HealthPartners
UnityPoint Health

2019 Medicare Part D
Prior Authorization Requirements

Effective: December 1, 2019

Formulary ID 19061, Version 21
Last Updated: 11/19/2019

ABILIFY MYCITE

MEDICATION(S)
ABILIFY MYCITE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: (1) PRESCRIBED FOR PATIENTS WITH FDA-APPROVED INDICATIONS, AND (2) DOCUMENTED COMPLIANCE CONCERNS WITH ORAL THERAPY, AND (3) WHEN THE PATIENT HAS TRIED AND FAILED, IS UNABLE TO TOLERATE OR HAS CONTRAINDICATIONS TO INJECTABLE THERAPY.

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.

ACTEMRA

MEDICATION(S)
ACTEMRA, ACTEMRA ACTPEN

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND/OR FUNCTIONAL ASSESSMENT AND TREATMENT GOALS, AND (3) FOR RHEUMATOID ARTHRITIS AND JUVENILE IDIOPATHIC ARTHRITIS ONLY, DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH 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 RHEUMATOLOGY

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.

ACTIMMUNE

MEDICATION(S)
ACTIMMUNE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

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

AIMOVIG

MEDICATION(S)
AIMOVIG AUTOINJECTOR, AIMOVIG AUTOINJECTOR (2 PACK), AJOVY, EMGALITY PEN, EMGALITY 120 MG/ML SYRINGE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) PATIENT HAS GREATER THAN OR EQUAL TO 4 MIGRAINE DAYS PER MONTH, AND (3) PATIENT HAS A DOCUMENTED INADQUATE 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. RENEWAL CRITERIA: DOCUMENTATION OF A POSITIVE RESPONSE.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY 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.

ANDROGEN THERAPY

MEDICATION(S)
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 25 MG/2.5 GM PKT, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT, TESTOSTERON CYP 1,000 MG/10 ML, TESTOSTERON CYP 2,000 MG/10 ML, TESTOSTERONE CYP 1,000 MG/5 ML, TESTOSTERONE CYP 100 MG/ML, TESTOSTERONE CYP 200 MG/ML, TESTOSTERONE CYP 500 MG/2.5 ML, TESTOSTERONE CYP 500 MG/5 ML, TESTOSTERONE CYP 6,000 MG/30ML, TESTOSTERONE ENANTHATE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 IN MALES OF LESS THAN 300 NG/DL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

ANTICONVULSANTS - SELECT AGENTS

MEDICATION(S)
APTIOM, BANZEL, FYCOMPA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

ANTIDEPRESSANTS - NON-PREFERRED AGENTS

MEDICATION(S)
DRIZALMA SPRINKLE, FETZIMA, TRINTELLIX, VIIBRYD

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

ANTINEOPLASTIC INJECTABLES

MEDICATION(S)

ABRAXANE, ALIMTA, ALIQOPA, AMIFOSTINE, ARRANON, ARSENIC TRIOXIDE 10 MG/10ML VL, ARZERRA, AVASTIN, AZACITIDINE, BAVENCIO, BELEODAQ, BENDEKA, BESPONSA, BICNU, BLINCYTO, BORTEZOMIB, BUSULFAN, CAMPTOSAR 300 MG/15 ML VIAL, CARBOPLATIN, CARMUSTINE, CISPLATIN, CLOFARABINE, CYRAMZA, DACARBAZINE, DACTINOMYCIN, DARZALEX, DAUNORUBICIN HCL, DECITABINE, DOCETAXEL, EMPLICITI, EPIRUBICIN HCL, ERBITUX, ERWINAZE, FASLODEX, FLUDARABINE PHOSPHATE, FOLOTYN, FULVESTRANT, GAZYVA, GEMCITABINE HCL, HALAVEN, HERCEPTIN, HERCEPTIN HYLECTA, IDARUBICIN HCL, IFOSFAMIDE, IMFINZI, INFUGEM, IRINOTECAN HCL, IXEMPRA, JEVTANA, KADCYLA, KANJINTI 420 MG VIAL, KEYTRUDA, KYPROLIS, LARTRUVO, LIBTAYO, LUMOXITI, LUPRON DEPOT, LUPRON DEPOT (LUPANETA), LUPRON DEPOT-PED 11.25 MG 3MO, LUPRON DEPOT-PED 7.5 MG KIT, MELPHALAN HCL, MITOMYCIN, MITOXANTRONE HCL, MUSTARGEN, MUTAMYCIN, MVASI, MYLOTARG, ONCASPAR, ONIVYDE, OPDIVO, OXALIPLATIN, PACLITAXEL, PERJETA, POLIVY, PORTRAZZA, POTELIGEO, PROLEUKIN, RITUXAN HYCELA, ROMIDEPSIN, SYLVANT, TECENTRIQ, TEMODAR 100 MG VIAL, TEMSIROLIMUS, THIOTEPA, TORISEL, TREANDA, TRELSTAR, TRISENOX 12 MG/6 ML VIAL, UNITUXIN, UVADEX, VECTIBIX, VELCADE, VINCASAR PFS, VINCRISTINE SULFATE, VINORELBINE TARTRATE, VYXEOS, YERVOY, ZANOSAR

COVERED USES

ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

ANTINEOPLASTIC INJECTABLES WITH BVD

MEDICATION(S)
BLEO 15K, BLEOMYCIN SULFATE, CLADRIBINE, CYTARABINE, DOXORUBICIN 10 MG/5 ML VIAL, DOXORUBICIN 150 MG/75 ML VIAL, DOXORUBICIN 20 MG/10 ML VIAL, DOXORUBICIN 200 MG/100 ML VIAL, DOXORUBICIN 50 MG/25 ML VIAL, DOXORUBICIN HCL LIPOSOME, FLUOROURACIL 1,000 MG/20 ML VL, FLUOROURACIL 2,500 MG/50 ML VL, FLUOROURACIL 2.5 GM/50 ML BTL, FLUOROURACIL 2.5 GM/50 ML VIAL, FLUOROURACIL 5 GM/100 ML BTL, FLUOROURACIL 5 GM/100 ML VIAL, FLUOROURACIL 5,000 MG/100 ML, FLUOROURACIL 500 MG/10 ML VIAL, IMLYGIC, VINBLASTINE SULFATE, YONDELIS

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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
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.

ANTIPARKINSON AGENTS

MEDICATION(S)
NEUPRO

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF SIGNIFICANT SIDE EFFECTS, LOSS OF EFFICACY, OR COMPLIANCE CONCERNS WITH REGULAR RELEASE PRAMIPEXOLE OR ROPINIROLE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

ATYPICAL ANTIPSYCHOTIC AGENTS

MEDICATION(S)
FANAPT, PALIPERIDONE ER, REXULTI, SAPHRIS, VRAYLAR

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

AUSTEDO

MEDICATION(S)
AUSTEDO

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

CABLIVI

MEDICATION(S)
CABLIVI

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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
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.

CENEGERMIN

MEDICATION(S)
OXERVATE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND/OR FUNCTIONAL ASSESSMENT AND TREATMENT GOALS, (3) FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, AND PLAQUE PSORIASIS: DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH ENBREL AND HUMIRA, OR FOR CROHN'S DISEASE: DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO HUMIRA. 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
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.

CLOMIPRAMINE

MEDICATION(S)
CLOMIPRAMINE HCL

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: DIAGNOSIS OF OBSESSIVE-COMPULSIVE DISORDER, OR DOCUMENTATION THAT THE PATIENT IS MONITORED FOR ADVERSE DRUG EVENTS.

AGE RESTRICTION
RESTRICTIONS APPLY TO PATIENTS GREATER THAN 64 YEARS OF AGE.

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

CLONIDINE EXTENDED RELEASE

MEDICATION(S)
CLONIDINE HCL ER

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTED FAILURE WITH STANDARD GENERIC ADHD MEDICATIONS SUCH AS METHYLPHENIDATE OR DEXTROAMPHETAMINE-AMPHETAMINE COMBINATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

COPAXONE 20MG

MEDICATION(S)
COPAXONE 20 MG/ML SYRINGE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 GLATOPA 20MG OR GLATIRAMER 20MG.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGY

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.

COPAXONE 40MG

MEDICATION(S)
COPAXONE 40 MG/ML SYRINGE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 GLATIRAMER 40MG.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGY

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.

COSENTYX

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL: (1) MEDICAL CHART DOCUMENTATION OF TREATMENT GOALS AND BASELINE DISEASE ACTIVITY/FUNCTIONAL ASSESSMENT, AND (2) DIAGNOSIS OF: (A) MODERATE TO SEVERE PLAQUE PSORIASIS (AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP, AND/OR GENITAL REGIONS, PUSTULAR PSORIASIS), OR (B) ANKYLOSING SPONDYLITIS, OR (C) PSORIATIC ARTHRITIS, AND (3) MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE TO BOTH 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 DERMATOLOGY AND RHEUMATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY

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.

CYSTARAN

MEDICATION(S)
CYSTARAN

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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
N/A

DAKLINZA

MEDICATION(S)
DAKLINZA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, (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, AND (3) DOCUMENTED CLINICAL INAPPROPRIATENESS OF OR INABILITY TO TOLERATE HARVONI, EPCLUSA, OR MAVYRET REGIMENS.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
DURATION PER GENOTYPE AND DIAGNOSIS. 12-24 WEEKS PER FDA APPROVED LABELING OR CLINICAL GUIDELINES.

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

DALFAMPRIDINE ER

MEDICATION(S)
DALFAMPRIDINE ER

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

DESVENLAFAXINE

MEDICATION(S)
DESVENLAFAXINE SUC ER 100 MG TABLET (GENERIC FOR PRISTIQ), DESVENLAFAXINE SUC ER 25 MG TABLET (GENERIC FOR PRISTIQ), DESVENLAFAXINE SUC ER 50 MG TABLET (GENERIC FOR PRISTIQ)

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 TO VENLAFAXINE ER AND DULOXETINE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

DIFICID

MEDICATION(S)
DIFICID

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

DIGOXIN

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

DIHYDROERGOTAMINE

MEDICATION(S)
DIHYDROERGOTAMINE MESYLATE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

DULERA

MEDICATION(S)
DULERA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 ADVAIR.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

DUPIXENT

MEDICATION(S)
DUPIXENT

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(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.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY AN ALLERGIST, IMMUNOLOGIST, OR DERMATOLOGIST.

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.

EMSAM

MEDICATION(S)
EMSAM

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

ENBREL

MEDICATION(S)
ENBREL, ENBREL MINI, ENBREL SURECLICK

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL: (1) DOCUMENTATION OF TREATMENT GOALS AND BASELINE DISEASE ACTIVITY/FUNCTIONAL ASSESSMENT, AND (2) DIAGNOSIS OF: (A) RHEUMATOID ARTHRITIS W/DOCUMENTATION OF CONTRAINDICATION/INTOLERANCE TO/FAILURE (C/I/F) W/CONCURRENT USE OF 2 OF THE FOLLOWING FOR 3 MOS: METHOTREXATE, HYDROXYCHLOROQUINE, LEFLUNOMIDE, OR SULFASALAZINE, OR (B) JUVENILE IDIOPATHIC ARTHRITIS OR PSORIATIC ARTHRITIS W/DOCUMENTATION OF C/I/F TO BOTH OF THE FOLLOWING FOR 1 MONTH: CONTINUOUS TREATMENT WITH ONE NSAID AND METHOTREXATE, OR (C) ANKYLOSING SPONDYLITIS WITH DOCUMENTATION OF C/I/F TO CONTINUOUS TREATMENT WITH ONE NSAID FOR 1 MONTH, AND FOR PERIPHERAL DISEASE ONLY, DOCUMENTATION OF C/I/F W/ONE OF THE FOLLOWING: CONTINUOUS LOCAL CORTICOSTEROID INJECTION THERAPY (WHEN DISEASE PROCESS PERMITS), METHOTREXATE, OR SULFASALAZINE, OR (D) PLAQUE PSORIASIS W/AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP, AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS, W/DOCUMENTATION OF C/I/F TO 2 OF THE FOLLOWING FOR 3 MOS: TOPICAL CORTICOSTEROID THERAPY, PHOTOTHERAPY, METHOTREXATE, CYCLOSPORINE, ACITRETIN. RENEWAL: DOCUMENTATION TREATMENT GOALS HAVE BEEN MET.

AGE RESTRICTION
N/A

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

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.

ENZYME REPLACEMENT

MEDICATION(S)
ADAGEN, ALDURAZYME, CERDELGA, CHOLBAM, ELAPRASE, ELELYSO, ELITEK, FABRAZYME, ILARIS, LUMIZYME, NAGLAZYME, NITISINONE, ORFADIN, VPRIV

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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
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.

EPCLUSA

MEDICATION(S)
EPCLUSA, SOFOSBUVIR-VELPATASVIR

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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
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, PROCRIT, PROCRIT 20,000 UNITS/2 ML VIAL, RETACRIT

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

FAMOTIDINE INJECTION

MEDICATION(S)
FAMOTIDINE 20 MG/2 ML VIAL, FAMOTIDINE 200 MG/20 ML VIAL, FAMOTIDINE 40 MG/4 ML VIAL, FAMOTIDINE 500 MG/50 ML VIAL

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF: (A) FAILURE WITH ORAL FORMULARY HISTAMINE 2 RECEPTOR ANTAGONISTS FAMOTIDINE AND RANITIDINE, OR (B) MEDICAL CONTRAINDICATIONS TO ORAL HISTAMINE 2 RECEPTOR ANTAGONISTS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

FDA-APPROVED INDICATIONS

MEDICATION(S)

ABILIFY MAINTENA, AMIKACIN SULFATE, ANADROL-50, APOKYN, ARALAST NP, ARISTADA, ARISTADA INITIO, ATGAM, BENLYSTA, BERINERT, CAPASTAT SULFATE, CASPOFUNGIN ACETATE, CAYSTON, CHLORAMPHENICOL SOD SUCCINATE, CHORIONIC GONAD 10,000 UNIT VL, CINRYZE, CORLANOR, CYCLOSERINE, DAPTOMYCIN, DEMSER, DEXRAZOXANE, EPIDIOLEX, ERAXIS (WATER DILUENT), FIRAZYR, FOMEPIZOLE, GLASSIA, HAEGARDA, HETLIOZ, ICATIBANT, INVEGA SUSTENNA, INVEGA TRINZA, KALBITOR, KEPIVANCE, KHAPZORY, KORLYM, KRYSTEXXA, LEVOLEUCOVORIN CALCIUM, LUPRON DEPOT-PED 11.25 MG KIT, LUPRON DEPOT-PED 15 MG KIT, LUPRON DEPOT-PED 30 MG 3MO KIT, MESNA, MOVANTIK, MOZOBIL, NAYZILAM, NUPLAZID, OXANDROLONE, PERSERIS, PROLASTIN C (1,000 MG VIAL), PROLASTIN C (1,000 MG/20 ML VL), QUININE SULFATE, RANEXA, RANOLAZINE ER, RIFAMPIN IV 600 MG VIAL, RUCONEST, SIRTURO, SODIUM PHENYLBUTYRATE 500MG TB, SOLIRIS, SOMATULINE DEPOT, SOMAVERT, SYMPROIC, SYNAGIS, SYNAREL, TAKHZYRO, TARGRETIN 1% GEL, TOBI PODHALER, TOBRAMYCIN SULFATE, TRANEXAMIC ACID 1,000 MG/10 ML, VISTOGARD, XYREM, ZEMAIRA, ZORBTIVE, ZULRESSO, ZYPREXA RELPREVV

COVERED USES

ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

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

OTHER CRITERIA

N/A

FDA-APPROVED INDICATIONS - DOSE LIMIT

MEDICATION(S)
FIRDAPSE, RUZURGI, STRENSIQ

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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
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.

FDA-APPROVED INDICATIONS WITH BVD

MEDICATION(S)
ABELCET, AMBISOME, AMPHOTERICIN B, BIVIGAM, CARIMUNE NF NANOFILTERED, CUTAQUIG, CUVITRU, FLEBOGAMMA DIF, FOSCARNET SODIUM, GAMASTAN, GAMASTAN S-D, GAMMAGARD LIQUID, GAMMAGARD S-D, GAMMAKED, GAMMAPLEX, GAMUNEX-C, HIZENTRA, HYQVIA, OCTAGAM, PANZYGA, PRIVIGEN, PULMOZYME, TOBRAMYCIN 300 MG/5 ML AMPULE, TOBRAMYCIN PAK 300 MG/5 ML, XEMBIFY, ZORTRESS

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

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.

FONDAPARINUX

MEDICATION(S)
FONDAPARINUX SODIUM

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D, DIAGNOSIS OF HEPARIN-INDUCED THROMBOCYTOPENIA, AND DIAGNOSIS OF MALIGNANCY WITH HYPERCOAGULABLE STATE.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND DOCUMENTATION OF FAILURE OR MEDICAL CONTRAINDICATIONS WITH ENOXAPARIN, OR (2) DIAGNOSIS OF HEPARIN-INDUCED THROMBOCYTOPENIA, OR (3) DIAGNOSIS OF MALIGNANCY WITH HYPERCOAGULABLE STATE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

FORTEO

MEDICATION(S)
FORTEO

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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, ADEQUATE CALCIUM INTAKE AND VITAMIN D INTAKE WITH VITAMIN D SERUM LEVELS OF 30 NG/ML OR HIGHER, AND (2) DOCUMENTED FAILURE OF, INTOLERANCE TO, OR CONTRAINDICATIONS TO TYMLOS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

FULYZAQ

MEDICATION(S)
MYTESI

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND CONTRAINDICATIONS OR INADEQUATE RESPONSE TO LOPERAMIDE AND DIPHENOXYLATE/ATROPINE. RENEWAL CRITERIA: 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

GALAFOLD

MEDICATION(S)
GALAFOLD

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) TREATMENT OF ADULT 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.

HARVONI

MEDICATION(S)
HARVONI, LEDIPASVIR-SOFOSBUVIR

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 12 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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA AGENTS

MEDICATION(S)
JUXTAPID, KYNAMRO

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 AND ENDOCRINOLOGY.

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

OTHER CRITERIA
N/A

HUMIRA

MEDICATION(S)
HUMIRA, HUMIRA PEDIATRIC CROHN'S, 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 PSOR-UV-ADOL HS

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL: (1) DOCUMENTATION OF TREATMENT GOALS AND BASELINE DISEASE ACTIVITY/FUNCTIONAL ASSESSMENT, AND (2) DIAGNOSIS OF: (A) RHEUMATOID ARTHRITIS W/DOCUMENTATION OF CONTRAINDICATION/INTOLERANCE TO/FAILURE (C/I/F) W/CONCURRENT USE OF 2 OF THE FOLLOWING FOR 3 MOS: METHOTREXATE, HYDROXYCHLOROQUINE, LEFLUNOMIDE, OR SULFASALAZINE, OR (B) JUVENILE IDIOPATHIC ARTHRITIS OR PSORIATIC ARTHRITIS W/DOCUMENTATION OF C/I/F TO BOTH OF THE FOLLOWING FOR 1 MONTH: CONTINUOUS TREATMENT WITH ONE NSAID AND METHOTREXATE, OR (C) ANKYLOSING SPONDYLITIS W/DOCUMENTATION OF C/I/F TO CONTINUOUS TREATMENT WITH ONE NSAID FOR 1 MONTH, AND FOR PERIPHERAL DISEASE ONLY, DOCUMENTATION OF C/I/F W/ONE OF THE FOLLOWING: CONTINUOUS LOCAL CORTICOSTEROID INJECTION THERAPY (WHEN DISEASE PROCESS PERMITS), METHOTREXATE, OR SULFASALAZINE, OR (D) PLAQUE PSORIASIS W/AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP, AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS, W/DOCUMENTATION OF C/I/F TO 2 OF THE FOLLOWING FOR 3 MOS: TOPICAL CORTICOSTEROID THERAPY, PHOTOTHERAPY, METHOTREXATE, CYCLOSPORINE, ACITRETIN, OR (E) MODERATELY TO SEVERELY ACTIVE CROHN'S DISEASE W/: (I) FISTULIZING DISEASE, OR (II) DOCUMENTATION OF C/I/F TO 1 OF THE FOLLOWING: PREDNISONE OR BUDESONIDE FOR 14 DAYS, OR AZATHIOPRINE, 6-MERCAPTOPURINE, OR METHOTREXATE FOR 3 MOS, OR (F) MODERATE TO SEVERELY ACTIVE ULCERATIVE COLITIS W/DOCUMENTATION OF C/I/F TO 2 OF THE FOLLOWING FOR 3 MOS: SULFASALAZINE, MESALAMINE, BALSALAZIDE, PREDNISONE, BUDESONIDE, AZATHIOPRINE, 6-MERCAPTOPURINE, OR (G) HIDRADENITIS SUPPURATIVA, OR (H) NON-INFECTIOUS INTERMEDIATE, POSTERIOR AND PANUVEITIS. RENEWAL: DOCUMENTATION TREATMENT GOALS HAVE BEEN MET.

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
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.

IDIOPATHIC PULMONARY FIBROSIS AGENTS

MEDICATION(S)
ESBRIET, OFEV

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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
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

INBRIJA

MEDICATION(S)
INBRIJA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF PARKINSON'S DISEASE WITH OFF EPISODES, AND (2) PATIENT IS (A) TAKING ORAL CARBIDOPA/LEVODOPA AT LEAST 4 TIMES PER DAY, OR (B) UNABLE TO TOLERATE TAKING ORAL CARBIDOPA/LEVODOPA AT LEAST 4 TIMES PER DAY, OR (C) INTOLERANT OR HAS A CONTRAINDICATION TO ORAL CARBIDOPA/LEVODOPA, AND (3) PATIENT (A) HAS TRIED AND FAILED AT LEAST ONE OF THE FOLLOWING AGENTS FOR AT LEAST 4 WEEKS IN COMBINATION WITH ORAL CARBIDOPA/LEVODOPA (E.G. DOPAMINE AGONIST, COMT INHIBITOR, OR MAO-B INHIBITOR) TO REDUCE NUMBER AND FREQUENCY OF OFF EPISODES (I) RASAGILINE, (II) ROPINOROLE, (III) ENTACAPONE, (IV) PRAMIPEXOLE, (V) ROTIGOTINE, (VI) SELEGILINE, OR (B) IS INTOLERANT OR HAS A CONTRAINDICATION TO ORAL CARBIDOPA/LEVODOPA, AND (4) PATIENT IS FREE OF UNDERLYING LUNG DISEASE. FOR PATIENTS WITH LIMITED PULMONARY FUNCTION (FEV LESS THAN 50%), ATTESTATION FROM PROVIDER IS REQUIRED ACKNOWLEDGING INBRIJA HAS NOT BEEN STUDIED IN THIS POPULATION AND DRUG MAY BE INEFFECTIVE DUE TO LACK OF INSPIRATORY CAPACITY. PROVIDER ATTESTS THAT POTENTIAL BENEFITS OUTWEIGH RISKS, AND (5) ATTESTATION FROM PROVIDER ACKNOWLEDGING THAT PATIENT HAS OR WILL RECEIVE EDUCATION ON PROPER INBRIJA INHALER TECHNIQUE. RENEWAL CRITERIA: PROVIDER DOCUMENTATION OF REDUCED OFF PERIOD FREQUENCY OR IMPROVEMENT IN OFF PERIOD SYMPTOMS WITH USE OF INBRIJA.

AGE RESTRICTION
LIMITED TO ADULTS AGE 18 YEARS AND OLDER.

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

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.

INFECTIOUS DISEASE SELECT AGENTS

MEDICATION(S)
CRESEMBA 186 MG CAPSULE, LINEZOLID, LINEZOLID-0.9% NACL, LINEZOLID-D5W, NOXAFIL 40 MG/ML SUSPENSION, NOXAFIL DR 100 MG TABLET, POSACONAZOLE, SIVEXTRO, VORICONAZOLE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 SPECIALIST.

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

OTHER CRITERIA
N/A

INGREZZA

MEDICATION(S)
INGREZZA, INGREZZA INITIATION PACK

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) MEDICAL CHART DOCUMENTATION OF FUNCTIONAL IMPAIRMENT DUE TO 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.

ITRACONAZOLE

MEDICATION(S)
ITRACONAZOLE, SPORANOX 10 MG/ML SOLUTION

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR COMPLEX FUNGAL NAIL INFECTIONS (ONYCHOMYCOSIS): DOCUMENTED FAILURE ON ORAL TERBINAFINE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

KALYDECO

MEDICATION(S)
KALYDECO, ORKAMBI, SYMDEKO

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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
N/A

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.

KEVZARA

MEDICATION(S)
KEVZARA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH ACTEMRA. RENEWAL CRITERIA: DOCUMENTATION OF A POSITIVE RESPONSE.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY.

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.

KINERET

MEDICATION(S)
KINERET

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND/OR FUNCTIONAL ASSESSMENT AND TREATMENT GOALS (3) FOR RHEUMATOLOGY: MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE TO 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 RHEUMATOLOGY, PEDIATRICIAN (FOR CHILDREN WITH CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES), AND GENETICS SPECIALISTS WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

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.

LATUDA

MEDICATION(S)
LATUDA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

LIDOCAINE PATCH

MEDICATION(S)
LIDOCAINE 5% PATCH

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF A MEDICALLY ACCEPTED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR DIAGNOSIS OF POSTHERPETIC NEURALGIA OR DIABETIC NEUROPATHY, DOCUMENTATION THAT THE PATIENT HAS TRIED AND FAILED GABAPENTIN.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

LOTRONEX

MEDICATION(S)
ALOSETRON HCL

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

MARQIBO

MEDICATION(S)
MARQIBO

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

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

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

MAVENCLAD

MEDICATION(S)
MAVENCLAD

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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, TECFIDERA, 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
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.

MAVYRET

MEDICATION(S)
MAVYRET

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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
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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

MEDICALLY ACCEPTED INDICATIONS

MEDICATION(S)
ARMODAFINIL, CYCLOBENZAPRINE 10 MG TABLET, CYCLOBENZAPRINE 5 MG TABLET, CYCLOTENS, MODAFINIL

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION OR CMS-APPROVED COMPENDIA ACCEPTED INDICATION FOR THE REQUESTED MEDICATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

MEDROXYPROGESTERONE 400 MG/ML IM INJECTION

MEDICATION(S)
DEPO-PROVERA 400 MG/ML VIAL

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF CANCER FOR A NEW START PATIENT, OR (2) DOCUMENTATION THAT A PATIENT IS CURRENTLY RECEIVING OR HAS PREVIOUSLY RECEIVED AND BENEFITED FROM DEPO-PROVERA 400MG/ML INTRAMUSCULAR INJECTION FOR THE TREATMENT OF CANCER.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

METABOLIC DISORDER AGENTS

MEDICATION(S)
ARCALYST, CARBAGLU, KUVAN, RAVICTI, SUCRAID

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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.

METHOXSALEN

MEDICATION(S)
METHOXSALEN

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 DERMATOLOGY AND ONCOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

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

OTHER CRITERIA
N/A

MIACALCIN INJECTION

MEDICATION(S)
MIACALCIN

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND DOCUMENTATION OF TRIAL AND FAILURE OR MEDICAL CONTRAINDICATIONS TO BISPHOSPHONATES

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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.

MULTAQ

MEDICATION(S)
MULTAQ

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTED FAILURE WITH OR MEDICAL CONTRAINDICATIONS TO FIRST-LINE MEDICATIONS SUCH AS AMIODARONE, FLECAINIDE, PROPAFENONE OR SOTALOL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY CARDIOLOGY

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

OTHER CRITERIA
N/A

NARCOTIC AGENTS

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

NATPARA

MEDICATION(S)
NATPARA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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.

NON-PREFERRED SOMATOSTATIN

MEDICATION(S)
SIGNIFOR LAR

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF TRIAL AND FAILURE WITH ONE LONG-ACTING SOMATOSTATIN ANALOGUE (SUCH AS SANDOSTATIN LAR). RENEWAL: 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

NON-PREFERRED TOBRAMYCIN

MEDICATION(S)
BETHKIS

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 TRIAL AND FAILURE WITH GENERIC TOBRAMYCIN NEBULIZED SOLUTION, AND (3) CARE MANAGED BY A CYSTIC FIBROSIS SPECIALIST. RENEWAL CRITERIA: DOCUMENTATION OF A POSITIVE RESPONSE AND THE PATIENT HAS BEEN SEEN WITHIN THE LAST 12 MONTHS FOR CYSTIC FIBROSIS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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.

NORTHERA

MEDICATION(S)
NORTHERA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

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

NUEDEXTA

MEDICATION(S)
NUEDEXTA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

NUZYRA

MEDICATION(S)
NUZYRA 150 MG TABLET, NUZYRA 150 MG TABLET-7 DAY, NUZYRA 150 MG-7 DAY WITH LOAD

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

OLUMIANT

MEDICATION(S)
OLUMIANT

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND/OR FUNCTIONAL ASSESSMENT AND TREATMENT GOALS, AND (3) FOR RHEUMATOID ARTHRITIS, DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH 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 RHEUMATOLOGY

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.

OLYSIO

MEDICATION(S)
OLYSIO

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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, AND (3) DOCUMENTED CLINICAL INAPPROPRIATENESS OF OR INABILITY TO TOLERATE HARVONI, EPCLUSA, OR MAVYRET. IF GENOTYPE 1A: DOCUMENTATION PATIENT IS NEGATIVE FOR NS3 Q80K POLYMORPHISM.

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
DURATION PER GENOTYPE AND DIAGNOSIS. 12-24 WEEKS PER FDA APPROVED LABELING OR CLINICAL GUIDELINES.

OTHER CRITERIA
DOSE IS LIMITED TO THE FDA-APPROVED DOSE OF 150MG DAILY. MUST BE USED IN A COMBINATION ANTIVIRAL TREATMENT REGIMEN SUPPORTED BY FDA APPROVED LABELING OR RELEVANT CLINICAL GUIDELINES.

ORAL DISSOLVE TABLETS PROTECTED CLASS

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

ORAL LIQUID PROTECTED CLASS

MEDICATION(S)
VERSACLOZ

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

ORAL ONCOLOGY AGENTS

MEDICATION(S)
ALECENSA, ALUNBRIG, BALVERSA, BOSULIF, BRAFTOVI, CABOMETYX, CALQUENCE, COMETRIQ, COPIKTRA, COTELLIC, DAURISMO, ERIVEDGE, ERLEADA, FARYDAK, GILOTRIF, IBRANCE, ICLUSIG, IDHIFA, IMBRUVICA, INLYTA, INREBIC, IRESSA, JAKAFI, KISQALI, KISQALI FEMARA CO-PACK, LENVIMA, LONSURF, LORBRENA, LYNPARZA, MEKINIST, MEKTOVI, NERLYNX, NINLARO, NUBEQA, ODOMZO, PIQRAY, POMALYST, ROZLYTREK, RUBRACA, RYDAPT, STIVARGA, TAFINLAR, TAGRISSO, TALZENNA, TIBSOVO, TURALIO, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, XALKORI, XOSPATA, XPOVIO, YONSA, ZEJULA, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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, ORENCIA CLICKJECT

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND/OR FUNCTIONAL ASSESSMENT AND TREATMENT GOALS, AND (3) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH 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 RHEUMATOLOGY

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.

ORENITRAM

MEDICATION(S)
ORENITRAM ER

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
(1) (A) DIAGNOSIS OF VASOREACTIVE PULMONARY ARTERIAL HYPERTENSION (PAH) AS CONFIRMED BY PRETREATMENT RIGHT HEART CATHETERIZATION AND TRIAL AND FAILURE OF CALCIUM CHANNEL BLOCKER THERAPY, OR (B) DIAGNOSIS OF NON-VASOREACTIVE PAH AS CONFIRMED BY PRETREATMENT RIGHT HEART CATHETERIZATION, AND (2) A PREVIOUS TRIAL OF ONE PREFERRED AGENT SUCH AS UPTRAVI, AND (3) DEMONSTRATED MEDICAL NECESSITY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PULMONOLOGY OR CARDIOLOGY.

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.

ORILISSA

MEDICATION(S)
ORILISSA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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.

OTEZLA

MEDICATION(S)
OTEZLA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PLAQUE PSORIASIS INITIAL CRITERIA: (1) DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS (AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP, AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS), AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND TREATMENT GOALS. PSORIATIC ARTHRITIS INITIAL CRITERIA: (1) DIAGNOSIS OF PSORIATIC ARTHRITIS, AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND/OR FUNCTIONAL ASSESSMENT AND TREATMENT GOALS. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY, OR THAT SIGNIFICANT PROGRESS TOWARD ACHIEVEMENT OF TREATMENT GOALS HAS OCCURRED.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY OR DERMATOLOGY.

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.

PANTOPRAZOLE IV

MEDICATION(S)
PANTOPRAZOLE SODIUM 40 MG VIAL

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF: (A) FAILURE WITH ORAL FORMULARY PROTON PUMP INHIBITORS OMEPRAZOLE AND LANSOPRAZOLE, OR (B) MEDICAL CONTRAINDICATIONS TO ORAL PROTON PUMP INHIBITORS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

PARICALCITOL

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

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 15 MG/3 ML SOLUTION, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL 20 MG/4 ML SOLUTION, 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, AZATHIOPRINE SODIUM, BCG (TICE STRAIN), BCG VACCINE (TICE STRAIN), BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, CROMOLYN 20 MG/2 ML NEB SOLN, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, DEXAMETHASONE 0.5 MG TABLET, DEXAMETHASONE 0.5 MG/5 ML ELX, DEXAMETHASONE 0.5 MG/5 ML LIQ, DEXAMETHASONE 0.75 MG TABLET, DEXAMETHASONE 1 MG TABLET, DEXAMETHASONE 1.5 MG TABLET, DEXAMETHASONE 2 MG TABLET, DEXAMETHASONE 4 MG TABLET, DEXAMETHASONE 6 MG TABLET, DEXAMETHASONE 120 MG/30 ML VL, DEXAMETHASONE 20 MG/5 ML VIAL, DEXAMETHASONE 4 MG/ML SYRINGE, DEXAMETHASONE 4 MG/ML VIAL, DRONABINOL, EMEND 125 MG POWDER PACKET, ENGERIX-B ADULT, ENGERIX-B PEDIATRIC-ADOLESCENT, GANCICLOVIR SODIUM, 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 2.5 MG TABLET, METHOTREXATE 250 MG/10 ML VIAL, METHOTREXATE 50 MG/2 ML VIAL, METHOTREXATE SODIUM, METHYLPREDNISOLONE 16 MG TAB, METHYLPREDNISOLONE 32 MG TAB, METHYLPREDNISOLONE 4 MG TABLET, METHYLPREDNISOLONE 8 MG TAB, METHYLPREDNISOLON AC 160MG/2ML, METHYLPREDNISOLONE 40 MG/ML VL, METHYLPREDNISOLONE 80 MG/ML VL, METHYLPREDNISOLONE AC 80MG/2ML, METHYLPREDNISOLONE SS 1 GM VL, METHYLPREDNISOLONE SS 40 MG VL, MILLIPRED 5 MG TABLET, MYCOPHENOLATE MOFETIL, NEBUPENT, NULOJIX, 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, PROGRAF 0.2 MG GRANULE PACKET, PROGRAF 1 MG GRANULE PACKET, PROGRAF 5 MG/ML AMPULE, RABAVERT, RAPAMUNE 1 MG/ML ORAL SOLN, RECOMBIVAX HB, SIMULECT, SIROLIMUS, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 1 MG CAPSULE, TACROLIMUS 5 MG CAPSULE, TRIMETHOBENZAMIDE HCL

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, PEGASYS PROCLICK

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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.

PENDING CMS APPROVAL

MEDICATION(S)
REVCOVI, SPRAVATO, VYNDAMAX

COVERED USES
Pending CMS Approval

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PENICILLAMINE

MEDICATION(S)
D-PENAMINE, DEPEN

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR CYSTINURIA: DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO THIOLA. RENEWAL CRITERIA: DOCUMENTATION OF POSITIVE RESPONSE TO THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PROVIDERS SPECIALIZING IN GENETICS AND METABOLISM, GASTROENTEROLOGY, HEPATOLOGY, 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.

PHENOXYBENZAMINE

MEDICATION(S)
PHENOXYBENZAMINE HCL

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

PRADAXA

MEDICATION(S)
PRADAXA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 XARELTO AND ELIQUIS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

PROCARBAZINE

MEDICATION(S)
MATULANE

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) USE IN COMBINATION WITH OTHER ANTICANCER DRUGS FOR THE TREATMENT OF STAGE III AND IV HODGKIN'S DISEASE, OR (2) DIAGNOSIS OF A MEDICALLY-ACCEPTED INDICATION. RENEWAL: 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
DOSE UP TO THE RECOMMENDED MAX OF 6 MG/KG/DAY FOR ADULTS OR 100 MG PER SQUARE METER PER DAY FOR PEDIATRICS.

PROMACTA

MEDICATION(S)
PROMACTA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 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 - NON-ORAL

MEDICATION(S)
EPOPROSTENOL SODIUM, REMODULIN, SILDENAFIL 10 MG/12.5 ML VIAL, TREPROSTINIL, TYVASO, VELETRI, VENTAVIS

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF VASOREACTIVE PULMONARY ARTERIAL HYPERTENSION (PAH) AS CONFIRMED BY PRETREATMENT RIGHT HEART CATHETERIZATION AND TRIAL AND FAILURE OF CALCIUM CHANNEL BLOCKER THERAPY, OR (2) DIAGNOSIS OF NON-VASOREACTIVE PAH AS CONFIRMED BY PRETREATMENT RIGHT HEART CATHETERIZATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PULMONOLOGY OR CARDIOLOGY.

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

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.

PULMONARY ARTERIAL HYPERTENSION - ORAL PREFERRED

MEDICATION(S)
ADEMPAS, AMBRISENTAN, BOSENTAN, LETAIRIS, OPSUMIT, TRACLEER, UPTRAVI

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 VASOREACTIVE PULMONARY ARTERIAL HYPERTENSION (PAH) ONLY, CONFIRMED BY PRETREATMENT RIGHT HEART CATHETERIZATION AND TRIAL AND FAILURE OF CALCIUM CHANNEL BLOCKER THERAPY, AND (3) FOR NON-VASOREACTIVE PAH ONLY, CONFIRMED BY PRETREATMENT RIGHT HEART CATHETERIZATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PULMONOLOGY OR CARDIOLOGY.

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.

RASUVO

MEDICATION(S)
RASUVO

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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
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.

REMICADE

MEDICATION(S)
REMICADE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF ANKYLOSING SPONDYLITIS, RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, PLAQUE PSORIASIS, CROHNS DISEASE OR ULCERATIVE COLITIS, AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND/OR FUNCTIONAL ASSESSMENT AND TREATMENT GOALS, AND (3) CONCURRENT USE WITH METHOTREXATE (FOR RHEUMATOLOGY INDICATIONS ONLY), AND (4) MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE TO: (A) ENBREL AND HUMIRA (FOR RHEUMATOLOGY AND DERMATOLOGICAL INDICATIONS), OR (B) HUMIRA (FOR GASTROENTEROLOGY INDICATIONS OTHER THAN FISTULIZING CROHNS DISEASE). 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: CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

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.

REPATHA

MEDICATION(S)
REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF (A) HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA CONFIRMED WITH A BASELINE LDL-C greater than 190 MG/DL, OR (B) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE AS DEFINED BY THE 2013 ACC/AHA GUIDELINE ON THE TREATMENT OF BLOOD CHOLESTEROL TO REDUCE ARTEROSCLEROTIC CARDIOVASCULAR RISK IN ADULTS, OR (C) HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA, AND (2) DOCUMENTATION OF (A) INABILITY TO ACHIEVE AND MAINTAIN LDL LEVEL LESS THAN OR EQUAL TO 70 MG/DL WITH STANDARD THERAPY (DEFINED AS A HIGH INTENSITY STATIN SUCH AS ATORVASTATIN 40-80MG DAILY), OR (B) INTOLERANCE (DEFINED AS INTOLERABLE MYALGIA OR MYOPATHY, OR ALT GREATER THAN OR EQUAL TO 3 TIMES ULN) TO STATIN THERAPY PROVEN WITH TWO TRIALS, OR (C) CONTRAINDICATIONS (DEFINED AS MYOSITIS WITH CREATINE KINASE LEVEL GREATER THAN OR EQUAL TO 10 TIMES ULN OR RHABDOMYOLYSIS) TO STANDARD THERAPY, AND (3) DOCUMENTATION OF CURRENT CHOLESTEROL LAB VALUES AND CHOLESTEROL TREATMENT HISTORY. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY, OR THAT SIGNIFICANT PROGRESS TOWARD ACHIEVEMENT OF TREATMENT GOALS HAS OCCURRED.

AGE RESTRICTION
N/A

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

RITUXAN

MEDICATION(S)
RITUXAN

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D, DIAGNOSIS AUTOIMMUNE HEMOLYTIC ANEMIA, AND DIAGNOSIS OF IDIOPATHIC THROMBOCYTOPENIC PURPURA.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
RHEUMATOLOGY: (1) DIAGNOSIS OF AN FDA-APPROVED RHEUMATOLOGY DISORDER, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR FAILURE WITH ENBREL AND HUMIRA. HEMATOLOGY: (1) DIAGNOSIS OF IDIOPATHIC THROMBOCYTOPENIC PURPURA OR AUTOIMMUNE HEMOLYTIC ANEMIA AND (2) PATIENTS WITH INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATIONS TO CORTICOSTEROIDS .

AGE RESTRICTION
N/A

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

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

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.

SABRIL

MEDICATION(S)
SABRIL 500 MG TABLET, VIGABATRIN, VIGADRONE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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) DOCUMENTED FAILURE ON TWO OTHER FORMULARY SEIZURE MEDICATIONS SUCH AS CARBAMAZEPINE, DIVALPROEX, LEVETIRACETAM, GABAPENTIN, TOPIRAMATE, AND OTHERS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGIST

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.

SEROSTIM

MEDICATION(S)
SEROSTIM

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

SIGNIFOR

MEDICATION(S)
SIGNIFOR

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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)

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF VASOREACTIVE PULMONARY ARTERIAL HYPERTENSION (PAH) AS CONFIRMED BY PRETREATMENT RIGHT HEART CATHETERIZATION AND TRIAL AND FAILURE OF CALCIUM CHANNEL BLOCKER THERAPY, OR (2) DIAGNOSIS OF NON-VASOREACTIVE PAH AS CONFIRMED BY PRETREATMENT RIGHT HEART CATHETERIZATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PULMONOLOGY OR CARDIOLOGY.

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. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

SILIQ

MEDICATION(S)
SILIQ

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
PLAQUE PSORIASIS INITIAL CRITERIA: (1) DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS (AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS), AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND TREATMENT GOALS, AND (3) MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH COSENTYX AND TALTZ. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY DERMATOLOGY

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.

SIMPONI

MEDICATION(S)
SIMPONI

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND/OR FUNCTIONAL ASSESSMENT AND TREATMENT GOALS, AND (3) FOR RHEUMATOLOGY: MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH ENBREL AND HUMIRA, OR FOR GASTROENTEROLOGY: DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO HUMIRA. 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
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.

SKYRIZI

MEDICATION(S)
SKYRIZI, SKYRIZI (2 SYRINGES) KIT

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS WITH AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, SCALP, AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS, WITH DOCUMENTATION OF CONTRAINDICATIONS, INTOLERANCE OR FAILURE TO 2 OF THE FOLLOWING: TOPICAL CORTICOSTEROID THERAPY, PHOTOTHERAPY, METHOTREXATE, CYCLOSPORINE, OR ACITRETIN. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
ADULTS (18 YEARS AND OLDER)

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY A DERMATOLOGY 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.

SOMATROPIN

MEDICATION(S)
NORDITROPIN FLEXPRO

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CRITERIA FOR CHILDREN: EITHER 1 OR 2 OR 3: (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 MG/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) PANHYPOPITUITARISM, (3) DIAGNOSIS OF 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 5NG/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
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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
PLAQUE PSORIASIS INITIAL CRITERIA: (1) (A) DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS (AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP, AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS), OR (B) PSORIATIC ARTHRITIS, AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND TREATMENT GOALS, AND (3) MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH COSENTYX. MODERATELY TO SEVERELY ACTIVE CROHNS DISEASE INITIAL: (1) DOCUMENTATED CONTRAINDICATION, INTOLERANCE TO, OR FAILURE ON 1 OF THE FOLLOWING: PREDNISONE OR A CORTICOSTEROID EQUIVALENT FOR 2 WEEKS, OR AN IMMUNOMODULATORY MED FOR 3 OR MORE MOS, AND (2) MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE TO HUMIRA. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY, OR THAT SIGNIFICANT PROGRESS TOWARD ACHIEVEMENT OF TREATMENT GOALS HAS OCCURRED.

AGE RESTRICTION
N/A

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

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.

SUBLINGUAL IMMUNOTHERAPY

MEDICATION(S)
GRASTEK, RAGWITEK

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 OF SUBCUTANEOUS IMMUNOTHERAPY.

AGE RESTRICTION
LIMITED TO THOSE AGES SPECIFIED WITHIN THE FDA-APPROVED LABEL

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

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

OTHER CRITERIA
N/A

SYNRIBO

MEDICATION(S)
SYNRIBO

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

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

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

TADALAFIL

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) (A) DIAGNOSIS OF VASOREACTIVE PULMONARY ARTERIAL HYPERTENSION (PAH) AS CONFIRMED BY PRETREATMENT RIGHT HEART CATHETERIZATION AND TRIAL AND FAILURE OF CALCIUM CHANNEL BLOCKER THERAPY, OR (B) DIAGNOSIS OF NON-VASOREACTIVE PAH AS CONFIRMED BY PRETREATMENT RIGHT HEART CATHETERIZATION, AND (2) TRIAL AND FAILURE OF SILDENAFIL ORAL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PULMONOLOGY OR CARDIOLOGY.

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.

TALTZ

MEDICATION(S)
TALTZ AUTOINJECTOR, TALTZ AUTOINJECTOR (2 PACK), TALTZ AUTOINJECTOR (3 PACK), TALTZ SYRINGE, TALTZ SYRINGE (2 PACK), TALTZ SYRINGE (3 PACK)

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF: (A) MODERATE TO SEVERE PLAQUE PSORIASIS (AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS), OR (B) PSORIATIC ARTHRITIS, AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND TREATMENT GOALS, AND (3) MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH COSENTYX. 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
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.

THALASSEMIA AGENTS

MEDICATION(S)
DEFERASIROX, DEFERASIROX 360 MG TAB, DEFERASIROX 90 MG TAB, EXJADE, FERRIPROX, JADENU, JADENU SPRINKLE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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
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.

THIOLA

MEDICATION(S)
THIOLA, THIOLA EC

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 NEPHROLOGY.

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.

TREMFYA

MEDICATION(S)
TREMFYA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
PLAQUE PSORIASIS INITIAL CRITERIA: (1) DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS (AT LEAST 5% BODY SURFACE AREA, OR PRESENTATION IN PALMAR, PLANTAR, FACIAL, SCALP AND/OR GENITAL REGIONS, OR PUSTULAR PSORIASIS), AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND TREATMENT GOALS, AND (3) MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH COSENTYX. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY DERMATOLOGY

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.

TRICYCLIC ANTIDEPRESSANTS IN ELDERLY

MEDICATION(S)
AMITRIPTYLINE HCL, DOXEPIN 10 MG CAPSULE, DOXEPIN 10 MG/ML ORAL CONC, DOXEPIN 100 MG CAPSULE, DOXEPIN 150 MG CAPSULE, DOXEPIN 25 MG CAPSULE, DOXEPIN 50 MG CAPSULE, DOXEPIN 75 MG CAPSULE, IMIPRAMINE HCL, TRIMIPRAMINE MALEATE

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: DIAGNOSIS OF A MEDICALLY ACCEPTED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND DOCUMENTATION THAT THE PATIENT IS MONITORED FOR ADVERSE DRUG EVENTS.

AGE RESTRICTION
RESTRICTIONS APPLY TO PATIENTS GREATER THAN 64 YEARS OF AGE.

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

TRIENTINE

MEDICATION(S)
TRIENTINE HCL

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF WILSON'S DISEASE AND (2) DEMONSTRATED INTOLERANCE 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.

TYMLOS

MEDICATION(S)
TYMLOS

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF POSTMENOPAUSAL OSTEOPOROSIS AT HIGH RISK FOR FRACTURE DEFINED AS A HISTORY OF OSTEOPOROTIC FRACTURE OR MULTIPLE RISK FACTORS FOR FRACTURE, OR (2) POSTMENOPAUSAL OSTEOPOROSIS AND (A) INTOLERANCE TO, FAILURE WITH, OR CONTRAINDICATION TO BISPHOSPHONATE THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

TYSABRI

MEDICATION(S)
TYSABRI

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 NEUROLOGY: DOCUMENTED FAILURE WITH ONE PREFERRED AGENT, SUCH AS AUBAGIO, AVONEX, GLATIRAMER 40MG, EXTAVIA, GILENYA, GLATOPA 20MG, GLATIRAMER 20MG, PLEGRIDY, REBIF, OR TECFIDERA, OR FOR GASTROENTEROLOGY: DOCUMENTATION OF AN INADEQUATE RESPONSE TO CONVENTIONAL THERAPY, SUCH AS MERCAPTOPURINE, AZATHIOPRINE OR METHOTREXATE, OR WITH MEDICAL NECESSITY FOR EARLIER USE OF TYSABRI.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGY AND GASTROENTEROLOGY

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.

VALCHLOR

MEDICATION(S)
VALCHLOR

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: (1) FOR THE TOPICAL TREATMENT OF STAGE 1A OR 1B MYCOSIS FUNGOIDES-TYPE CUTANEOUS T-CELL LYMPHOMA IN PATIENTS WHO HAVE RECEIVED PRIOR SKIN-DIRECTED THERAPY. RENEWAL CRITERIA: 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
APPROVALS ARE LIMITED TO A QUANTITY OF TWO 60 GRAM TUBES PER MONTH.

VIEKIRA

MEDICATION(S)
TECHNIVIE, VIEKIRA PAK, VIEKIRA XR

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, (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, AND (3) DOCUMENTED CLINICAL INAPPROPRIATENESS OF OR INABILITY TO TOLERATE HARVONI, EPCLUSA, OR MAVYRET.

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
DURATION PER GENOTYPE AND DIAGNOSIS. 12-24 WEEKS PER FDA APPROVED LABELING OR CLINICAL GUIDELINES.

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

VIRAZOLE

MEDICATION(S)
RIBAVIRIN 6 GM INHALATION VIAL

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, OR (2) FOR TREATMENT OF RESPIRATORY SYNCYTIAL VIRUS INFECTION FOLLOWING STEM CELL TRANSPLANT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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.

VORAXAPAR

MEDICATION(S)
ZONTIVITY

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 CONCOMITANT ASPIRIN AND CLOPIDOGREL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

VOSEVI

MEDICATION(S)
VOSEVI

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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.

VYNDAQEL

MEDICATION(S)
VYNDAQEL

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PRESCRIBED FOR PATIENTS WITH FDA-APPROVED INDICATIONS, AND (2) PATIENT IS DIAGNOSED WITH NYHA CLASS I, II OR III AT BASELINE (IN THE PREVIOUS 6 MONTHS), AND (3) 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 (4) PATIENT IS NEGATIVE FOR LIGHT CHAIN AMYLOIDOSIS, AND (5) NO PRIOR LIVER OR HEART TRANSPLANT, OR IMPLANTED CARDIAC MECHANICAL ASSIST DEVICE, AND (6) CARDIAC INVOLVEMENT BY ECHOCARDIOGRAPHY, WITH AN END DIASTOLIC INTERVENTRICULAR SEPTAL WALL THICKNESS GREATER THAN 12 MM. RENEWAL CRITERIA: MEDICATION HAS DEMONSTRATED EFFICACY BY MAINTAINING NYHA CLASS I-III.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

PRESCRIBER RESTRICTION
N/A

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.

XATMEP

MEDICATION(S)
XATMEP

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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 METHOTREXATE TABLETS OR INJECTION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

REQUIRED MEDICAL INFORMATION
INITIAL CRTIERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND/OR FUNCTIONAL ASSESSMENT AND TREATMENT GOALS, AND (3) FOR RHEUMATOID ARTHRITIS AND PSORIATIC ARTHRITIS: MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH ENBREL AND HUMIRA, OR FOR ULCERATIVE COLITIS: DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO HUMIRA. 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
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.

XENAZINE

MEDICATION(S)
TETRABENAZINE

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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.

XERMELO

MEDICATION(S)
XERMELO

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) FOR PREVENTION OF SKELETAL-RELATED EVENTS IN PATIENTS WITH BONE METASTESES FROM SOLID TUMORS WITH INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO ZOLEDRONIC ACID, 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
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

OTHER CRITERIA
N/A

XIFAXAN

MEDICATION(S)
XIFAXAN

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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

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

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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: SYMPTOMS FOR LONGER THAN 6 MONTHS, AND 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).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
FOR CHRONIC URTICARIA: RESERVED FOR PRESCRIBING BY AN ALLERGIST, IMMUNOLOGIST, OR DERMATOLOGIST.

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.

XTANDI

MEDICATION(S)
XTANDI

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: (1) DIAGNOSIS OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER, AND (2) PRIOR TREATMENT WITH ABIRATERONE (ZYTIGA) WITH NEW DISEASE PROGRESSION OR IN CASES WHERE ABIRATERONE REGIMENS ARE CONTRAINDICATED OR NOT TOLERATED. RENEWAL CRITERIA: DOCUMENTATION OF NO DISEASE PROGRESSION AND NO NEW CHEMOTHERAPY REGIMENS. FAILURE IS DEFINED AS SYMPTOMS OF PROGRESSIVE DISEASE OR A SUSTAINED INCREASE IN PSA OF 25-30% OVER AT LEAST TWO MONTHS.

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.

ZALTRAP

MEDICATION(S)
ZALTRAP

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

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

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

ZYFLO

MEDICATION(S)
ZILEUTON ER

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

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

OTHER CRITERIA
N/A

ZYTIGA

MEDICATION(S)
ABIRATERONE ACETATE, ZYTIGA

COVERED USES
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

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 (1) DISEASE PROGRESSION HAS NOT OCCURRED, AND (2) NO OTHER CHEMOTHERAPY REGIMENS HAVE BEEN INITIATED. FAILURE IS DEFINED AS SYMPTOMS OF PROGRESSIVE DISEASE OR A SUSTAINED INCREASE IN PSA OF 25-30% OVER AT LEAST TWO MONTHS.

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.