HealthPartners
UnityPoint Health

2021 Medicare Part D
Prior Authorization Requirements

Effective: January 1st, 2021

Formulary ID 21403, Version 8
Last Updated: 10/05/2020

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.

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.

ANDROGEN THERAPY

MEDICATION(S)
TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 10 MG GEL PUMP, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 25 MG/2.5 GM PKT, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT, TESTOSTERON CYP 1,000 MG/10 ML, TESTOSTERON CYP 2,000 MG/10 ML, TESTOSTERONE CYP 1,000 MG/5 ML, TESTOSTERONE CYP 100 MG/ML, TESTOSTERONE CYP 200 MG/ML, TESTOSTERONE CYP 500 MG/2.5 ML, TESTOSTERONE CYP 500 MG/5 ML, TESTOSTERONE CYP 6,000 MG/30ML, TESTOSTERONE ENANTHATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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

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

ANTINEOPLASTIC INJECTABLES

MEDICATION(S)
DARZALEX FASPRO, FULVESTRANT, LUPRON DEPOT, LUPRON DEPOT (LUPANETA), LUPRON DEPOT-PED 11.25 MG 3MO, LUPRON DEPOT-PED 7.5 MG KIT, MVASI, POLIVY 140 MG VIAL, 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, 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.

CENEGERMIN

MEDICATION(S)
OXERVATE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 2 YEARS AND OLDER.

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

COVERAGE DURATION
8 WKS PER FDA LABELING.

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

CIMZIA

MEDICATION(S)
CIMZIA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF: (1) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ACTEMRA, OLUMIANT AND ORENCIA, OR (2) PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG ORENCIA, OR (3) PLAQUE PSORIASIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, COSENTYX, OTEZLA AND SKYRIZI, OR (4) ANKYLOSING SPONDYLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, AND COSENTYX, OR (5) CROHN'S DISEASE WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG HUMIRA, OR (6) 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.

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
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

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)
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

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

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.

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

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

COVERAGE DURATION

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 20 MG CAPSULE, ORFADIN 4 MG/ML SUSPENSION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
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.

ERYTHROPOIESIS STIMULATING AGENTS

MEDICATION(S)
ARANESP, RETACRIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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.

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, ALINIA 100 MG/5 ML SUSPENSION, AMIKACIN SULFATE, ANADROL-50, APOKYN, ARALAST NP, ARISTADA, ARISTADA INITIO, ARMODAFINIL, BENLYSTA 200 MG/ML AUTOINJECT, BENLYSTA 200 MG/ML SYRINGE, BERINERT, CALCIPOTRIENE 0.005% CREAM, CALCIPOTRIENE 0.005% OINTMENT, CALCIPOTRIENE 0.005% SOLUTION, CASPOFUNGIN ACETATE, CAYSTON, CHLOROQUINE PHOSPHATE, COLISTIMETHATE, COMFORT PAC-CYCLOBENZAPRINE, CORLANOR, CYCLOBENZAPRINE 10 MG TABLET, CYCLOBENZAPRINE 5 MG TABLET, CYCLOSERINE, CYCLOTENS, DEMSER, EPIDIOLEX, ERAXIS (WATER DILUENT), GLASSIA, HAEGARDA, 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, PENTAMIDINE 300 MG VIAL, PERSERIS, PRETOMANID, PROLASTIN C, QUININE SULFATE, RIFAMPIN IV 600 MG VIAL, RUCONEST, SIRTURO, SODIUM PHENYLBUTYRATE 500MG TB, SOMATULINE DEPOT, SOMAVERT, SYMPROIC, SYNAREL, TAKHZYRO, TOBI PODHALER, TOBRAMYCIN SULFATE, VALTOCO, VISTOGARD, XCOPRI, ZEMAIRA, ZORBTIVE, ZULRESSO, ZYPREXA RELPREVV

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

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)
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, DRONABINOL, FLEBOGAMMA DIF, GAMASTAN, GAMASTAN S-D, GAMMAGARD LIQUID, GAMMAGARD S-D, GAMMAKED 1 GRAM/10 ML VIAL, GAMMAKED 10 GRAM/100 ML VIAL, GAMMAKED 20 GRAM/200 ML VIAL, GAMMAKED 5 GRAM/50 ML VIAL, GAMMAPLEX, GAMUNEX-C, HIZENTRA, HYQVIA, OCTAGAM, PANZYGA, PRIVIGEN, XEMBIFY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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.

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.

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

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

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

COVERAGE DURATION

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, 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.

ITRACONAZOLE

MEDICATION(S)
ITRACONAZOLE 10 MG/ML SOLUTION

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

KALYDECO

MEDICATION(S)
KALYDECO, ORKAMBI, SYMDEKO

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: DIAGNOSIS OF RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ACTEMRA, OLUMIANT AND ORENCIA. 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.

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

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

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.

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 SUSTAINED INCREASE IN BLOOD PRESSURE WITHIN 3 MINUTES OF STANDING.

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.

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.

NUZYRA

MEDICATION(S)
NUZYRA 150 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

COVERAGE DURATION
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: DIAGNOSIS OF RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, AND RINVOQ. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY

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)

ABIRATERONE ACETATE, AFINITOR 10 MG TABLET, AFINITOR DISPERZ, ALECENSA, ALUNBRIG, AYVAKIT, BALVERSA, BOSULIF, BRAFTOVI, BRUKINSA, CABOMETYX, CALQUENCE, CAPRELSA, COMETRIQ, COPIKTRA, COTELLIC, DAURISMO, ERIVEDGE, ERLEADA, EVEROLIMUS 2.5 MG TABLET, EVEROLIMUS 5 MG TABLET, EVEROLIMUS 7.5 MG TABLET, FARYDAK, GAVRETO, GILOTRIF, IBRANCE, ICLUSIG, IDHIFA, IMBRUVICA 140 MG CAPSULE, IMBRUVICA 420 MG TABLET, IMBRUVICA 560 MG TABLET, IMBRUVICA 70 MG CAPSULE, INLYTA, INQOVI, INREBIC, IRESSA, JAKAFI, KISQALI, KISQALI FEMARA CO-PACK, KOSELUGO, LENVIMA, LONSURF, LORBRENA, LYNPARZA, MATULANE, MEKINIST, MEKTOVI, NERLYNX, NEXAVAR, NINLARO, NUBEQA, ODOMZO, ONUREG, PEMAZYRE, PIQRAY, POMALYST, QINLOCK, RETEVMO, ROZLYTREK, RUBRACA, RYDAPT, SPRYCEL, STIVARGA, SUTENT, SYNRIBO, TABRECTA, TAFINLAR, TAGRISSO, TALZENNA, TARGRETIN 1% GEL, TASIGNA, TAZVERIK, TIBSOVO, TUKYSA, TURALIO, TYKERB, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VOTRIENT, XALKORI, XOSPATA, XPOVIO, XTANDI, YONSA, ZEJULA, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA 150 MG TABLET, ZYTIGA 500 MG TABLET

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

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

REQUIRED MEDICAL INFORMATION

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

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

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

OTHER CRITERIA

LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.

ORENCIA

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY

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
MAY NOT USE OTEZLA CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY OR DERMATOLOGY.

COVERAGE DURATION
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.

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 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML VIAL, 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 10% IV SOLUTION, AMINOSYN II 15% IV SOLUTION, AMINOSYN-PF, APREPITANT, AZASAN, AZATHIOPRINE, BCG VACCINE (TICE STRAIN), BETHKIS, BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE MODIFIED, EMEND 125 MG POWDER PACKET, ENGERIX-B 20 MCG/ML SYRN, ENGERIX-B PEDIATRIC-ADOLESCENT, GENGRAF, GRANISETRON HCL 1 MG TABLET, 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, MYCOPHENOLATE 200 MG/ML SUSP, MYCOPHENOLATE 250 MG CAPSULE, MYCOPHENOLATE 500 MG TABLET, ONDANSETRON 4 MG/5 ML SOLUTION, ONDANSETRON HCL 24 MG TABLET, ONDANSETRON HCL 4 MG TABLET, ONDANSETRON HCL 8 MG TABLET, ONDANSETRON ODT, 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, PULMOZYME, RABAVERT, RECOMBIVAX HB 10 MCG/ML SYR, RECOMBIVAX HB 10 MCG/ML VIAL, RECOMBIVAX HB 40 MCG/ML VIAL, RECOMBIVAX HB 5 MCG/0.5 ML SYR, SIROLIMUS, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 1 MG CAPSULE, TACROLIMUS 5 MG CAPSULE, TOBRAMYCIN 300 MG/5 ML AMPULE, VENTAVIS, ZORTRESS 1 MG TABLET

DETAILS

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

PEGASYS

MEDICATION(S)
PEGASYS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

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

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

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

PEGINTRON

MEDICATION(S)
PEGINTRON

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PENDING CMS APPROVAL

MEDICATION(S)

ACTEMRA 162 MG/0.9 ML SYRINGE, ACTEMRA ACTPEN, AJOVY AUTOINJECTOR, AJOVY SYRINGE, CINRYZE, COSENTYX (2 SYRINGES), COSENTYX PEN, COSENTYX PEN (2 PENS), COSENTYX SYRINGE, D-PENAMINE, DRIZALMA SPRINKLE, DUPIXENT PEN, DUPIXENT SYRINGE, EMGALITY PEN, EMGALITY SYRINGE, FETZIMA, GATTEX, HARVONI 33.75-150 MG PELLET PK, HARVONI 45-200 MG PELLET PACKT, HARVONI 45-200 MG TABLET, HETLIOZ, ISTURISA, KINERET, LEDIPASVIR-SOFOSBUVIR, LIDOCAINE 5% PATCH, LIDOPURE PATCH, NUCALA, NURTEC ODT, OXBRYTA, PENICILLAMINE 250 MG TABLET, REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE, REYVOW, SOFOSBUVIR-VELPATASVIR, TADALAFIL 20 MG TABLET (GENERIC FOR ADCIRCA) , TALICIA, TRINTELLIX, VASCEPA, VIIBRYD, VYNDAMAX, VYNDAQEL, XYREM, ZILACAINE PATCH

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

N/A

OTHER CRITERIA

N/A

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 - ORAL PREFERRED

MEDICATION(S)
ADEMPAS, AMBRISENTAN, BOSENTAN, OPSUMIT, TRACLEER 32 MG TABLET FOR SUSP, 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.

REVCOVI

MEDICATION(S)
REVCOVI

PA INDICATION INDICATOR
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

RINVOQ

MEDICATION(S)
RINVOQ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
INITIAL CRITERIA: DIAGNOSIS OF RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE WITH CONCURRENT USE OF 2 OF THE FOLLOWING FOR 3 MONTHS: METHOTREXATE, HYDROXYCHLOROQUINE, LEFLUNOMIDE, OR SULFASALAZINE. 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.

SAVELLA

MEDICATION(S)
SAVELLA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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
INITIAL CRITERIA: DIAGNOSIS OF PLAQUE PSORIASIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, COSENTYX, OTEZLA AND SKYRIZI. 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: DIAGNOSIS OF: (1) ANKYLOSING SPONDYLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, AND COSENTYX, OR (2) PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, COSENTYX AND OTEZLA, OR (3) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO AT LEAST TWO PREFERRED DRUGS. PREFERRED DRUGS INCLUDE ENBREL, HUMIRA, AND RINVOQ, OR (4) ULCERATIVE COLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG 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
MAY NOT USE SKYRIZI CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
RESERVED FOR PRESCRIBING BY 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
N/A

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

STELARA

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

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

SUCRALFATE

MEDICATION(S)
SUCRALFATE 1 GM/10 ML SUSP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION THAT THE PATIENT HAS DIFFICULTY SWALLOWING.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 18 AND OLDER.

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

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

OTHER CRITERIA
N/A

THALASSEMIA AGENTS

MEDICATION(S)
DEFERASIROX, FERRIPROX, FERRIPROX (2 TIMES A DAY), JADENU 180 MG TABLET

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

REQUIRED MEDICAL INFORMATION
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 OR MEDICAL CONTRAINDICATION TO PENICILLAMINE. RENEWAL CRITERIA: DOCUMENTATION OF POSITIVE RESPONSE.

AGE RESTRICTION
N/A

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

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

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

TRIKAFTA

MEDICATION(S)
TRIKAFTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

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

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

AGE RESTRICTION
RESERVED FOR PATIENTS AGE 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.

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.

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.

XATMEP

MEDICATION(S)
XATMEP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

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

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
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 CRITERIA: DIAGNOSIS OF: (1) PSORIATIC ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG ORENCIA, OR (2) RHEUMATOID ARTHRITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO OLUMIANT AND AT LEAST ONE OTHER PREFERRED DRUG. PREFERRED DRUGS INCLUDE ACTEMRA AND ORENCIA, OR (3) ULCERATIVE COLITIS WITH DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO THE PREFERRED DRUG 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.

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