON COMPLETION OF TREATMENT.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 3 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, HEPATOLOGY, INFECTIOUS DISEASE SPECIALISTS, OR TRANSPLANT SPECIALIST.

COVERAGE DURATION
DURATION PER GENOTYPE AND DIAGNOSIS. 12 WEEKS PER FDA APPROVED LABELING OR CLINICAL GUIDELINES.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ERYTHROPOIESIS STIMULATING AGENTS

MEDICATION(S)
ARANESP, RETACRIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR CANCER DIAGNOSIS: DOCUMENTED CHEMOTHERAPY-ASSOCIATED ANEMIA (HEMOGLOBIN LESS THAN 10G/DL OR HEMATOCRIT LESS THAN 30%).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.

EUCRISA

MEDICATION(S)
EUCRISA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO ONE PRESCRIPTION-STRENGTH TOPICAL CORTICOSTEROID, PIMECROLIMUS CREAM OR TACROLIMUS OINTMENT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

EVRYSDI

MEDICATION(S)
EVRYSDI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
THE PATIENT HAS NOT RECEIVED ZOLGENSMA OR CELL THERAPY. THE PATIENT WILL NOT BE USING SPINRAZA CONCURRENTLY WITH EVRYSDI AND THE LAST DOSE OF SPINRAZA (IF APPLICABLE) WILL BE AT LEAST 90 DAYS BEFORE THE INITIATION OF THERAPY WITH EVRYSDI. THE PATIENT MUST NOT BE DEPENDENT ON EITHER OF THE FOLLOWING: (1) INVASIVE VENTILATION OR TRACHEOSTOMY, OR (2) USE OF NON-INVASIVE VENTILATION BEYOND USE FOR NAPS AND NIGHTTIME SLEEP.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF SPINAL MUSCULAR ATROPHY (SMA), CONFIRMED BY GENETIC TESTING OF 5Q-AUTOSOMAL RECESSIVE SMA , AND (2) DOCUMENTATION OF BASELINE MOTOR FUNCTION BY ONE OF THE FOLLOWING EXAMS: (1) HAMMERSMITH INFANT NEUROLOGIC EXAM [HINE] (INFANT TO EARLY CHILDHOOD), (2) HAMMERSMITH FUNCTIONAL MOTOR SCALE EXPANDED [HFMSE], (3) UPPER LIMB MODULE [ULM] TEST (NON-AMBULATORY), OR (4) CHILDRENS HOSPITAL OF PHILADELPHIA INFANT TEST OF NEUROMUSCULAR DISORDERS [CHOP-INTEND]. RENEWAL CRITERIA: DOCUMENTATION OF CLINICALLY SIGNIFICANT IMPROVEMENT OF MOTOR FUNCTION AS DEMOSTRATED IN ONE OF THE FOLLOWING TESTS: (1) HINE: (A) IMPROVEMENT OR MAINTENANCE OF PREVIOUS IMPROVEMENT IN ONE OF THE FOLLOWING: (I) AT LEAST 2 POINT (OR MAXIMAL SCORE) INCREASE IN ABILITY TO KICK, OR (II) AT LEAST 1 POINT INCREASE IN ANY OTHER HINE MILESTONE (E.G. HEAD CONTROL, ROLLING, SITTING, CRAWLING, ETC) EXCLUDING VOLUNTARY GRASP, AND, (B) ONE OF THE FOLLOWING: (I) DEMONSTRATED IMPROVEMENT IN MORE CATEGORIES THAN WORSENING (EXCLUDING VOLUNTARY GRASP) FROM PRETREATMENT BASELINE, OR (II) ACHIEVEMENT OR MAINTENANCE OF ANY NEW MOTOR MILESTONES WHEN THEY WOULD OTHERWISE BE UNEXPECTED TO DO SO, OR (2) HFMSE: IMPROVEMENT OR MAINTENANCE OF PREVIOUS IMPROVEMENT IN ONE OF THE

FOLLOWING: (A) AT LEAST 3 POINT INCREASE IN SCORE FROM PRETREATMENT BASELINE, OR (B) ANY NEW MOTOR MILESTONES WHEN THEY WOULD OTHERWISE BE UNEXPECTED TO DO SO, OR (3) ULM: IMPROVEMENT OR MAINTENANCE OF PREVIOUS IMPROVEMENT IN ONE OF THE FOLLOWING: (A) AT LEAST 2 POINT INCREASE IN SCORE FROM PRETREATMENT BASELINE, OR, (B) ANY NEW MOTOR MILESTONES WHEN THEY WOULD OTHERWISE BE UNEXPECTED TO DO SO, OR (4) CHOP-INTEND: IMPROVEMENT OR MAINTENANCE OF PREVIOUS IMPROVEMENT IN ONE OF THE FOLLOWING: (A) AT LEAST 4 POINT INCREASE IN SCORE FROM PRETREATMENT BASELINE, OR (B) ANY NEW MOTOR MILESTONES WHEN THEY WOULD OTHERWISE BE UNEXPECTED TO DO SO.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH NEUROLOGIST OR PEDIATRIC NEUROMUSCULAR SPECIALIST.

COVERAGE DURATION

12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES. A CURRENT WEIGHT IS REQUIRED FOR ALL REQUESTS.

FDA-APPROVED INDICATIONS

MEDICATION(S)
AMIKACIN SULFATE, ANADROL-50, APOKYN, APOMORPHINE HCL, ARALAST NP, ARISTADA, ARISTADA INITIO, ARMODAFINIL, BENLYSTA 200 MG/ML AUTOINJECT, BENLYSTA 200 MG/ML SYRINGE, BERINERT, BYNFEZIA, CASPOFUNGIN ACETATE, CAYSTON, COLISTIMETHATE, CORLANOR, CYCLOSERINE, DOJOLVI, EPIDIOLEX, ERAXIS (WATER DILUENT), GLASSIA, HAEGARDA, ICATIBANT, INVEGA HAFYERA, INVEGA TRINZA, KALBITOR, KORLYM, LACRISERT, LANREOTIDE ACETATE, LUPRON DEPOT-PED 11.25 MG KIT, LUPRON DEPOT-PED 15 MG KIT, LUPRON DEPOT-PED 30 MG 3MO KIT, METYROSINE, MODAFINIL, MOZOBIL, NAYZILAM, NITAZOXANIDE, NUPLAZID, OXANDROLONE, PENTAMIDINE 300 MG VIAL, PERSERIS, PRETOMANID, PROLASTIN C, QUININE SULFATE, RUCONEST, SAJAZIR, SIRTURO, SODIUM PHENYLBUTYRATE 500MG TB, SOMATULINE DEPOT, SOMAVERT, SYMPROIC, SYNAREL, TAKHZYRO, TOBI PODHALER, TOBRAMYCIN SULFATE, VALTOCO, VISTOGARD, XCOPRI, ZEMAIRA, ZORBTIVE, ZULRESSO, ZYPREXA RELPREVV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA

N/A

FDA-APPROVED INDICATIONS - DOSE LIMIT

MEDICATION(S)
ILARIS, RUZURGI, STRENSIQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

FDA-APPROVED INDICATIONS WITH BVD

MEDICATION(S)
ABELCET, AMBISOME, AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME, ASCENIV, BIVIGAM, CUTAQUIG, CUVITRU, DRONABINOL, FLEBOGAMMA DIF, GAMASTAN, GAMASTAN S-D, GAMMAGARD LIQUID, GAMMAGARD S-D, GAMMAKED, GAMMAPLEX, GAMUNEX-C, HIZENTRA, HYQVIA, OCTAGAM, PANZYGA, PRIVIGEN, XEMBIFY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.

FORTEO

MEDICATION(S)
FORTEO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF: (A) FRAGILITY FRACTURE OF THE SPINE OR HIP WITHIN THE LAST FIVE YEARS, OR (B) SEVERE OSTEOPOROSIS WITH A T-SCORE OF SPINE, HIP OR FEMORAL NECK OF MINUS 3.5 OR LOWER, OR (C) OSTEOPOROSIS WITH A T-SCORE OF MINUS 2.5 OR LOWER AND (I) INTOLERANCE OR CONTRAINDICATION TO BISPHOSPHONATE THERAPY, OR (II) PROGRESSIVE BONE LOSS DEFINED AS BONE LOSS OF THREE PERCENT OR HIGHER DESPITE THERAPY WITH BISPHOSPHONATES, AND (2) DOCUMENTED FAILURE OF, INTOLERANCE TO, OR CONTRAINDICATIONS TO TYMLOS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
LIMITED TO 2 YEARS UNLESS THE PATIENT REMAINS AT OR HAS RETURNED TO HAVING A HIGH RISK FOR FRACTURE.

OTHER CRITERIA
N/A

GALAFOLD

MEDICATION(S)
GALAFOLD

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PROVIDERS SPECIALIZING IN GENETICS AND METABOLISM, GASTROENTEROLOGY, HEMATOLOGY, AND NEPHROLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

GATTEX

MEDICATION(S)
GATTEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) TREATMENT OF PATIENTS WITH SHORT BOWEL SYNDROME, AND (2) WHO HAVE BEEN DEPENDENT ON PARENTERAL (OR A COMBINATION OF PARENTERAL AND ENTERAL) NUTRITION FOR ALL NUTRITIONAL REQUIREMENTS FOR AT LEAST ONE YEAR, AND (3) IN WHOM A TAPER FROM PARENTERAL REQUIREMENTS HAS NOT BEEN POSSIBLE OR PLANNED. RENEWAL CRITERIA: MEDICAL RECORD DOCUMENTATION OF POSITIVE RESPONSE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
DOSE IS LIMITED TO THE FDA-APPROVED DOSE OF 0.05 MG/KG PER DAY.

GIMOTI

MEDICATION(S)
GIMOTI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO TWO PREFERRED MEDICATIONS: (1) METOCLOPRAMIDE TABLETS OR SOLUTION AND (2) METOCLOPRAMIDE ODT TABLETS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

HARVONI

MEDICATION(S)
HARVONI 33.75-150 MG PELLET PK, HARVONI 45-200 MG PELLET PACKT, HARVONI 45-200 MG TABLET, LEDIPASVIR-SOFOSBUVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF HEPATITIS C GENOTYPE AND BASELINE VIRAL LOAD, PROVIDER ATTESTATION OF READINESS TO TREAT, PATIENT ATTESTATION OF READINESS FOR TREATMENT, AND SUBMISSION OF VIROLOGIC RESPONSE UPON COMPLETION OF TREATMENT.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 3 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, HEPATOLOGY, INFECTIOUS DISEASE SPECIALISTS, OR TRANSPLANT SPECIALIST.

COVERAGE DURATION
12-24 WKS PER DIAGNOSIS, FDA LABELING OR CLINICAL GUIDELINES. 8 WK APPROVALS PER PROVIDER REQUEST.

OTHER CRITERIA
DOSE IS LIMITED TO THE FDA-APPROVED REGIMEN OF ONE TABLET DAILY.

HIGH-STRENGTH OPIOID AGENTS

MEDICATION(S)
BUPRENORPHINE, FENTANYL 100 MCG/HR PATCH, FENTANYL 12 MCG/HR PATCH, FENTANYL 25 MCG/HR PATCH, FENTANYL 50 MCG/HR PATCH, FENTANYL 75 MCG/HR PATCH, METHADONE 10 MG/5 ML SOLUTION, METHADONE 10 MG/ML ORAL CONC, METHADONE 5 MG/5 ML SOLUTION, METHADONE HCL 10 MG TABLET, METHADONE HCL 5 MG TABLET, METHADONE INTENSOL, MORPHINE SULF ER 15 MG TABLET, MORPHINE SULF ER 30 MG TABLET, MORPHINE SULF ER 60 MG TABLET, TRAMADOL HCL-ACETAMINOPHEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) PROVIDER ATTESTATION OF INTENT TO MONITOR FOR SIDE EFFECTS AND APPROPRIATE USE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA AGENTS

MEDICATION(S)
JUXTAPID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL: (1) CONFIRMED DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA, AND (2) THERAPEUTIC FAILURE, INTOLERANCE, OR CONTRAINDICATION TO ONE HIGH-INTENSITY STATIN THERAPY AND TO ONE PCSK9-INHIBITOR (SUCH AS REPATHA).
RENEWAL: DOCUMENTATION OF BENEFICIAL RESPONSE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY CARDIOLOGY, ENDOCRINOLOGY, LIPIDOLOGY OR IN CONSULTATION WITH THESE SPECIALISTS.

COVERAGE DURATION
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
N/A

HUMIRA

MEDICATION(S)
HUMIRA, HUMIRA PEN, HUMIRA PEN CROHN'S-UC-HS, HUMIRA PEN PSOR-UVEITS-ADOL HS, HUMIRA(CF), HUMIRA(CF) PEDIATRIC CROHN'S, HUMIRA(CF) PEN 40 MG/0.4 ML, HUMIRA(CF) PEN CROHN'S-UC-HS, HUMIRA(CF) PEN PEDIATRIC UC, HUMIRA(CF) PEN PSOR-UV-ADOL HS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE HUMIRA CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE WITH CONCURRENT USE OF 2 OF THE FOLLOWING FOR 3 MONTHS: METHOTREXATE, HYDROXYCHLOROQUINE, LEFLUNOMIDE, OR SULFASALAZINE, OR (2) JUVENILE IDIOPATHIC ARTHRITIS OR PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO BOTH OF THE FOLLOWING FOR 1 MONTH: TREATMENT WITH ONE NSAID AND METHOTREXATE, OR (3) ANKYLOSING SPONDYLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO TREATMENT WITH ONE NSAID FOR 1 MONTH, AND FOR PERIPHERAL DISEASE ONLY, DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE WITH ONE OF THE FOLLOWING: LOCAL CORTICOSTEROID INJECTION THERAPY (WHEN DISEASE PROCESS PERMITS), METHOTREXATE, OR SULFASALAZINE, OR (4) PLAQUE PSORIASIS WITH AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP, AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS, WITH MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO 2 OF THE FOLLOWING FOR 3 MONTHS: TOPICAL CORTICOSTEROID THERAPY, PHOTOTHERAPY, METHOTREXATE, CYCLOSPORINE, ACITRETIN, OR (5) CROHN'S DISEASE WITH: (I) FISTULIZING OR SEVERE DISEASE, OR (II) DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO 1 OF THE FOLLOWING: PREDNISONE OR BUDESONIDE FOR 14 DAYS, OR AZATHIOPRINE, 6-MERCAPTOPURINE, OR METHOTREXATE FOR 3 MONTHS, OR (6) ULCERATIVE COLITIS WITH: (I) SEVERE DISEASE,

OR (II) DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO 2 OF THE FOLLOWING FOR 3 MONTHS: SULFASALAZINE, MESALAMINE, BALSALAZIDE, PREDNISONE, BUDESONIDE, AZATHIOPRINE, 6-MERCAPTOPURINE, OR (7) HIDRADENITIS SUPPURATIVA, OR (8) NON-INFECTIOUS INTERMEDIATE, POSTERIOR AND PANUVEITIS. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

RESERVED FOR PRESCRIBING BY DERMATOLOGY, GASTROENTEROLOGY, OPHTHALMOLOGY, AND RHEUMATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

COVERAGE DURATION

12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

IDIOPATHIC PULMONARY FIBROSIS AGENTS

MEDICATION(S)
ESBRIET, OFEV, PIRFENIDONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PULMONOLOGY

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES

INBRIJA

MEDICATION(S)
INBRIJA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE INBRIJA CONCURRENTLY WITH APOMORPHINE.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: RESERVED FOR PATIENTS: (1) WITH A DIAGNOSIS OF PARKINSON'S DISEASE WITH OFF EPISODES, (2) WITH A PROVIDER ATTESTATION THAT PATIENT HAS OR WILL RECEIVE EDUCATION ON PROPER INHALER TECHNIQUE, (3) WHO ARE TAKING CARBIDOPA/LEVODOPA, (4) WHO HAVE TRIED AND FAILED AT LEAST ONE OF THE FOLLOWING AGENTS FOR AT LEAST 4 WEEKS IN COMBINATION WITH CARBIDOPA/LEVODOPA TO REDUCE THE NUMBER AND FREQUENCY OF OFF EPISODES: (A) RASAGILINE, (B) ROPINIROLE, (C) ENTACAPONE, (D) PRAMIPEXOLE, (E) ROTIGOTINE, OR (F) SELEGILINE, AND (5) PATIENT HAS (A) NO UNDERLYING LUNG DISEASE, OR (B) LIMITED PULMONARY FUNCTION (FEV LESS THAN 50%) WITH A PROVIDER ATTESTATION ACKNOWLEDGING INBRIJA HAS NOT BEEN STUDIED IN THIS POPULATION AND DRUG MAY BE INEFFECTIVE DUE TO LACK OF INSPIRATORY CAPACITY, AND PROVIDER ATTESTS POTENTIAL BENEFITS OUTWEIGH RISKS. RENEWAL CRITERIA: PROVIDER DOCUMENTATION OF IMPROVEMENT IN OFF PERIOD SYMPTOMS.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH NEUROLOGY.

COVERAGE DURATION
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

INFECTIOUS DISEASE SELECT AGENTS

MEDICATION(S)
CRESEMBA 186 MG CAPSULE, LINEZOLID, LINEZOLID-0.9% NACL, LINEZOLID-D5W, POSACONAZOLE, SIVEXTRO, VORICONAZOLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE, TRANSPLANT, HEMATOLOGY OR ONCOLOGY SPECIALIST.

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

INGREZZA

MEDICATION(S)
INGREZZA, INGREZZA INITIATION PACK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: MEDICAL CHART DOCUMENTATION OF MODERATE-TO-SEVERE TARDIVE DYSKINESIA SYMPTOMS. RENEWAL CRITERIA: (1) DOCUMENTATION THAT THE PATIENT HAS BEEN SEEN WITHIN THE LAST 12 MONTHS, AND (2) DOCUMENTATION OF EFFECTIVENESS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGY OR PSYCHIATRY.

COVERAGE DURATION
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF POSITIVE RESPONSE.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ISTURISA

MEDICATION(S)
ISTURISA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PATIENTS WITH CUSHINGS DISEASE, AND (2) PATIENTS FOR WHOM PITUITARY SURGERY IS NOT AN OPTION OR HAS NOT BEEN CURATIVE, AND (3) THE PATIENT HAS TRIED AND FAILED, IS UNABLE TO TOLERATE OR HAS CONTRAINDICATIONS TO AT LEAST TWO OF THE FOLLOWING: KETOCONAZOLE, CABERGOLINE OR PASIREOTIDE. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION OF CLINICAL IMPROVEMENT (REDUCTION IN 24-HOUR URINARY FREE CORTISOL).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
N/A

ITRACONAZOLE

MEDICATION(S)
ITRACONAZOLE 10 MG/ML SOLUTION, ITRACONAZOLE 100 MG/10 ML CUP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION THAT THE PATIENT HAS DIFFICULTY SWALLOWING.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

KALYDECO

MEDICATION(S)
KALYDECO, ORKAMBI, SYMDEKO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: (1) DOCUMENTATION THAT THE PATIENT HAS BEEN SEEN WITHIN THE LAST 12 MONTHS, AND (2) DOCUMENTATION OF EFFECTIVENESS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY A SPECIALIST FROM A CYSTIC FIBROSIS TREATMENT CENTER OR A PULMONOLOGIST.

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

KINERET

MEDICATION(S)
KINERET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE KINERET CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS), OR (2) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ACTEMRA AND ORENCIA, OR (3) DEFICIENCY OF INTERLEUKIN-1 RECEPTOR ANTAGONIST (DIRA) WITH GENETIC TESTING CONFIRMING MUTATION IN THE IL1RN GENE AND BODYWEIGHT OF MORE THAN 22 POUNDS. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH RHEUMATOLOGY, PEDIATRICS (FOR CHILDREN WITH CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES), GENETICS, A DERMATOLOGY SPECIALIST OR A PHYSICIAN SPECIALIZING IN THE TREATMENT OF AUTOINFLAMMATORY DISORDERS.

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

LATUDA

MEDICATION(S)
LATUDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO ONE OF THE FOLLOWING ALTERNATIVES: RISPERIDONE, ZIPRASIDONE, OLANZAPINE, QUETIAPINE REGULAR RELEASE, QUETIAPINE EXTENDED RELEASE OR ARIPIPRAZOLE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

LIDOCAINE PATCH

MEDICATION(S)
LIDOCAINE 5% PATCH

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

LOTRONEX

MEDICATION(S)
ALOSETRON HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
8 WEEKS, THEN BALANCE OF CONTRACT YEAR ONLY IF SIGNIFICANT IMPROVEMENT IN DISABILITY.

OTHER CRITERIA
N/A

MAVENCLAD

MEDICATION(S)
MAVENCLAD

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE MAVENCLAD CONCURRENTLY WITH OTHER MULTIPLE SCLEROSIS DISEASE MODIFYING DRUGS.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PRESCRIBED FOR PATIENTS WITH FDA-APPROVED INDICATIONS, AND (2) PATIENT HAS NOT ACHIEVED SUSTAINED REMISSION AFTER TREATMENT WITH AT LEAST TWO PRIOR DISEASE MODIFYING THERAPIES (EXAMPLE GILENYA, DIMETHYL FUMARATE, ETC.), AND (3) PATIENT HAS NOT PREVIOUSLY COMPLETED TWO ANNUAL TREATMENT COURSES (A TOTAL OF FOUR TREATMENT CYCLES) WITH MAVENCLAD. RENEWAL CRITERIA: (1) PATIENT HAS EXPERIENCED BENEFIT FROM THERAPY DEMONSTRATED BY REDUCTION IN SYMPTOMS, DISEASE PROGRESSION OR A REDUCTION IN RELAPSE FREQUENCY, AND (2) PATIENT HAS NOT ALREADY COMPLETED TWO ANNUAL TREATMENT COURSES (A TOTAL OF FOUR TREATMENT CYCLES) WITH MAVENCLAD.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH NEUROLOGY.

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

MAVYRET

MEDICATION(S)
MAVYRET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF HEPATITIS C GENOTYPE AND BASELINE VIRAL LOAD, PROVIDER ATTESTATION OF READINESS TO TREAT, PATIENT ATTESTATION OF READINESS FOR TREATMENT, AND SUBMISSION OF VIROLOGIC RESPONSE UPON COMPLETION OF TREATMENT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, HEPATOLOGY, INFECTIOUS DISEASE SPECIALISTS, OR TRANSPLANT SPECIALIST.

COVERAGE DURATION
8-16 WKS PER DIAGNOSIS, FDA LABELING OR CLINICAL GUIDELINES. 8 WK APPROVALS PER PROVIDER REQUEST.

OTHER CRITERIA
DOSE IS LIMITED TO THE FDA-APPROVED REGIMEN OF THREE TABLETS DAILY.

MECASERMIN

MEDICATION(S)
INCRELEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY ENDOCRINOLOGY.

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

METABOLIC DISORDER AGENTS

MEDICATION(S)
CARBAGLU, CARGLUMIC ACID, JAVYGTOR, RAVICTI, SAPROPTERIN DIHYDROCHLORIDE, SUCRAID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION OF POSITIVE RESPONSE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PROVIDERS SPECIALIZING IN GENETICS AND METABOLISM

COVERAGE DURATION
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

MYFEMBREE

MEDICATION(S)
MYFEMBREE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: RESERVED FOR PATIENTS WITH: (1) A DIAGNOSIS OF HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS (FIBROIDS) IN PREMENOPAUSAL WOMEN, AND THE PATIENT HAS TRIED AND FAILED OR HAS CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING: (A) PREFERRED CONTRACEPTIVE PREPARATION (FOR EXAMPLE, ORAL CONTRACEPTIVE OR VAGINAL CONTRACEPTIVE), (B) LEVONORGESTREL INTRA-UTERINE DEVICE (IUD), OR (C) ORAL TRANEXAMIC ACID, OR (2) A DIAGNOSIS OF MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS, AND PATIENT HAS A DOCUMENTED INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO (A) PRESCRIPTION STRENGTH NSAID, AND (B) CONTINUOUS ORAL CONTRACEPTIVE THERAPY OR PROGESTERONE THERAPY. RENEWAL CRITERIA: PHYSICIAN ATTESTATION OF A POSITIVE RESPONSE.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 YEARS AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH AN OB/GYN SPECIALIST.

COVERAGE DURATION
SIX MONTHS, THEN 18 MONTHS IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

NARCOTIC AGENTS

MEDICATION(S)
FENTANYL CITRATE OTFC 200 MCG, FENTANYL CITRATE OTFC 400 MCG, LAZANDA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION THAT THE PATIENT HAS DIFFICULTY SWALLOWING OR HAS COMPLIANCE CONCERNS WITH ORAL NARCOTIC TABLETS, CAPSULES, OR LIQUID.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

NATPARA

MEDICATION(S)
NATPARA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) HISTORY OF HYPOPARATHYROIDISM FOR AT LEAST 18 MONTHS, AND (3) SERUM THYROID FUNCTION TESTS WITHIN LABORATORY NORMAL LIMITS (FOR PATIENTS NOT ON THYROID REPLACEMENT) OR THYROID REPLACEMENT THERAPY MUST BE STABLE FOR AT LEAST 3 MONTHS (FOR PATIENTS TAKING THYROID REPLACEMENT), AND (4) SERUM MAGNESIUM LEVEL WITHIN LABORATORY NORMAL LIMITS, AND (5) UPON INITIATION OF NATPARA THERAPY, NATPARA TO BE USED AS AN ADJUNCT TO CALCITRIOL AT LEAST 0.25 MCG/DAY. RENEWAL CRITERIA: SERUM CALCIUM CONCENTRATION MUST BE MAINTAINED IN THE LOWER HALF OF LABORATORY NORMAL REFERENCE RANGE.

AGE RESTRICTION
LIMITED TO ADULTS AGE 18 YEARS AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY ENDOCRINOLOGY.

COVERAGE DURATION
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
ALL FDA-LABELED DOSAGE AND ADMINISTRATION GUIDELINES MUST BE MET.

NORTHERA

MEDICATION(S)
DROXIDOPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF CONTRAINDICATIONS OR TRIAL AND FAILURE OF AT LEAST TWO FIRST LINE DRUG THERAPIES (FOR EXAMPLE FLUDROCORTISONE AND MIDODRINE). RENEWAL CRITERIA: MEDICAL RECORD DOCUMENTATION OF CONTINUED EFFECTIVENESS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH A CARDIOLOGIST OR NEUROLOGIST

COVERAGE DURATION
ONE MONTH, WITH APPROVAL EVERY THREE MONTHS IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
N/A

NOURIANZ

MEDICATION(S)
NOURIANZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF PARKINSONS DISEASE WITH AT LEAST 2 HOURS OF OFF EPISODES PER DAY, AND (2) PATIENT IS CURRENTLY TAKING CARBIDOPA/LEVODOPA, AND (3) PATIENT HAS TRIED AND FAILED AT LEAST ONE OF THE FOLLOWING AGENTS FOR AT LEAST 4 WEEKS IN COMBINATION WITH CARBIDOPA/LEVODOPA TO REDUCE THE NUMBER AND FREQUENCY OF OFF EPISODES: (A) RASAGILINE, (B) ROPINIROLE, (C) ENTACAPONE, (D) PRAMIPEXOLE, (E) ROTIGOTINE, OR (F) SELEGILINE . RENEWAL CRITERIA: PROVIDER DOCUMENTATION OF IMPROVEMENT IN OFF PERIOD SYMPTOMS.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH NEUROLOGY.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

NUCALA

MEDICATION(S)
NUCALA 100 MG/ML AUTO-INJECTOR, NUCALA 100 MG/ML POWDER VIAL, NUCALA 100 MG/ML SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE NUCALA CONCURRENTLY WITH ANOTHER BIOLOGIC THERAPY FOR THE TREATMENT OF ASTHMA SUCH AS CINQAIR, DUPIXENT, FASENRA OR XOLAIR.

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. FOR SEVERE ASTHMA: INITIAL CRITERIA: (1) FOR PATIENTS DIAGNOSED WITH ASTHMA THEY HAVE A PRE-TREATMENT SERUM EOSINOPHIL COUNT OF 150 CELLS/MCL OR GREATER AT SCREENING (WITHIN THE PREVIOUS 6 WEEKS), AND (2) PATIENT HAS INADEQUATE ASTHMA CONTROL DESPITE USE OF AT LEAST TWO OF THE FOLLOWING STANDARD THERAPIES: (A) INHALED STEROIDS (SUCH AS FLOVENT), AND (B) LONG-ACTING BETA-AGONIST (SUCH AS SEREVENT), AND (C) ORAL STEROIDS, AND (3) INADEQUATE ASTHMA CONTROL DESPITE STANDARD THERAPIES IS DEFINED AS ONE OF THE FOLLOWING: (A) AT LEAST 2 EXACERBATIONS REQUIRING ORAL SYSTEMIC CORTICOSTEROIDS IN THE LAST 12 MONTHS, OR (B) AT LEAST 1 EXACERBATION TREATED IN A HOSPITAL OR REQUIRING MECHANICAL VENTILATION IN THE LAST 12 MONTHS. RENEWAL CRITERIA: (1) PATIENT HAS NOT EXPERIENCED UNACCEPTABLE TOXICITY FROM THE DRUG SUCH AS PARASITIC (HELMINTH) INFECTION OR HERPES ZOSTER INFECTION, AND (2) PATIENT HAS A CLINICALLY MEANINGFUL RESPONSE TO THE MEDICATION AS DEFINED: (A) DECREASED FREQUENCY OF EXACERBATIONS DEFINED AS: (I) IMPROVEMENT OF ASTHMA CONTROL, DEMONSTRATED BY DECREASED USE OF ORAL OR SYSTEMIC CORTICOSTEROIDS, OR (II) LESS FREQUENT HOSPITALIZATIONS, OR (III) REDUCED FREQUENCY OF EMERGENCY DEPARTMENT VISITS, OR (B) IMPROVEMENT IN LUNG FUNCTION MEASURED IN FEV1. FOR EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS: DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO CYCLOPHOSPHAMIDE OR

METHOTREXATE. FOR HYPEREOSINOPHILIC SYNDROME: DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO AT LEAST TWO ORAL AGENTS (FOR EXAMPLE IMATINIB, HYDROXYUREA OR CYCLOSPORINE). FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPS: (1) PATIENT IS CURRENTLY RECEIVING THERAPY WITH AN INTRANASAL CORTICOSTEROID OR HAS TRIED AND FAILED OR HAS MEDICAL CONTRAINDICATION TO INTRANASAL CORTICOSTEROIDS, AND (2) PATIENT HAS A HISTORY SURGERY TO TREAT NASAL POLYPS OR HAS A CONTRAINIDCATION TO SURGICAL INTERVENTION.

AGE RESTRICTION

RESERVED FOR PATIENTS AGE 6 AND OLDER.

PRESCRIBER RESTRICTION

RESERVED FOR PRESCRIBING BY AN ASTHMA SPECIALIST, ALLERGIST, PULMONOLOGIST, HEMATOLOGIST, OTOLARYNGOLOGIST OR RHEUMATOLOGIST.

COVERAGE DURATION

12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

NUEDEXTA

MEDICATION(S)
NUEDEXTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

NURTEC ODT

MEDICATION(S)
NURTEC ODT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE NURTEC ODT CONCURRENTLY WITH OTHER CGRP ANTAGONISTS FOR ACUTE MIGRAINE (FOR EXAMPLE UBRELVY AND REYVOW).

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF ACUTE MIGRAINE (WITH OR WITHOUT AURA), AND MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE TO AT LEAST TWO TRIPTAN DRUGS (EXAMPLES SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN) OR (2) DIAGNOSIS OF EPISODIC MIGRAINE (THE PATIENT HAS EXPERIENCED AT LEAST 4 MIGRAINE DAYS PER MONTH OVER AT LEAST 3 CONSECUTIVE MONTHS) AND MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE TO EMGALITY AND AJOVY. RENEWAL CRITERIA: (1) REAUTHORIZATIONS WILL REQUIRE MEDICAL CHART DOCUMENTATION THAT THE PATIENT HAS BEEN SEEN WITHIN THE PAST 12 MONTHS, AND (2) PROVIDER ATTESTATION OF CLINICAL IMPROVEMENT AND THAT THE MEDICATION CONTINUES TO BE EFFECTIVE.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH A NEUROLOGIST, A HEADACHE SPECIALIST OR A PAIN SPECIALIST.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA

N/A

NUZYRA

MEDICATION(S)
NUZYRA 150 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) RESERVED FOR PATIENTS WITH: (A) DIAGNOSIS OF COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA WITH AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO A QUINOLONE SUCH AS LEVOFLOXACIN OR MOXIFLOXACIN, OR (B) DIAGNOSIS OF ACUTE BACTERIAL SKIN AND SKIN STRUCTURE INFECTIONS WITH AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO LINEZOLID, AND (2) CULTURE AND SENSITIVITY INFORMATION INDICATES BACTERIA ARE SUSCEPTIBLE TO NUZYRA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST.

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

OCALIVA

MEDICATION(S)
OCALIVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: RESERVED FOR PATIENTS (1) WITH A DIAGNOSIS OF PRIMARY BILIARY CHOLANGITIS AND (2) WHO (A) HAVE FAILED TO ACHIEVE AN AKLALINE PHOSPHATASE (ALP) LEVEL OF LESS THAN 1.67 TIMES THE UPPER LIMIT OF NORMAL AFTER AT LEAST 12 MONTHS OF TREATMENT WITH URSODEOXYCHOLIC ACID (UDCA) OR (B) HAVE A HISTORY OF CONTRAINDICATION OR INTOLERANCE TO UDCA. RENEWAL CRITERIA: DOCUMENTATION OF (1) REDUCTION IN ALP LEVEL TO 1.67 TIMES THE UPPER LIMIT OF NORMAL OR LESS AND (2) THE PATIENT HAS BEEN SEEN WITHIN THE LAST 14 MONTHS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES. MUST BE USED IN COMBINATION WITH URSODEOXYCHOLIC ACID (UDCA) UNLESS UDCA IS CONTRAINDICATED OR NOT TOLERATED.

ORAL DISSOLVE TABLETS PROTECTED CLASS

MEDICATION(S)
ARIPIPRAZOLE ODT, CLOZAPINE ODT, RISPERIDONE ODT, SPRITAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE WITH OR CONTRAINDICATION TO ONE REGULAR TABLET DOSAGE FORM OF THE REQUESTED MEDICATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

ORAL LIQUID PROTECTED CLASS

MEDICATION(S)
CHLORPROMAZINE 100 MG/ML CONC, CHLORPROMAZINE 30 MG/ML CONC, EPRONTIA, VERSACLOZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION THAT THE PATIENT HAS DIFFICULTY SWALLOWING OR HAS COMPLIANCE CONCERNS WITH REGULAR TABLET OR CAPSULE DOSAGE FORMS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

ORAL ONCOLOGY AGENTS

MEDICATION(S)

ABIRATERONE ACETATE, AFINITOR 10 MG TABLET, AFINITOR DISPERZ, ALECENSA, ALUNBRIG, AYVAKIT, BALVERSA, BEXAROTENE, BOSULIF, BRAFTOVI, BRUKINSA, CABOMETYX, CALQUENCE, CAPRELSA, COMETRIQ, COPIKTRA, COTELLIC, DAURISMO, ERIVEDGE, ERLEADA, ERLOTINIB HCL, EVEROLIMUS 10 MG TABLET, EVEROLIMUS 2 MG TAB FOR SUSP, EVEROLIMUS 2.5 MG TABLET, EVEROLIMUS 3 MG TAB FOR SUSP, EVEROLIMUS 5 MG TAB FOR SUSP, EVEROLIMUS 5 MG TABLET, EVEROLIMUS 7.5 MG TABLET, EXKIVITY, FARYDAK, FOTIVDA, GAVRETO, GILOTRIF, IBRANCE, ICLUSIG, IDHIFA, IMBRUVICA 140 MG CAPSULE, IMBRUVICA 420 MG TABLET, IMBRUVICA 560 MG TABLET, IMBRUVICA 70 MG CAPSULE, IMBRUVICA 70 MG/ML SUSPENSION, INLYTA, INQOVI, INREBIC, IRESSA, JAKAFI, KISQALI, KISQALI FEMARA CO-PACK, KOSELUGO, LAPATINIB, LENVIMA, LONSURF, LORBRENA, LUMAKRAS, LYNPARZA, LYTGOBI, MATULANE, MEKINIST, MEKTOVI, NERLYNX, NEXAVAR, NILUTAMIDE, NINLARO, NUBEQA, ODOMZO, ONUREG, ORGOVYX, PEMAZYRE, PIQRAY, POMALYST, QINLOCK, RETEVMO, REZUROCK, ROZLYTREK, RUBRACA, RYDAPT, SCEMBLIX, SORAFENIB, SPRYCEL, STIVARGA, SUNITINIB MALATE, SUTENT, SYNRIBO, TABRECTA, TAFINLAR, TAGRISSO, TALZENNA, TARGRETIN 1% GEL, TASIGNA, TAZVERIK, TECVAYLI, TEPMETKO, TIBSOVO, TRUSELTIQ, TUKYSA, TURALIO, UKONIQ, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VONJO, VOTRIENT, WELIREG, XALKORI, XOSPATA, XPOVIO, XTANDI, YONSA, ZEJULA, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION

INITIAL CRITERIA FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION THAT DISEASE PROGRESSION HAS NOT OCCURRED.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ORENCIA

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE ORENCIA CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) JUVENILE IDIOPATHIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL AND HUMIRA, OR (2) PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, COSENTYX AND OTEZLA, OR (3) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, AND RINVOQ. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY AND TRANSPLANT SPECIALIST

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ORIAHNN

MEDICATION(S)
ORIAHNN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: RESERVED FOR PATIENTS WITH: (1) A DIAGNOSIS OF HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS (FIBROIDS) IN PREMENOPAUSAL WOMEN, AND (2) THE PATIENT HAS TRIED AND FAILED OR HAS CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING: (A) PREFERRED CONTRACEPTIVE PREPARATIONS (FOR EXAMPLE, ORAL OR VAGINAL CONTRACEPTIVES), OR (B) LEVONORGESTREL INTRA-UTERINE DEVICE (IUD), OR (C) ORAL TRANEXAMIC ACID, AND (3) SURGICAL INTERVENTION HAS BEEN DISCUSSED AND IS NOT AN APPROPRIATE TREATMENT OPTION OR PATIENT DECLINES. RENEWAL CRITERIA: PHYSICIAN ATTESTATION OF IMPROVEMENT OF HEAVY MNSTRUAL BLEEDING.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 YEARS AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH A OB/GYN SPECIALIST.

COVERAGE DURATION
SIX MONTHS, THEN 18 MONTHS WHEN RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ORILISSA

MEDICATION(S)
ORILISSA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) PATIENT HAS A DOCUMENTED INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO (A) PRESCRIPTION STRENGTH NSAID, AND (B) CONTINUOUS ORAL CONTRACEPTIVE THERAPY OR PROGESTERONE THERAPY.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH OBSTETRICS/GYNECOLOGY.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ORLADEYO

MEDICATION(S)
ORLADEYO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE ORLADEYO CONCURRENTLY WITH OTHER BIOLOGIC PROPHYLACTIC THERAPY.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: RESERVED FOR PATIENTS WHO HAVE (1) A DIAGNOSIS OF HEREDITARY ANGIOEDEMA (HAE) WITH LABORATORY CONFIRMATION INCLUDING ONE OF THE FOLLOWING: (A) TYPE I DEFINED AS SERUM C4 LESS THAN 14 MG/DL AND C1 INHIBITOR (C1INH) LESS THAN 19.9 MG/DL, OR (B) TYPE II DEFINED AS A FUNCTIONAL C1INH LESS THAN 72%, OR (C) A KNOWN HAE-CAUSING C1INH MUTATION, AND (2) DOCUMENTATION OF FAILURE OR MEDICAL CONTRAINDICATION TO TAKHZYRO, AND (3) DOCUMENTATION OF FAILURE OR MEDICAL CONTRAINDICATION TO ANDROGEN THERAPY (DANAZOL) FOR HAE PROPHYLAXIS, AND (4) DOCUMENTATION OF A HAE MANAGEMENT PLAN AND USE OF THIS THERAPY IS IN ACCORDANCE WITH THAT PLAN. RENEWAL CRITERIA: (1) MEDICAL CHART DOCUMENTATION OF THE NUMBER AND SEVERITY OF HAE ATTACKS OCCURRING IN THE PREVIOUS 6 MONTHS, AND (2) PATIENT HAS EXPERIENCED A REDUCTION IN THE NUMBER OF HAE ATTACKS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY A HEMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST.

COVERAGE DURATION
SIX MONTHS, THEN EVERY SIX MONTHS IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

OTEZLA

MEDICATION(S)
OTEZLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE OTEZLA CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO BOTH OF THE FOLLOWING FOR 1 MONTH: CONTINUOUS TREATMENT WITH ONE NSAID AND METHOTREXATE, OR (2) PLAQUE PSORIASIS WITH AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP, AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS, WITH MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO 2 OF THE FOLLOWING FOR 3 MONTHS: TOPICAL CORTICOSTEROID THERAPY, PHOTOTHERAPY, METHOTREXATE, CYCLOSPORINE, ACITRETIN, OR (3) DIAGNOSIS OF ORAL ULCERS ASSOCIATED WITH BEHCET DISEASE. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY OR DERMATOLOGY.

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

OXBRYTA

MEDICATION(S)
OXBRYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE OXBRYTA CONCURRENTLY WITH ENDARI OR ADAKVEO.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PATIENTS WITH SICKLE CELL DISEASE, AND (2) PATIENT HAS EXPERIENCED ONE OR MORE PAINFUL VASO-OCCLUSIVE CRISES WITHIN THE PREVIOUS 12 MONTHS DESPITE THE USE OF HYDROXYUREA, UNLESS HYDROXYUREA IS CONTRAINDICATED, AND (3) PATIENT WILL BE USING OXBRYTA AS MONOTHERAPY OR IN COMBINATION WITH HYDROXYUREA. RENEWAL CRITERIA: DOCUMENTATION THAT THE PATIENT HAS BEEN SEEN BY THE PRESCRIBER IN THE PAST 12 MONTHS AND POSITIVE RESPONSE TO THERAPY DEFINED AS REDUCTION IN THE NUMBER OF VASO-OCCLUSIVE ATTACKS OR AT LEAST A 1.0 G/DL INCREASE IN HEMOGLOBIN.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 4 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY A PRACTITIONER WITH EXPERTISE IN SICKLE CELL DISEASE.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

PARICALCITOL

MEDICATION(S)
PARICALCITOL 1 MCG CAPSULE, PARICALCITOL 2 MCG CAPSULE, PARICALCITOL 4 MCG CAPSULE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE WITH CALCITRIOL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.

PART D VS PART B

MEDICATION(S)

ACETYLCYSTEINE 10% VIAL, ACETYLCYSTEINE 20% VIAL, ACYCLOVIR SODIUM, ALBUTEROL 100 MG/20 ML SOLN, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL 5 MG/ML SOLUTION, ALBUTEROL SUL 0.63 MG/3 ML SOL, ALBUTEROL SUL 1.25 MG/3 ML SOL, ALBUTEROL SUL 2.5 MG/3 ML SOLN, AMINOSYN II, AMINOSYN II WITH ELECTROLYTES, AMINOSYN M, AMINOSYN 8.5%-ELECTROLYTES SOL, AMINOSYN-HBC, AMINOSYN-PF, APREPITANT, AZASAN, AZATHIOPRINE, BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, CYCLOPHOSPHAMIDE 25 MG TABLET, CYCLOPHOSPHAMIDE 50 MG TABLET, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE 250 MG/5 ML AMPUL, CYCLOSPORINE MODIFIED, EMEND 125 MG POWDER PACKET, ENGERIX-B ADULT, ENGERIX-B PEDIATRIC-ADOLESCENT, EVEROLIMUS 0.25 MG TABLET, EVEROLIMUS 0.5 MG TABLET, EVEROLIMUS 0.75 MG TABLET, EVEROLIMUS 1 MG TABLET, GENGRAF, GRANISETRON HCL 1 MG TABLET, HEPARIN 20,000 UNIT/500 ML-D5W, IMOVAX RABIES VACCINE, INTRALIPID, IPRATROPIUM BR 0.02% SOLN, IPRATROPIUM-ALBUTEROL, METHOTREXATE, METHOTREXATE SODIUM, MYCOPHENOLATE 200 MG/ML SUSP, MYCOPHENOLATE 250 MG CAPSULE, MYCOPHENOLATE 500 MG TABLET, MYCOPHENOLIC ACID, ONDANSETRON 4 MG/5 ML SOLUTION, ONDANSETRON HCL 24 MG TABLET, ONDANSETRON HCL 4 MG TABLET, ONDANSETRON HCL 8 MG TABLET, ONDANSETRON ODT, PENTAMIDINE 300 MG INHAL POWDR, PREDNISOLONE, PREDNISOLONE 10 MG/5 ML SOLN, PREDNISOLONE 15 MG/5 ML SOLN, PREDNISOLONE 20 MG/5 ML SOLN, PREDNISOLONE 5 MG/5 ML SOLN, PREDNISOLONE SOD PH 25 MG/5 ML, PREDNISONE 1 MG TABLET, PREDNISONE 10 MG TABLET, PREDNISONE 2.5 MG TABLET, PREDNISONE 20 MG TABLET, PREDNISONE 5 MG TABLET, PREDNISONE 5 MG/5 ML SOLUTION, PREDNISONE 50 MG TABLET, PREDNISONE INTENSOL, PREHEVBRIO, PROGRAF 0.2 MG GRANULE PACKET, PROGRAF 1 MG GRANULE PACKET, PULMOZYME, RABAVERT, RECOMBIVAX HB, RIBAVIRIN 6 GM INHALATION VIAL, SIROLIMUS, TACROLIMUS 0.5 MG CAPSULE (IR), TACROLIMUS 1 MG CAPSULE (IR), TACROLIMUS 5 MG CAPSULE (IR), TOBRAMYCIN 300 MG/4 ML AMPULE, TOBRAMYCIN 300 MG/5 ML AMPULE, TYVASO, VENTAVIS, ZORTRESS 1 MG TABLET

DETAILS

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

PEGASYS

MEDICATION(S)
PEGASYS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR TREATMENT OF HEPATITIS C, DOCUMENTATION OF HCV GENOTYPE, VIRAL LOAD AND LIVER FUNCTION TESTS, AND DOCUMENTATION OF INTOLERANCE TO OR ADVERSE EFFECTS FROM PRIOR USE OF PEGINTRON.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, OR HEPATOLOGY, OR INFECTIOUS DISEASE SPECIALISTS.

COVERAGE DURATION
12-48 WEEKS PER FDA APPROVED LABELING OR CLINICAL GUIDELINES FOR PATIENT DIAGNOSIS AND GENOTYPE.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

PEGINTRON

MEDICATION(S)
PEGINTRON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR TREATMENT OF HEPATITIS C, DOCUMENTATION OF HCV GENOTYPE, VIRAL LOAD AND LIVER FUNCTION TESTS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, OR HEPATOLOGY, OR INFECTIOUS DISEASE SPECIALISTS.

COVERAGE DURATION
DURATION PER DIAGNOSIS. 12-48 WEEKS PER FDA APPROVED LABELING OR CLINICAL GUIDELINES.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

PENICILLAMINE

MEDICATION(S)
D-PENAMINE, PENICILLAMINE 250 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF (1) HOMOZYGOUS CYSTINURIA AND URINARY CYSTINE GREATER THAN 500MG/DAY AFTER TREATMENT WITH POTASSIUM CITRATE AND CAPTOPRIL, OR MEDICAL DOCUMENTATION FOR CONTRAINDICATION TO THEIR USE, OR (2) WILSON'S DISEASE. RENEWAL CRITERIA: DOCUMENTATION THAT THE PATIENT HAS BEEN SEEN BY THE PRESCRIBER IN THE PAST 12 MONTHS AND POSITIVE RESPONSE TO THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH HEPATOLOGY, NEPHROLOGY OR RHEUMATOLOGY.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

PHENOXYBENZAMINE

MEDICATION(S)
PHENOXYBENZAMINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO ONE GENERIC ALPHA-BLOCKER, SUCH AS TERAZOSIN OR DOXAZOSIN.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

PROMACTA

MEDICATION(S)
PROMACTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY HEMATOLOGY, INFECTIOUS DISEASE AND HEPATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF POSITIVE RESPONSE.

OTHER CRITERIA
N/A

PULMONARY ARTERIAL HYPERTENSION - ORAL PREFERRED

MEDICATION(S)
ADEMPAS, AMBRISENTAN, BOSENTAN, OPSUMIT, TRACLEER 32 MG TABLET FOR SUSP, UPTRAVI 1,000 MCG TABLET, UPTRAVI 1,200 MCG TABLET, UPTRAVI 1,400 MCG TABLET, UPTRAVI 1,600 MCG TABLET, UPTRAVI 200 MCG TABLET, UPTRAVI 200-800 TITRATION PACK, UPTRAVI 400 MCG TABLET, UPTRAVI 600 MCG TABLET, UPTRAVI 800 MCG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) PATIENT HAS A DIAGNOSIS OF GROUP 1 PULMONARY HYPERTENSION AS CONFIRMED BY PRETREATMENT RIGHT HEART CATHETERIZATION WITH THE FOLLOWING RESULTS: (A) MEAN PULMONARY ARTERIAL PRESSURE OF EQUAL TO OR GREATER THAN 20 MMHG AND (B) PULMONARY CAPILLARY WEDGE PRESSURE OF EQUAL TO OR LOWER THAN 15 MMHG AND (C) PULMONARY VASCULAR RESISTANCE OF EQUAL TO OR GREATER THAN 3 WOOD UNITS, AND (3) A NEGATIVE RESPONSE TO ACUTE PULMONARY VASODILATOR TESTING OR A TRIAL AND FAILURE OR CONTRAINDICATION TO CALCIUM CHANNEL BLOCKER THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PULMONOLOGY OR CARDIOLOGY.

COVERAGE DURATION
12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

PYRUKYND

MEDICATION(S)
PYRUKYND

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF HEMOLYTIC ANEMIA WITH PYRUVATE KINASE (PK) DEFICIENCY. RENEWAL CRITERIA: DOCUMENTATION THAT THE PATIENT HAS BEEN SEEN BY THE PRESCRIBER IN THE PAST 12 MONTHS AND CLINICALLY MEANINGFUL RESPONSE TO THERAPY AS DEFINED BY HEMOGLOBIN AND HEMOLYSIS LABORATORY RESULTS AND TRANSFUSION REQUIREMENTS.

AGE RESTRICTION
18 YEARS OF AGE OR OLDER

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
SIX MONTHS, THEN 12 MONTHS IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

RASUVO

MEDICATION(S)
RASUVO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
RESERVED FOR PATIENTS WHO HAVE: (1) LACK OF RESPONSE TO GENERIC METHOTREXATE INJECTION, OR (2) INTOLERANCE OR SIGNIFICANT ADVERSE EFFECTS FROM GENERIC METHOTREXATE INJECTION, OR (3) DEXTERITY CONCERNS, OR (4) VISUAL ACUITY CONCERNS, OR (5) IMPAIRED COGNITION PREVENTING SAFE USE OF GENERIC METHOTREXATE INJECTION, OR (6) MEDICAL CHART DOCUMENTATION OF NEEDLE PHOBIA PREVENTING USE OF GENERIC METHOTREXATE INJECTION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

REDITREX

MEDICATION(S)
REDITREX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
RESERVED FOR PATIENTS WHO HAVE: (1) LACK OF RESPONSE TO GENERIC METHOTREXATE INJECTION, OR (2) INTOLERANCE OR SIGNIFICANT ADVERSE EFFECTS FROM GENERIC METHOTREXATE INJECTION, OR (3) DEXTERITY CONCERNS, OR (4) VISUAL ACUITY CONCERNS, OR (5) IMPAIRED COGNITION PREVENTING SAFE USE OF GENERIC METHOTREXATE INJECTION, OR (6) MEDICAL CHART DOCUMENTATION OF NEEDLE PHOBIA PREVENTING USE OF GENERIC METHOTREXATE INJECTION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

REVCOVI

MEDICATION(S)
REVCOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF SEVERE COMBINED IMMUNODEFICIENCY DISEASE (SCID), AND (2) PATIENT HAS DEFICIENCY OF ADENOSINE DEAMINASE (ADA) CONFIRMED BY ONE OF THE FOLLOWING: (A) DECREASE IN ADENOSINE TRIPHOSPHATE (ATP) CONCENTRATION IN ERYTHROCYTES, OR, (B) ELEVATED ERYTHROCYTE DEOXYADENOSINE TRIPHOSPHATE LEVELS (GREATER THAN OR EQUAL TO 50 TIMES THE UPPER LIMIT OF NORMAL) OR, (C) MUTATION IN BOTH ALLELES OF THE ADA1 GENE, OR, (D) DEFICIENCY OR ABSENCE OF ADA IN FIBROBLASTS, ERYTHROCYTES OR PLASMA, OR, (E) POSITIVE SCREENING FOR T CELL RECEPTOR EXCISION CIRCLES (TRECS). RENEWAL CRITERIA: (1) ANNUAL REAUTHORIZATIONS WILL REQUIRE MEDICAL CHART DOCUMENTATION THAT THE PATIENT HAS BEEN SEEN WITHIN THE PAST 12 MONTHS, AND (2) PROVIDER ATTESTS PATIENT IS UNABLE TO RECEIVE OR HAS FAILED A PRIOR HEMATOPOIETIC STEM CELL TRANSPLANT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH A SPECIALIST

COVERAGE DURATION
SIX MONTHS, THEN 12 MONTHS IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

REYVOW

MEDICATION(S)
REYVOW

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE REYVOW CONCURRENTLY WITH OTHER CGRP ANTAGONISTS FOR ACUTE MIGRAINE (FOR EXAMPLE UBRELVY AND NURTEC ODT).

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF MIGRAINE (WITH OR WITHOUT AURA), AND (2) MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE TO AT LEAST TWO TRIPTAN DRUGS (EXAMPLES SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN). RENEWAL CRITERIA: (1) REAUTHORIZATIONS WILL REQUIRE MEDICAL CHART DOCUMENTATION THAT THE PATIENT HAS BEEN SEEN WITHIN THE PAST 12 MONTHS, AND (2) PROVIDER ATTESTATION OF CLINICAL IMPROVEMENT AND THAT THE MEDICATION CONTINUES TO BE EFFECTIVE.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH A NEUROLOGIST, A HEADACHE SPECIALIST OR A PAIN SPECIALIST.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
N/A

RINVOQ

MEDICATION(S)
RINVOQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE RINVOQ ER CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE WITH CONCURRENT USE OF 2 OF THE FOLLOWING FOR 3 MONTHS: METHOTREXATE, HYDROXYCHLOROQUINE, LEFLUNOMIDE, OR SULFASALAZINE, OR (2) PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST ONE PREFERRED DRUG. PREFERRED DRUGS INCLUDE ENBREL AND HUMIRA, OR (3) ULCERATIVE COLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST ONE PREFERRED DRUG. THE PREFERRED DRUG IS HUMIRA, OR (4) ATOPIC DERMATITIS: (1) MEDICAL CHART DOCUMENTATION OF MODERATE TO SEVERE ATOPIC DERMATITIS WITH AT LEAST 10% BODY SURFACE AREA (BSA) OR INVOLVEMENT WITH THE FACE, NECK, HANDS, FEET, OR GENITALS, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO ONE PRESCRIPTION-STRENGTH TOPICAL CORTICOSTEROID, OR (5) ANKYLOSING SPONDYLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST ONE PREFERRED DRUG. PREFERRED DRUGS INCLUDE ENBREL AND HUMIRA. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, DERMATOLOGY, ALLERGY,

IMMUNOLOGY AND RHEUMATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

SABRIL

MEDICATION(S)
VIGABATRIN, VIGADRONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR COMPLEX PARTIAL SEIZURES: DOCUMENTED FAILURE ON TWO OTHER FORMULARY SEIZURE MEDICATIONS SUCH AS CARBAMAZEPINE, DIVALPROEX, LEVETIRACETAM, GABAPENTIN, TOPIRAMATE, AND OTHERS OR CONTRAINDICATIONS TO THIER USE. FOR INFANTILE SPASMS - APPROVE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGIST

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

SAVELLA

MEDICATION(S)
SAVELLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO GABAPENTIN.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

SEROSTIM

MEDICATION(S)
SEROSTIM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION THAT OTHER THERAPIES HAVE PROVEN INEFFECTIVE FOR HIV-INFECTED PATIENTS DIAGNOSED WITH SIGNIFICANT WASTING.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

SIGNIFOR

MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL: DOCUMENTATION OF BENEFICIAL RESPONSE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
N/A

SILDENAFIL

MEDICATION(S)
SILDENAFIL 20 MG TABLET (GENERIC FOR REVATIO)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PULMONOLOGY OR CARDIOLOGY.

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

SIMPONI

MEDICATION(S)
SIMPONI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE SIMPONI CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) ANKYLOSING SPONDYLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, RINVOQ, AND COSENTYX, OR (2) PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO ORENCIA, OR (3) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ACTEMRA AND ORENCIA, OR (4) ULCERATIVE COLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG. PREFERRED DRUGS ARE HUMIRA OR RINVOQ. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY AND GASTROENTEROLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

COVERAGE DURATION
12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

SKYRIZI

MEDICATION(S)
SKYRIZI, SKYRIZI (2 SYRINGES) KIT, SKYRIZI ON-BODY, SKYRIZI PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE SKYRIZI CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) PLAQUE PSORIASIS WITH AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP, AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS, WITH MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO 2 OF THE FOLLOWING FOR 3 MONTHS: TOPICAL CORTICOSTEROID THERAPY, PHOTOTHERAPY, METHOTREXATE, CYCLOSPORINE, ACITRETIN, OR (2) PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO BOTH OF THE FOLLOWING FOR 1 MONTH: TREATMENT WITH ONE NSAID AND METHOTREXATE, OR (3) CROHN'S DISEASE WITH: (I) FISTULIZING OR SEVERE DISEASE, OR (II) DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO 1 OF THE FOLLOWING: PREDNISONE OR BUDESONIDE FOR 14 DAYS, OR AZATHIOPRINE, 6-MERCAPTOPURINE, OR METHOTREXATE FOR 3 MONTHS. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY DERMATOLOGY, GASTROENTEROLOGY AND RHEUMATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

COVERAGE DURATION
12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

SOMATROPIN

MEDICATION(S)
NORDITROPIN FLEXPRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CRITERIA FOR CHILDREN: EITHER 1 OR 2: (1) SHORT STATURE INITIAL: A) CURRENT HEIGHT IS 2.25 OR MORE STANDARD DEVIATIONS BELOW NORMAL, OR B) TARGET ADULT HEIGHT OF 2 OR MORE STANDARD DEVIATIONS BELOW MIDPARENTAL HEIGHT, OR C) HEIGHT VELOCITY OF MINUS 2 OR MORE STANDARD DEVIATIONS FOR AGE AND TANNER STAGE, AND D) GROWTH HORMONE (GH) PROVOCATIVE TESTING (GH PEAK LESS THAN 10 NG/ML), OR E) SERUM IGF LEVELS (IGF-1 OR IGFBP-3) LESS THAN 1 STANDARD DEVIATION BELOW NORMAL, OR F) IGF GENERATION TEST (STIMULATE LEVEL 3 TIMES BASELINE OR GREATER THAN 250MG/ML). (1) SHORT STATURE RENEWAL: A) DOCUMENTATION OF POSITIVE RESPONSE, AND B) GROWTH VELOCITY IS GREATER THAN OR EQUAL TO 2 CM/YEAR, AND C) PATIENT HAS NOT ACHIEVED MATURE BONE AGE (17 OR GREATER FOR BOYS OR 15 OR GREATER FOR GIRLS), (2) DIAGNOSIS OF PANHYPOPITUITARISM, PRADER-WILLI, TURNER SYNDROME, OR NOONAN SYNDROME AND EPIPHYSES ARE NOT CLOSED. CRITERIA FOR ADULTS: PATIENT HAS GROWTH HORMONE DEFICIENCY (GHD) WITH 1 OR 2 AND 3 AND 4 AND 5 LISTED BELOW: (1) HISTORY OF HYPOTHALAMIC OR PITUITARY DISEASE OR HISTORY OF CRANIAL IRRADIATION, OR (2) LOW IGF-1 LEVELS BASED ON AGE ADJUSTED VALUES AND SERUM GROWTH HORMONE CONCENTRATION OF LESS THAN 5 NG/ML (PEAK LEVELS) FOLLOWING STIMULATION TESTING. ITT (INSULIN TOLERANCE TEST) IS THE DIAGNOSTIC TEST OF CHOICE UNLESS CONTRAINDICATED, AND (3) COMPLETE PITUITARY HORMONE FUNCTION HAS BEEN TESTED AND REPLACED WHEN APPROPRIATE, AND (4) THREE OF THE FOLLOWING: A) ALTERED BODY COMPOSITION WITH INCREASED BODY FAT MASS AND DECREASED LEAN BODY MASS, OR B) DECREASED MUSCLE STRENGTH AND EXERCISE CAPACITY, OR C) REDUCED BONE DENSITY OR PRESENCE OF A FRAGILITY FRACTURE, OR

D) POOR SLEEP, OR E) IMPAIRED SENSE OF WELL BEING, AND (5) SECONDARY MEDICAL ILLNESSES THAT AFFECT GH HAVE BEEN RULED OUT.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

RESERVED FOR PRESCRIBING BY ENDOCRINOLOGY

COVERAGE DURATION

12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

SPRAVATO

MEDICATION(S)
SPRAVATO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: (1) PRESCRIBED FOR PATIENTS WITH TREATMENT-RESISTANT DEPRESSION (FOR PATIENTS WITH AN INADEQUATE RESPONSE TO THREE OR MORE CLASSES OF THERAPIES), AND (2) A BASELINE MEASUREMENT OF DEPRESSION IS REQUIRED. DOCUMENTATION CAN INCLUDE PHQ9 SCORES OR SUICIDE RISK ASSESSMENT, AND (3) DOCUMENTATION OF COMPLIANCE WITH THE REMS CERTIFICATION PROGRAM RENEWAL CRITERIA: (1) PATIENT HAS BEEN SEEN BY PROVIDER WITHIN THE PAST 12 MONTHS, AND, (2) PATIENT HAS BEEN ADHERENT TO THERAPY, AND, (3) DOCUMENTATION OF A POSITIVE RESPONSE IS REQUIRED.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY A BEHAVIORAL HEALTH PROVIDER

COVERAGE DURATION
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

STELARA

MEDICATION(S)
STELARA 45 MG/0.5 ML SYRINGE, STELARA 45 MG/0.5 ML VIAL, STELARA 90 MG/ML SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE STELARA CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) CROHN'S DISEASE WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG CIMZIA, OR (2) PLAQUE PSORIASIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, COSENTYX, OTEZLA AND SKYRIZI, OR (3) PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG ORENCIA, OR (3) ULCERATIVE COLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG. PREFERRED DRUGS ARE HUMIRA OR RINVOQ. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY DERMATOLOGY, RHEUMATOLOGY, AND GASTROENTEROLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

SUCRALFATE

MEDICATION(S)
SUCRALFATE 1 GM/10 ML SUSP, SUCRALFATE 1 GM/10 ML SUSP CUP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION THAT THE PATIENT HAS DIFFICULTY SWALLOWING.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

SUNOSI

MEDICATION(S)
SUNOSI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF TRIAL AND FAILURE OR CONTRAINDICATION TO MODAFINIL OR ARMODAFINIL.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY A SLEEP SPECIALIST OR A NEUROLOGIST.

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

TADALAFIL

MEDICATION(S)
TADALAFIL 20 MG TABLET (GENERIC FOR ADCIRCA)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION (PAH) AS CONFIRMED BY NEGATIVE RESPONSE TO ACUTE PULMONARY VASODILATOR TESTING OR A TRIAL AND FAILURE OF CALCIUM CHANNEL BLOCKER THERAPY. RENEWAL CRITERIA: (1) DOCUMENTATION THAT THE PATIENT HAS BEEN SEEN WITHIN THE LAST 12 MONTHS, AND (2) DOCUMENTATION OF CLINICAL EFFECTIVENESS INCLUDING BUT NOT LIMITED TO IMPROVED HEMODYNAMIC STATUS OR REDUCTION IN HOSPITALIZATIONS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PULMONOLOGY OR CARDIOLOGY.

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

TALICIA

MEDICATION(S)
TALICIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
RESERVED FOR PATIENTS WHO HAVE MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE TO ONE FIRST-LINE OPTION. FIRST LINE OPTIONS INCLUDE TRIPLE THERAPY (PROTON PUMP INHIBITOR, CLARITHROMYCIN, AND AMOXICILLIN OR METRONIDAZOLE) AND QUADRUPLE THERAPY (PROTON PUMP INHIBITOR, BISMUTH, TETRACYCLINE OR MINOCYCLINE, AND METRONIDAZOLE).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

THALASSEMIA AGENTS

MEDICATION(S)
DEFERASIROX, DEFERIPRONE, DEFERIPRONE (3 TIMES A DAY), FERRIPROX 1,000 MG TABLET, FERRIPROX 100 MG/ML SOLUTION, FERRIPROX (2 TIMES A DAY), FERRIPROX (3 TIMES A DAY)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY HEMATOLOGY AND ONCOLOGY.

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

THIOLA

MEDICATION(S)
THIOLA EC, TIOPRONIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY UROLOGY OR NEPHROLOGY.

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

TREMFYA

MEDICATION(S)
TREMFYA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE TREMFYA CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) PLAQUE PSORIASIS WITH AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP, AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS, WITH MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO 2 OF THE FOLLOWING FOR 3 MONTHS: TOPICAL CORTICOSTEROID THERAPY, PHOTOTHERAPY, METHOTREXATE, CYCLOSPORINE, OR ACITRETIN, OR (2) PSORIATIC ARTHRITIS WITH MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO BOTH OF THE FOLLOWING FOR ONE MONTH: TREATMENT WITH ONE NSAID AND METHOTREXATE. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY DERMATOLOGY AND RHEUMATOLOGY.

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A

TRIENTINE

MEDICATION(S)
TRIENTINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF WILSON'S DISEASE AND (2) DEMONSTRATED INTOLERANCE OR MEDICAL CONTRAINDICATION TO PENICILLAMINE. RENEWAL CRITERIA: DOCUMENTATION OF POSITIVE RESPONSE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PROVIDERS SPECIALIZING IN GENETICS AND METABOLISM, GASTROENTEROLOGY, AND HEPATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF POSITIVE RESPONSE.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

TRIKAFTA

MEDICATION(S)
TRIKAFTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE TRIKAFTA CONCURRENTLY WITH OTHER CFTR MODULATOR THERAPIES (ANY CURRENT CFTR MODULATOR THERAPIES WILL BE DISCONTINUED PRIOR TO INITIATION OF TRIKAFTA).

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF CYSTIC FIBROSIS, AND (2) PATIENT HAS AT LEAST ONE F508DEL MUTATION ON THE CFTR GENE (HOMOZYGOUS OR HETEROZYGOUS MUTATION). RENEWAL CRITERIA: (1) PATIENT HAS BEEN SEEN BY THE PROVIDER IN THE PAST 12 MONTHS, AND (2) PROVIDER ATTESTS PATIENT CONTINOUS TO CLINICALLY BENEFIT FROM THERAPY (E.G. IMPROVED FEV1 OR REDUCTION IN PULMONARY EXACERBATIONS).

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 6 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PULMONOLOGIST OR A SPECIALIST FROM A CYSTIC FIBROSIS TREATMENT CENTER.

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

TYMLOS

MEDICATION(S)
TYMLOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF: (A) FRAGILITY FRACTURE OF THE SPINE OR HIP WITHIN THE LAST FIVE YEARS, OR (B) SEVERE OSTEOPOROSIS WITH A T-SCORE OF SPINE, HIP OR FEMORAL NECK OF MINUS 3.5 OR LOWER, OR (C) OSTEOPOROSIS WITH A T-SCORE OF MINUS 2.5 OR LOWER AND (I) INTOLERANCE OR CONTRAINDICATION TO BISPHOSPHONATE THERAPY, OR (II) PROGRESSIVE BONE LOSS DEFINED AS BONE LOSS OF THREE PERCENT OR HIGHER DESPITE THERAPY WITH BISPHOSPHONATES.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVALS ARE LIMITED TO 2 YEARS.

OTHER CRITERIA
N/A

VALCHLOR

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION THAT DISEASE PROGRESSION HAS NOT OCCURRED.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
APPROVALS ARE LIMITED TO A QUANTITY OF TWO 60 GRAM TUBES PER MONTH.

VASCEPA

MEDICATION(S)
ICOSAPENT ETHYL, VASCEPA 0.5 GM CAPSULE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PATIENTS WITH CARDIOVASCULAR DISEASE OR WITH DIABETES AND OTHER RISK FACTORS WITH (A) CURRENTLY RECEIVING A HIGH INTENSITY STATIN (ATORVASTATIN 40-80 MG DAILY OR ROSUVASTATIN 20-40 MG DAILY) OR HAVING AN INTOLERANCE OR CONTRAINDICATION TO A STATIN, AND (B) A FASTING TRIGLYCERIDE LEVEL GREATER THAN 150 MG/DL, OR (2) FOR HYPERGLYCERIDEMIA (TRIGLYCERIDE LEVELS EQUAL TO OR HIGHER THAN 500 MG/DL) WITH AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO GEMFIBROZIL OR FENOFIBRATE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

VERQUVO

MEDICATION(S)
VERQUVO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE WITH AT LEAST TWO OF THE FOLLOWING THERAPIES: (A) ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS, ANGIOTENSIN II RECEPTOR BLOCKERS (ARB) OR ANGIOTENSIN RECEPTOR-NEPRILYSIN INHIBITORS (ARNI), (B) BETA-BLOCKERS, OR (C) ALDOSTERONE ANTAGONISTS (SPIRONOLACTONE OR EPLERENONE). RENEWAL CRITERIA: DOCUMENTATION OF (1) POSITIVE RESPONSE AND (2) THE PATIENT HAS BEEN SEEN WITHIN THE LAST 14 MONTHS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

VORAXAPAR

MEDICATION(S)
ZONTIVITY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO CLOPIDOGREL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

VOSEVI

MEDICATION(S)
VOSEVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF HEPATITIS C GENOTYPE AND BASELINE VIRAL LOAD, PROVIDER ATTESTATION OF READINESS TO TREAT, PATIENT ATTESTATION OF READINESS FOR TREATMENT, AND SUBMISSION OF VIROLOGIC RESPONSE UPON COMPLETION OF TREATMENT.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, HEPATOLOGY, INFECTIOUS DISEASE SPECIALISTS, OR TRANSPLANT SPECIALIST.

COVERAGE DURATION
12 WKS PER DIAGNOSIS, FDA LABELING OR CLINICAL GUIDELINES.

OTHER CRITERIA
DOSE IS LIMITED TO THE FDA-APPROVED REGIMEN OF ONE TABLET DAILY.

VYNDAMAX

MEDICATION(S)
VYNDAMAX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE VYNDAMAX CONCURRENTLY WITH ONPATTRO OR TEGSEDI.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PATIENT IS DIAGNOSED WITH WILD TYPE OR HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS CARDIOMYOPATHY, AND (2) PATIENT HAS CLINICAL HISTORY OF HEART FAILURE (HF), WITH DOCUMENTATION OF EITHER OF THE FOLLOWING: (A) AT LEAST 1 PRIOR HOSPITALIZATION FOR HF, OR (B) CLINICAL EVIDENCE OF HF (WITHOUT HOSPITALIZATION) MANIFESTED BY SIGNS OR SYMPTOMS OF VOLUME OVERLOAD OR ELEVATED INTRA-CARDIAC PRESSURES (E.G., ELEVATED JUGULAR VENOUS PRESSURE, SHORTNESS OF BREATH OR SIGNS OF PULMONARY CONGESTION ON X-RAY OR AUSCULTATION, PERIPHERAL EDEMA) THAT REQUIRES TREATMENT WITH A DIURETIC FOR IMPROVEMENT, AND (3) PATIENT IS NEGATIVE FOR LIGHT CHAIN AMYLOIDOSIS. RENEWAL CRITERIA: (1) PATIENT HAS BEEN SEEN BY THEIR PRESCRIBER IN THE PAST 12 MONTHS, AND (2) MEDICATION HAS DEMONSTRATED EFFICACY.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

VYNDAQEL

MEDICATION(S)
VYNDAQEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PATIENT IS DIAGNOSED WITH WILD TYPE OR HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS CARDIOMYOPATHY, AND (2) PATIENT HAS CLINICAL HISTORY OF HEART FAILURE (HF), WITH DOCUMENTATION OF EITHER OF THE FOLLOWING: (A) AT LEAST 1 PRIOR HOSPITALIZATION FOR HF, OR (B) CLINICAL EVIDENCE OF HF (WITHOUT HOSPITALIZATION) MANIFESTED BY SIGNS OR SYMPTOMS OF VOLUME OVERLOAD OR ELEVATED INTRA-CARDIAC PRESSURES (E.G., ELEVATED JUGULAR VENOUS PRESSURE, SHORTNESS OF BREATH OR SIGNS OF PULMONARY CONGESTION ON X-RAY OR AUSCULTATION, PERIPHERAL EDEMA) THAT REQUIRES TREATMENT WITH A DIURETIC FOR IMPROVEMENT, AND (3) PATIENT IS NEGATIVE FOR LIGHT CHAIN AMYLOIDOSIS. RENEWAL CRITERIA: (1) PATIENT HAS BEEN SEEN BY THEIR PRESCRIBER IN THE PAST 12 MONTHS, AND (2) MEDICATION HAS DEMONSTRATED EFFICACY.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

WAKIX

MEDICATION(S)
WAKIX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE WAKIX CONCURRENTLY WITH XYREM OR XYWAV.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF NARCOLEPSY WITH CATAPLEXY AND ONE MONTH TRIAL AND FAILURE OR A MEDICAL CONTRAINDICATION WITH AN ANTIDEPRESSANT USED IN THE TREATMENT OF CATAPLEXY (SUCH AS FLUOXETINE OR CLOMIPRAMINE) OR (2) DIAGNOSIS OF NARCOLEPSY WITHOUT CATAPLEXY AND THE PATIENT HAS CONTRAINDICATIONS OR HAD NO IMPROVEMENT IN SYMPTOMS DESPITE ONE MONTH OF TREATMENT WITH TWO OF THE FOLLOWING THERAPIES: (A) MODAFINIL OR ARMODAFINIL OR (B) SUNOSI. RENEWAL CRITERIA: (1) PATIENT HAS BEEN SEEN BY THE PROVIDER IN THE PAST 12 MONTHS, AND (2) MEDICAL CHART DOCUMENTATION OF EFFICACY, SUCH AS IMPROVEMENT IN EXCESSIVE DAYTIME SLEEPINESS.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 YEARS AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY A PROVIDER EXPERIENCED IN THE MANAGEMENT OF NARCOLEPSY INCLUDING BUT NOT LIMITED TO, NEUROLOGIST AND SLEEP SPECIALIST.

COVERAGE DURATION
SIX MONTHS, THEN 12 MONTHS WHEN RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

XATMEP

MEDICATION(S)
XATMEP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: DOCUMENTATION THAT THE PATIENT HAS DIFFICULTY SWALLOWING OR HAS COMPLIANCE CONCERNS WITH METHOTREXATE TABLETS OR INJECTION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.

XELJANZ

MEDICATION(S)
XELJANZ, XELJANZ XR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE XELJANZ CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG ORENCIA, OR (2) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO OTHER PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ACTEMRA AND ORENCIA, OR (3) ULCERATIVE COLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG. PREFERRED DRUGS ARE HUMIRA OR RINVOQ, OR (4) POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ACTEMRA AND ORENCIA, OR (5) ANKYLOSING SPONDYLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, RINVOQ, AND COSENTYX. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY OR GASTROENTEROLOGY.

COVERAGE DURATION
12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

XENAZINE

MEDICATION(S)
TETRABENAZINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION OF POSITIVE RESPONSE TO THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGY.

COVERAGE DURATION
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF POSITIVE RESPONSE.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

XENLETA

MEDICATION(S)
XENLETA 600 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR DIAGNOSIS OF COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP), DOCUMENTATION THAT IT IS CAUSED BY A SUSCEPTIBLE BACTERIA, AND (3) DOCUMENTATION OF INADEQUATE RESPONSE OR CONTRAINDICATION TO TWO OTHER ANTIBIOTICS TO WHICH THE BACTERIA IS SUSCEPTIBLE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY INFECTIOUS DISEASE SPECIALIST.

COVERAGE DURATION
12 months

OTHER CRITERIA
DOSE IS LIMITED TO 600 MG EVERY 12 HOURS FOR 5 DAYS.

XERMELO

MEDICATION(S)
XERMELO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION OF POSITIVE RESPONSE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

OTHER CRITERIA
N/A

XGEVA

MEDICATION(S)
XGEVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) FOR PREVENTION OF SKELETAL-RELATED EVENTS IN PATIENTS WITH BONE METASTESES FROM SOLID TUMORS, OR (2) FOR TREATMENT OF ADULTS AND SKELATALLY MATURE ADOLESCENTS WITH GIANT CELL TUMOR OF BONE THAT IS UNRESECTABLE OR WHERE SURGICAL RESECTION IS LIKELY TO RESULT IN SEVERE MORBIDITY, OR (3) DIAGNOSIS OF HYPERCALCEMIA OF MALIGNANCY REFRACTORY TO BISPHOSPHONATE THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

XIFAXAN

MEDICATION(S)
XIFAXAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF HEPATIC ENCEPHALOPATHY AND DOCUMENTATION THAT SIDE EFFECTS HAVE LIMITED THE DOSE OF LACTULOSE, OR (2) DIAGNOSIS OF TRAVELER'S DIARRHEA AND DOCUMENTATION OF TRIAL AND FAILURE OF OR CONTRAINDICATIONS TO CIPROFLOXACIN, OR (3) DIAGNOSIS OF MODERATE TO SEVERE IRRITABLE BOWEL DISEASE, INCLUDING BLOATING, WITHOUT CONSTIPATION AND WITH (A) AN INADEQUATE RESPONSE TO FIRST LINE THERAPY INCLUDING AN ANTISPASMODIC AGENT SUCH AS DICYCLOMINE AND AN ANTIDIARRHEAL AGENT SUCH AS LOPERAMIDE OR DIPHENOXYLATE/ATROPINE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY FOR TREATMENT OF IRRITABLE BOWEL DISEASE

COVERAGE DURATION
12 months

OTHER CRITERIA
IRRITABLE BOWEL DISEASE: DOSE IS LIMITED TO 550 MG THREE TIMES DAILY FOR 14 DAYS. RETREATMENT IS LIMITED TO PATIENTS WITH A POSITIVE RESPONSE AND LIMITED TO A MAXIMUM OF TWO, 14 DAY TREATMENTS.

XOLAIR

MEDICATION(S)
XOLAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (1) FOR ASTHMA: DOCUMENTATION OF FAILURE WITH AT LEAST TWO OF THE FOLLOWING STANDARD THERAPIES: (A) REGULAR USE OF INHALED STEROIDS (SUCH AS FLOVENT), (B) REGULAR USE OF A LONG-ACTING BETA-AGONIST (SUCH AS SEREVENT), (C) REGULAR USE OR A TRIAL OF A LEUKOTRIENE ANTAGONIST (SUCH AS MONTELUKAST), AND (D) REGULAR OR PERIODIC USE OF ORAL STEROIDS (SUCH AS PREDNISONE), OR (2) FOR CHRONIC URTICARIA: DOCUMENTATION OF FAILURE WITH AT LEAST TWO OF THE STANDARD THERAPIES: (A) AN H1 ANTIHISTAMINE (SUCH AS LEVOCETIRIZINE), (B) AN H2 ANTIHISTAMINE (SUCH AS FAMOTIDINE), (C) LEUKOTRIENE ANTAGONIST (SUCH AS MONTELUKAST), AND (D) MULTIPLE COURSES OF OR DEPENDENT ON AN ORAL STEROID (SUCH AS PREDNISONE), OR (3) FOR NASAL POLYPS: PATIENT HAS TRIED AND FAILED OR HAS CONTRAINDICATIONS TO INTRANASAL CORTICOSTEROIDS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY AN ASTHMA SPECIALIST, ALLERGIST, PULMONOLOGIST, IMMUNOLOGIST, OTOLARYNGOLOGIST OR DERMATOLOGIST.

COVERAGE DURATION
12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

XYREM

MEDICATION(S)
XYREM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE XYREM CONCURRENTLY WITH SEDATIVE HYPNOTICS, XYWAV OR WAKIX.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF CATAPLEXY ASSOCIATED WITH NARCOLEPSY AND THE PATIENT HAS A MEDICAL CONTRAINDICATION OR NO IMPROVEMENT IN SYMPTOMS DESPITE ONE MONTH OF TREATMENT WITH EACH OF THE FOLLOWING THERAPIES: (A) AN ANTIDEPRESSANT USED IN THE TREATMENT OF CATAPLEXY (SUCH AS FLUOXETINE OR CLOMIPRAMINE) AND (B) WAKIX (WAKIX IS NOT REQUIRED FOR PATIENTS LESS THAN 18 YEARS OF AGE), OR (2) DIAGNOSIS OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY AND THE PATIENT HAS A MEDICAL CONTRAINDICATION OR NO IMPROVEMENT IN SYMPTOMS DESPITE ONE MONTH OF TREATMENT WITH WAKIX (WAKIX IS NOT REQUIRED FOR PATIENTS LESS THAN 18 YEARS OF AGE) AND SUNOSI. RENEWAL CRITERIA: (1) PATIENT HAS BEEN SEEN BY THE PROVIDER IN THE PAST 12 MONTHS, AND (2) MEDICAL CHART DOCUMENTATION OF EFFICACY, SUCH AS REDUCTION IN SYMPTOMS OF DAYTIME SLEEPINESS OR REDUCTION IN FREQUENCY OF CATAPLEXY ATTACKS.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 7 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY A PROVIDER EXPERIENCED IN THE MANAGEMENT OF NARCOLEPSY INCLUDING BUT NOT LIMITED TO, NEUROLOGIST AND SLEEP SPECIALIST.

COVERAGE DURATION
12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

XYWAV

MEDICATION(S)
XYWAV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE XYWAV CONCURRENTLY WITH SEDATIVE HYPNOTICS, XYREM OR WAKIX.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF CATAPLEXY ASSOCIATED WITH NARCOLEPSY AND THE PATIENT HAS A MEDICAL CONTRAINDICATION OR NO IMPROVEMENT IN SYMPTOMS DESPITE ONE MONTH OF TREATMENT WITH EACH OF THE FOLLOWING THERAPIES: (A) AN ANTIDEPRESSANT USED IN THE TREATMENT OF CATAPLEXY (SUCH AS FLUOXETINE OR CLOMIPRAMINE) AND (B) WAKIX (WAKIX IS NOT REQUIRED FOR PATIENTS LESS THAN 18 YEARS OF AGE), OR (2) DIAGNOSIS OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY AND THE PATIENT HAS A MEDICAL CONTRAINDICATION OR NO IMPROVEMENT IN SYMPTOMS DESPITE ONE MONTH OF TREATMENT WITH WAKIX (WAKIX IS NOT REQUIRED FOR PATIENTS LESS THAN 18 YEARS OF AGE) AND SUNOSI, OR (3) DIAGNOSIS OF IDIOPATHIC HYPERSOMNIA AND A MEDICAL CONTRAINDICATION OR NO IMPROVEMENT IN SYMPTOMS DESPITE ONE MONTH OF TREATMENT WITH AT LEAST TWO OF THE FOLLOWING THERAPIES: MODAFINIL, ARMODAFINIL, METHYLPHENIDATE OR AMPHETAMINES. RENEWAL CRITERIA: (1) PATIENT HAS BEEN SEEN BY THE PROVIDER IN THE PAST 12 MONTHS, AND (2) MEDICAL CHART DOCUMENTATION OF EFFICACY, SUCH AS REDUCTION IN SYMPTOMS OF DAYTIME SLEEPINESS OR REDUCTION IN FREQUENCY OF CATAPLEXY ATTACKS.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 7 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY A PROVIDER EXPERIENCED IN THE MANAGEMENT OF NARCOLEPSY INCLUDING BUT NOT LIMITED TO, NEUROLOGIST AND SLEEP SPECIALIST.

COVERAGE DURATION

12 months

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ZEPOSIA PA

MEDICATION(S)
ZEPOSIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE ZEPOSIA CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW STARTS ONLY: DIAGNOSIS OF: (1) ULCERATIVE COLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE RINVOQ AND HUMIRA, OR (2) RELAPSING FORMS OF MULTIPLE SCLEROSIS (MS), INCLUDING CLINICALLY ISOLATED SYNDROME, RELAPSING-REMITTING DISEASE, AND ACTIVE SECONDARY PROGRESSIVE DISEASE. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY AND NEUROLOGY

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ZOKINVY

MEDICATION(S)
ZOKINVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF ADEQUATE LIVER AND RENAL FUNCTION. RENEWAL CRITERIA: (1) THE PROVIDER ATTESTS THAT THE PATIENT HAS HAD A RESPONSE TO THE MEDICATION AND (2) THE PATIENT HAS BEEN SEEN WITHIN THE LAST 14 MONTHS.

AGE RESTRICTION
RESERVED FOR PATIENTS 12 MONTHS AND OLDER WITH BODY SURFACE AREA OF AT LEAST 0.39 M2.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH A PEDIATRIC ENDOCRINOLOGIST OR PEDIATRIC GENETICIST.

COVERAGE DURATION
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF POSITIVE RESPONSE.

OTHER CRITERIA
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ZYFLO

MEDICATION(S)
ZILEUTON ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE WITH MONTELUKAST.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A