2020 Medicare Part D
Prior Authorization Requirements

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ABILIFY MYCITE

MEDICATION(S)
ABILIFY MYCITE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: (1) PRESCRIBED FOR PATIENTS WITH 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 162 MG/0.9 ML SYRINGE, ACTEMRA ACTPEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (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 TWO PREFERRED PRODUCTS (PREFERRED PRODUCTS INCLUDE ENBREL, HUMIRA AND RINVOQ FOR RHEUMATOID ARTHRITIS, ENBREL AND HUMIRA FOR JUVENILE IDIOPATHIC ARTHRITIS). 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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 AUTOINJECTOR, AJOVY SYRINGE, EMGALITY PEN, EMGALITY 120 MG/ML SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR AIMOVIG, AJOVY, AND EMGALITY: (1) PATIENT HAS GREATER THAN OR EQUAL TO 4 MIGRAINE DAYS PER MONTH, AND (2) 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, OR FOR EMGALITY ONLY: (1) FOR PATIENTS DIAGNOSED WITH EPISODIC CLUSTER HEADACHES, THE PATIENT HAS A DOCUMENTED INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO AT LEAST TWO OTHER PROPHYLAXIS AGENTS (EX. VERAPAMIL, VALPROATE, LITHIUM OR TOPIRAMATE). 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% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 10 MG GEL PUMP, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT, 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTED TESTOSTERONE DEFICIENCY 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, FINTEPLA, FYCOMPA, RUFINAMIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGY.

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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)
CISPLATIN 50 MG VIAL, DARZALEX FASPRO, FULVESTRANT, KANJINTI, LUPRON DEPOT, LUPRON DEPOT (LUPANETA), LUPRON DEPOT-PED 11.25 MG 3MO, LUPRON DEPOT-PED 7.5 MG KIT, MVASI, POLIVY, TRELSTAR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

ANTIPARKINSON AGENTS

MEDICATION(S)
NEUPRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF 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)
CAPLYTA, FANAPT, PALIPERIDONE ER, REXULTI, SAPHRIS, SAPHRIS - 10 MG TAB SUBLINGUAL, SECUADO, VRAYLAR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

AUSTEDO

MEDICATION(S)
AUSTEDO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGY OR PSYCHIATRY.

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

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

BRIVIACT

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

CABLIVI

MEDICATION(S)
CABLIVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
LIMITED TO ADULTS AGE 18 YEARS AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY HEMATOLOGY/ONCOLOGY

COVERAGE DURATION

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.

CABOMETYX

MEDICATION(S)
CABOMETYX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: RENAL CELL CARCINOMA: (1) RENAL CELL CARCINOMA HAS RELAPSED OR IS STAGE IV, AND (2) PATIENT MEETS AT LEAST ONE OF THE FOLLOWING: (A) THIS MEDICATION IS BEING PRESCRIBED AS SECOND LINE TREATMENT FOR PATIENTS WITH CLEAR CELL HISTOLOGY WHO HAVE HAD DISEASE PROGRESSION ON A PRIOR THERAPY (SUCH AS SUTENT OR VOTRIENT), OR (B) THIS MEDICATION IS BEING PRESCRIBED AS FIRST LINE THERAPY FOR PATIENTS WITH CLEAR CELL HISTOLOGY AND POOR OR INTERMEDIATE RISK, OR (C) THIS MEDICATION IS BEING PRESCRIBED FOR PATIENTS WITH NON-CLEAR CELL HISTOLOGY. HEPATOCELLULAR CARCINOMA: PATIENT HAS BEEN PREVIOUSLY TREATED WITH NEXAVAR. 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.

CENEGERMIN

MEDICATION(S)
OXERVATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 2 YEARS AND OLDER.

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

COVERAGE DURATION
8 WKS PER FDA LABELING.

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

CIMZIA

MEDICATION(S)
CIMZIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (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 TWO PREFERRED PRODUCTS (PREFERRED PRODUCTS INCLUDE ENBREL HUMIRA AND RINVOQ FOR RHEUMATOID ARTHRITIS, ENBREL, HUMIRA, COSENTYX AND OTEZLA FOR PSORIATIC ARTHRITIS, ENBREL, HUMIRA, COSENTYX, OTEZLA AND SKYRIZI FOR PLAQUE PSORIASIS, AND ENBREL, HUMIRA AND COSENTYX FOR ANKYLOSING SPONDYLITIS), FOR CROHN'S DISEASE: DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO HUMIRA, OR FOR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: DIAGNOSIS OF NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS WITH SIGNS OF INFLAMMATION. 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.

CINRYZE

MEDICATION(S)
CINRYZE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

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

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

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

CLOMIPRAMINE

MEDICATION(S)
CLOMIPRAMINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

COSENTYX

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL: (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.

CROMOLYN

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

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

CYSTARAN

MEDICATION(S)
CYSTADROPS, CYSTARAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

DAKLINZA

MEDICATION(S)
DAKLINZA 30 MG TABLET, DAKLINZA 60 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, (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 ONE OF THE FOLLOWING: 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

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

DALIRESP

MEDICATION(S)
DALIRESP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE 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 200 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF CLOSTRIDIUM DIFFICILE INFECTION, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO TWO COURSES OF ORAL 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

DIHYDROERGOTAMINE

MEDICATION(S)
DIHYDROERGOTAMINE MESYLATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

DULERA

MEDICATION(S)
DULERA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE WITH ADVAIR, FLUTICASONE/SALMETEROL, WIXELA OR BREO, OR CONTRAINIDCATIONS TO THEIR 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

DUPIXENT

MEDICATION(S)
DUPIXENT PEN, DUPIXENT SYRINGE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ASTHMA -RESERVED FOR PRESCRIBING BY AN ALLERGIST OR PULMONOLOGIST. ATOPIC DERMATITIS-RESERVED FOR PRESCRIBING BY AN ALLERGIST, IMMUNOLOGIST, OR DERMATOLOGIST. CHRONIC RHINOSINUSITIS - RESERVED FOR PRESCRIBING BY AN ALLERGIST, PULMONOLOGIST OR OTOLARYNGOLOGIST.

COVERAGE DURATION

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.

EMGALITY

MEDICATION(S)
EMGALITY 100 MG/ML SYR(1 OF 3), EMGALITY 300 MG (100 MG X3SYR)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) 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, OR (4) FOR PATIENTS DIAGNOSED WITH EPISODIC CLUSTER HEADACHES, THE PATIENT HAS A DOCUMENTED INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO AT LEAST TWO OTHER PROPHYLAXIS AGENTS (EX. VERAPAMIL, VALPROATE, LITHIUM OR TOPIRAMATE). RENEWAL CRITERIA: DOCUMENTATION OF A POSITIVE RESPONSE.

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.

EMSAM

MEDICATION(S)
EMSAM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL: (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)
CERDELGA, CHOLBAM, ILARIS, NITISINONE, ORFADIN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
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)
SOFOSBUVIR-VELPATASVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 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 10,000 UNIT/ML VIAL, RETACRIT 2,000 UNIT/ML VIAL, RETACRIT 3,000 UNIT/ML VIAL, RETACRIT 4,000 UNIT/ML VIAL, RETACRIT 40,000 UNIT/ML VIAL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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, ARMODAFINIL, BENLYSTA 200 MG/ML AUTOINJECT, BENLYSTA 200 MG/ML SYRINGE, BERINERT, CASPOFUNGIN ACETATE, CAYSTON, COLISTIMETHATE, CORLANOR, CYCLOBENZAPRINE 10 MG TABLET, CYCLOBENZAPRINE 5 MG TABLET, CYCLOSERINE, DAPTOMYCIN, DEMSER, EPIDIOLEX, ERAXIS (WATER DILUENT), FIRAZYR, GLASSIA, HAEGARDA, HETLIOZ, ICATIBANT, INVEGA SUSTENNA, INVEGA TRINZA, KALBITOR, KORLYM, LUPRON DEPOT-PED 11.25 MG KIT, LUPRON DEPOT-PED 15 MG KIT, LUPRON DEPOT-PED 30 MG 3MO KIT, METYROSINE, MODAFINIL, MOVANTIK, MOZOBIL, NAYZILAM, NUPLAZID 10 MG TABLET, NUPLAZID 34 MG CAPSULE, OXANDROLONE, PERSERIS, PRETOMANID, PROLASTIN C, QUININE SULFATE, RANOLAZINE ER, RIFAMPIN IV 600 MG VIAL, RUCONEST, SIRTURO, SODIUM PHENYLBUTYRATE 500MG TB, SOMATULINE DEPOT, SOMAVERT, SYMPROIC, SYNAREL, TAKHZYRO, TARGRETIN 1% GEL, TOBI PODHALER, TOBRAMYCIN SULFATE, VALTOCO, VISTOGARD, XCOPRI, XYREM, ZEMAIRA, ZORBTIVE, ZULRESSO, ZYPREXA RELPREVV

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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, ASCENIV, BIVIGAM, CUTAQUIG, CUVITRU, EVEROLIMUS 0.25 MG TABLET, EVEROLIMUS 0.5 MG TABLET, EVEROLIMUS 0.75 MG TABLET, FLEBOGAMMA DIF, GAMASTAN, GAMASTAN S-D, GAMMAGARD LIQUID, GAMMAGARD S-D, GAMMAKED, GAMMAPLEX, GAMUNEX-C, HIZENTRA, HYQVIA, OCTAGAM, PANZYGA, PRIVIGEN, XEMBIFY, ZORTRESS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION OF FAILURE OR MEDICAL CONTRAINDICATIONS WITH ENOXAPARIN.

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

FULYZAQ

MEDICATION(S)
MYTESI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

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

GATTEX

MEDICATION(S)
GATTEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) TREATMENT OF 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 33.75-150 MG PELLET PK, HARVONI 45-200 MG PELLET PACKT, HARVONI 45-200 MG TABLET, LEDIPASVIR-SOFOSBUVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY CARDIOLOGY 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL: (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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY PULMONOLOGY

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
MAY NOT USE INBRIJA CONCURRENTLY WITH APOMORPHINE.

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

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

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

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

INFECTIOUS DISEASE SELECT AGENTS

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGY OR PSYCHIATRY.

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

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

ISTURISA

MEDICATION(S)
ISTURISA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

ITRACONAZOLE

MEDICATION(S)
ITRACONAZOLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR 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

JADENU

MEDICATION(S)
JADENU, JADENU SPRINKLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
RESERVED FOR PATIENTS WHO HAVE TRIED AND FAILED OR WHO HAVE CONTRAINDICATIONS TO GENERIC DEFERASIROX.

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.

KALYDECO

MEDICATION(S)
KALYDECO, ORKAMBI, SYMDEKO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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 OLUMIANT, ORENCIA OR 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (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 TWO PREFERRED PRODUCTS (PREFERRED PRODUCTS INCLUDE ENBREL, HUMIRA AND RINVOQ). RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY, 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR DIAGNOSIS OF POSTHERPETIC NEURALGIA, 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.

LORBRENA

MEDICATION(S)
LORBRENA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF DISEASE PROGRESSION AFTER TREATMENT WITH ONE OF THE FOLLOWING REGIMENS: (A) XALKORI AND AN ADDITIONAL ALK INHIBITOR (SUCH AS ALECENSA), OR (B) FIRST LINE TREATMENT WITH ALECENSA, ALUNBRIG, OR ZYKADIA. 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.

LOTRONEX

MEDICATION(S)
ALOSETRON HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

MAVENCLAD

MEDICATION(S)
MAVENCLAD

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PRESCRIBED FOR PATIENTS WITH FDA-APPROVED INDICATIONS, AND (2) PATIENT HAS NOT ACHIEVED SUSTAINED REMISSION AFTER TREATMENT WITH AT LEAST TWO PRIOR DISEASE MODIFYING THERAPIES (EXAMPLE GILENYA, 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

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

MECASERMIN

MEDICATION(S)
INCRELEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY ENDOCRINOLOGY.

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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, SAPROPTERIN DIHYDROCHLORIDE, SUCRAID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

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

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

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

METHOXSALEN

MEDICATION(S)
METHOXSALEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY 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

MULTAQ

MEDICATION(S)
MULTAQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTED 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
LIMITED TO ADULTS AGE 18 YEARS AND OLDER.

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY ENDOCRINOLOGY.

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

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

NEBULIZED MEDICATIONS

MEDICATION(S)
PULMOZYME, TOBRAMYCIN 300 MG/5 ML AMPULE, TOBRAMYCIN PAK 300 MG/5 ML

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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.

NON-PREFERRED TOBRAMYCIN

MEDICATION(S)
BETHKIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

NOURIANZ

MEDICATION(S)
NOURIANZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

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

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

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

NUCALA

MEDICATION(S)
NUCALA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PRESCRIBED FOR PATIENTS WITH FDA-APPROVED INDICATIONS, AND (2) FOR PATIENTS DIAGNOSED WITH ASTHMA THEY HAVE A PRE-TREATMENT SERUM EOSINOPHIL COUNT OF 150 CELLS/MCL OR GREATER AT SCREENING (WITHIN THE PREVIOUS 6 WEEKS), AND (3) PATIENT HAS INADEQUATE ASTHMA CONTROL DESPITE USE OF ALL OF THE FOLLOWING STANDARD THERAPIES: (A) INHALED STEROIDS (SUCH AS FLOVENT), AND (B) LONG-ACTING BETA-AGONIST (SUCH AS SEREVENT), AND (C) ORAL STEROIDS, AND (4) INADEQUATE ASTHMA CONTROL DESPITE STANDARD THERAPIES IS DEFINED AS ONE OF THE FOLLOWING: (A) AT LEAST 2 EXACERBATIONS REQUIRING ORAL SYSTEMIC CORTICOSTEROIDS IN THE LAST 12 MONTHS, OR (B) AT LEAST 1 EXACERBATION TREATED IN A HOSPITAL OR REQUIRING MECHANICAL VENTILATION IN THE LAST 12 MONTHS. RENEWAL CRITERIA: (1) PATIENT HAS NOT EXPERIENCED UNACCEPTABLE TOXICITY FROM THE DRUG SUCH AS PARASITIC (HELMINTH) INFECTION OR HERPES ZOSTER INFECTION, AND (2) PATIENT HAS A CLINICALLY MEANINGFUL RESPONSE TO THE MEDICATION AS DEFINED: (A) DECREASED FREQUENCY OF EXACERBATIONS DEFINED AS: (I) IMPROVEMENT OF ASTHMA CONTROL, DEMONSTRATED BY DECREASED USE OF ORAL OR SYSTEMIC CORTICOSTEROIDS, OR (II) LESS FREQUENT HOSPITALIZATIONS, OR (III) REDUCED FREQUENCY OF EMERGENCY DEPARTMENT VISITS, OR (B) IMPROVEMENT IN LUNG FUNCTION MEASURED IN FEV1.

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 6 AND OLDER.

PRESCRIBER RESTRICTION

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

COVERAGE DURATION

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

OTHER CRITERIA

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

NUEDEXTA

MEDICATION(S)
NUEDEXTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

NURTEC ODT

MEDICATION(S)
NURTEC ODT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

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

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

OTHER CRITERIA
N/A

NUZYRA

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

OCALIVA

MEDICATION(S)
OCALIVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY.

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

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

OLUMIANT

MEDICATION(S)
OLUMIANT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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 TWO PREFERRED PRODUCTS (PREFERRED PRODUCTS INCLUDE ENBREL, HUMIRA AND RINVOQ). RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY

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.

ORAL DISSOLVE TABLETS PROTECTED CLASS

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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, AYVAKIT, BALVERSA, BOSULIF, BRAFTOVI, BRUKINSA, CALQUENCE, COMETRIQ, COPIKTRA, COTELLIC, DAURISMO, ERIVEDGE, ERLEADA, FARYDAK, GAVRETO, GILOTRIF, IBRANCE, ICLUSIG, IDHIFA, IMBRUVICA, INLYTA, INQOVI, INREBIC, IRESSA, JAKAFI, KISQALI, KISQALI FEMARA CO-PACK, KOSELUGO, LENVIMA, LONSURF, LYNPARZA, MATULANE, MEKINIST, MEKTOVI, NERLYNX, NINLARO, NUBEQA, ODOMZO, ONUREG, PEMAZYRE, PIQRAY, POMALYST, QINLOCK, RETEVMO, ROZLYTREK, RUBRACA, RYDAPT, STIVARGA, TABRECTA, TAFINLAR, TAGRISSO, TALZENNA, TAZVERIK, TIBSOVO, TUKYSA, TURALIO, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, XOSPATA, XPOVIO, YONSA, ZEJULA, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

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

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ORENCIA

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (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 TWO PREFERRED PRODUCTS (PREFERRED PRODUCTS INCLUDE ENBREL, HUMIRA AND RINVOQ FOR RHEUMATOID ARTHRITIS, ENBREL, HUMIRA, COSENTYX AND OTEZLA FOR PSORIATIC ARTHRITIS, ENBREL AND HUMIRA FOR JUVENILE IDIOPATHIC ARTHRITIS). 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
(1) (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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

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

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

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

OTEZLA

MEDICATION(S)
OTEZLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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. BEHCET DISEASE INITIAL CRITERIA: DIAGNOSIS OF ORAL ULCERS ASSOCIATED WITH BEHCET DISEASE. 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.

OXBRYTA

MEDICATION(S)
OXBRYTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 12 AND OLDER.

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

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

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

PARICALCITOL

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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 100 MG/20 ML SOLN, 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, 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 0.75 MG TABLET, DEXAMETHASONE 1 MG TABLET, DEXAMETHASONE 1.5 MG TABLET, DEXAMETHASONE 2 MG TABLET, DEXAMETHASONE 4 MG TABLET, DEXAMETHASONE 6 MG TABLET, DRONABINOL, EMEND 125 MG POWDER PACKET, ENGERIX-B ADULT, ENGERIX-B PEDIATRIC-ADOLESCENT, 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, MILLIPRED, MYCOPHENOLATE 200 MG/ML SUSP, MYCOPHENOLATE 250 MG CAPSULE, MYCOPHENOLATE 500 MG TABLET, NEBUPENT, 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, RABAVERT, RECOMBIVAX HB, SIROLIMUS, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 1 MG CAPSULE, TACROLIMUS 5 MG CAPSULE, TOBRAMYCIN 300 MG/4 ML AMPULE, 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 180 MCG/0.5

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

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

PEGINTRON

MEDICATION(S)
PEGINTRON

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

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

PENICILLAMINE

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR 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, RHEUMATOLOGY 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

PRADAXA

MEDICATION(S)
PRADAXA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

PROMACTA

MEDICATION(S)
PROMACTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

OTHER CRITERIA
N/A

PULMONARY ARTERIAL HYPERTENSION - NON-ORAL

MEDICATION(S)
VENTAVIS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF 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 32 MG TABLET FOR SUSP, TYVASO, UPTRAVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF (A) 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.

REVCOVI

MEDICATION(S)
REVCOVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) DIAGNOSIS OF SEVERE COMBINED IMMUNODEFICIENCY DISEASE (SCID), AND (2) PATIENT HAS DEFICIENCY OF ADENOSINE DEAMINASE (ADA) CONFIRMED BY ONE OF THE FOLLOWING: (A) DECREASE IN ADENOSINE TRIPHOSPHATE (ATP) CONCENTRATION IN ERYTHROCYTES, OR, (B) ELEVATED ERYTHROCYTE DEOXYADENOSINE TRIPHOSPHATE LEVELS (GREATER THAN OR EQUAL TO 50 TIMES THE UPPER LIMIT OF NORMAL) OR, (C) MUTATION IN BOTH ALLELES OF THE ADA1 GENE, OR, (D) DEFICIENCY OR ABSENCE OF ADA IN FIBROBLASTS, ERYTHROCYTES OR PLASMA, OR, (E) POSITIVE SCREENING FOR T CELL RECEPTOR EXCISION CIRCLES (TRECS), AND (3) PATIENT IS NOT A CANDIDATE OR HAS FAILED A PRIOR HEMATOPOIETIC STEM CELL TRANSPLANT. RENEWAL CRITERIA: (1) ANNUAL REAUTHORIZATIONS WILL REQUIRE MEDICAL CHART DOCUMENTATION THAT THE PATIENT HAS BEEN SEEN WITHIN THE PAST 12 MONTHS, AND (2) PROVIDER ATTESTS PATIENT IS UNABLE TO RECEIVE OR HAS FAILED A PRIOR HEMATOPOIETIC STEM CELL TRANSPLANT.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
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.

REYVOW

MEDICATION(S)
REYVOW

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

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

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

OTHER CRITERIA
N/A

RINVOQ ER

MEDICATION(S)
RINVOQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (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 CONTRAINDICATION/INTOLERANCE TO/FAILURE (C/I/F) W/CONCURRENT USE OF 2 OF THE FOLLOWING FOR 3 MOS: METHOTREXATE, HYDROXYCHLOROQUINE, LEFLUNOMIDE, OR SULFASALAZINE. 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
N/A

SABRIL

MEDICATION(S)
VIGABATRIN, VIGADRONE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

SIGNIFOR

MEDICATION(S)
SIGNIFOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

SILDENAFIL

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
(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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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 TWO PREFERRED PRODUCTS (PREFERRED PRODUCTS INCLUDE ENBREL, HUMIRA, COSENTYX, OTEZLA AND SKYRIZI). 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (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 TWO PREFERRED PRODUCTS (PREFERRED PRODUCTS INCLUDE ENBREL, HUMIRA AND RINVOQ FOR RHEUMATOID ARTHRITIS, ENBREL, HUMIRA, COSENTYX AND OTEZLA FOR PSORIATIC ARTHRITIS, AND ENBREL, HUMIRA AND COSENTYX FOR ANKYLOSING SPONDYLITIS), 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CRITERIA FOR CHILDREN: EITHER 1 OR 2 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.

SPRAVATO

MEDICATION(S)
SPRAVATO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY A BEHAVIORAL HEALTH PROVIDER

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

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

STELARA

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
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 ENBREL, HUMIRA, COSENTYX OR OTEZLA FOR PSORIATIC ARTHRITIS, ENBREL, HUMIRA, COSENTYX, OTEZLA OR SKYRIZI FOR PLAQUE PSORIASIS. MODERATELY TO SEVERELY ACTIVE CROHNS DISEASE INITIAL: (1) DOCUMENTED 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 OR CIMZIA. MODERATE TO SEVERELY ACTIVE ULCERATIVE COLITIS INITIAL CRITERIA: (1) DOCUMENTED CONTRAINDICATION, INTOLERANCE TO, OR FAILURE ON 2 OF THE FOLLOWING FOR 3 MONTHS: SULFASALAZINE, MESALAMINE, BALSALAZIDE, PREDNISONE, BUDESONIDE, AZATHIOPRINE, 6-MERCAPTOPURINE, 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.

SUNOSI

MEDICATION(S)
SUNOSI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR DIAGNOSIS OF NARCOLEPSY - DOCUMENTATION OF TRIAL AND FAILURE OR CONTRAINDICATION TO MODAFINIL OR ARMODAFINIL. FOR DIAGNOSIS OF OBSTRUCTIVE SLEEP APNEA: (1) DOCUMENTATION OF TRIAL AND FAILURE OR CONTRAINDICATION TO MODAFINIL OR ARMODAFINIL, AND (2) DOCUMENTATION OF TRIAL AND FAILURE OR CONTRAINDICATION TO CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP).

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

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

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: 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, TADALAFIL 20 MG TABLET (GENERIC FOR ADCIRCA)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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.

TALICIA

MEDICATION(S)
TALICIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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, DEFERIPRONE, FERRIPROX, FERRIPROX (2 TIMES A DAY)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY HEMATOLOGY AND ONCOLOGY.

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY UROLOGY OR NEPHROLOGY.

COVERAGE DURATION
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.

TRIENTINE

MEDICATION(S)
TRIENTINE HCL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

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

TRIKAFTA

MEDICATION(S)
TRIKAFTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 12 AND OLDER.

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

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.

TYMLOS

MEDICATION(S)
TYMLOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF 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

VALCHLOR

MEDICATION(S)
VALCHLOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: (1) 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.

VASCEPA

MEDICATION(S)
ICOSAPENT ETHYL, VASCEPA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) PATIENTS WITH CARDIOVASCULAR DISEASE OR WITH DIABETES AND OTHER RISK FACTORS, AND (2) CURRENTLY RECEIVING A HIGH INTENSITY STATIN (ATORVASTATIN 40-80 MG DAILY OR ROSUVASTATIN 20-40 MG DAILY), AND (3) A FASTING TRIGLYCERIDE LEVEL BETWEEN 150 TO 499 MG/DL. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION WITH A REDUCTION IN TRIGLYCERIDES.

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.

VIEKIRA

MEDICATION(S)
VIEKIRA PAK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, (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 ONE OF THE FOLLOWING: 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

VOSEVI

MEDICATION(S)
VOSEVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

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

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

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

VYNDAMAX

MEDICATION(S)
VYNDAMAX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) 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. RENEWAL CRITERIA: (1) PATIENT HAS BEEN SEEN BY THEIR PRESCRIBER IN THE PAST 12 MONTHS, AND (2) 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.

VYNDAQEL

MEDICATION(S)
VYNDAQEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: (1) 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.

XALKORI

MEDICATION(S)
XALKORI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF CONFIRMATION OF ONE OF THE FOLLOWING TUMOR MUTATIONS: (A) ROS-1 REARRANGEMENT POSITIVE, OR (2) HIGH LEVEL MET AMPLIFICATION OR MET EXON 14 SKIPPING MUTATION. 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.

XATMEP

MEDICATION(S)
XATMEP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR NEW START PATIENTS: (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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL 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 TWO PREFERRED PRODUCTS WITH TWO PREFERRED PRODUCTS (PREFERRED PRODUCTS INCLUDE ENBREL, HUMIRA AND RINVOQ FOR RHEUMATOID ARTHRITIS, ENBREL, HUMIRA, COSENTYX AND OTEZLA FOR PSORIATIC ARTHRITIS), 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY NEUROLOGY.

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

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

XENLETA

MEDICATION(S)
XENLETA 600 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY INFECTIOUS DISEASE SPECIALIST.

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

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

XERMELO

MEDICATION(S)
XERMELO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

XGEVA

MEDICATION(S)
XGEVA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

XIFAXAN

MEDICATION(S)
XIFAXAN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (1) FOR ASTHMA: DOCUMENTATION OF FAILURE WITH AT LEAST TWO OF THE FOLLOWING STANDARD THERAPIES: (A) REGULAR USE OF INHALED STEROIDS (SUCH AS FLOVENT), (B) REGULAR USE OF A LONG-ACTING BETA-AGONIST (SUCH AS SEREVENT), (C) REGULAR USE OR A TRIAL OF A LEUKOTRIENE ANTAGONIST (SUCH AS MONTELUKAST), AND (D) REGULAR OR PERIODIC USE OF ORAL STEROIDS (SUCH AS PREDNISONE), OR (2) FOR CHRONIC URTICARIA: 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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: (1) DIAGNOSIS OF 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.

ZYFLO

MEDICATION(S)
ZILEUTON ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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 500 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA FOR NEW START PATIENTS: 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.