2017 PRIOR AUTHORIZATION CRITERIA

PMC Preferred Platino, PMC Max
Drugs
Acitretin Oral Cap 10 mg
Acitretin Oral Cap 25 mg
Acitretin Oral Cap 17.5 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Severely impaired liver or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracyclines. Pregnancy. Females of child-bearing potential who intend to become pregnant during therapy or at any time for at least 3 years after discontinuing therapy. Females of child-bearing potential who will not use reliable contraception while undergoing treatment and for at least 3 years following discontinuation. Females of child-bearing potential who drink alcohol during treatment or for two months after cessation of therapy.

Required Medical Information
Diagnosis of severe psoriasis

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
Drugs
Actimmune Subcutaneous Solution 2,000,000 unit/0.5ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
BSA, SCr, PLT, neutrophils, Hgb, LFT

Age Restriction
None

Prescriber Restriction
Chronic granulomatous disease: Immunologist.
Severe, Malignant Osteoporosis: Oncologist, Gynecologist, Rheumatologist, Orthopedist.

Coverage Duration
12 months

Other Criteria
None
Drugs
Adcirca Oral Tab 20 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
1. Use for erectile dysfunction.
2. Patients taking nitrates

Required Medical Information
1. Diagnosis 2. Diagnosis confirmed by right heart catheterization. For the FDA-approved indication of pulmonary arterial hypertension, patients currently on Adcirca may continue therapy if they have a diagnosis of PAH.

Age Restriction
18 years or older

Prescriber Restriction
Pneumologist, cardiologist

Coverage Duration
Initial – 6 months.
Renewal – 12 months

Other Criteria
None
ADEMPAS

Drugs
Adempas Oral Tab 0.5 mg
Adempas Oral Tab 1 mg
Adempas Oral Tab 1.5 mg
Adempas Oral Tab 2 mg
Adempas Oral Tab 2.5 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Pregnancy, concomitant use of nitrate, nitric oxide donor, or phosphodiesterase inhibitor

Required Medical Information
1. Diagnosis of: Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4) after surgical treatment or inoperable CTEPH to improve exercise capacity and WHO functional class OR Pulmonary Arterial Hypertension (PAH) (WHO Group 1) to improve exercise capacity, improve WHO functional class and to delay clinical worsening. 2. Diagnosis confirmed by right heart catheterization. 3. Pregnancy test in females of reproductive potential prior to initiation.

Age Restriction
18 years or older

Prescriber Restriction
Pulmonologist, cardiologist

Coverage Duration
12 months

Other Criteria
Participation in REMS Program for females.
ADHD/NARCOLEPSY

Drugs
Amphetamine-Dextroamphetamine Oral Tab. 5 mg
Amphetamine-Dextroamphetamine Oral Tab 7.5 mg
Amphetamine-Dextroamphetamine Oral Tab 10 mg
Amphetamine-Dextroamphetamine Oral Tab 12.5 mg
Amphetamine-Dextroamphetamine Oral Tab 15 mg
Amphetamine-Dextroamphetamine Oral Tab 20 mg
Amphetamine-Dextroamphetamine Oral Tab 30 mg
Amphetamine-Dextroamphetamine ER Oral Cap 5 mg
Amphetamine-Dextroamphetamine ER Oral Cap 10 mg
Amphetamine-Dextroamphetamine ER Oral Cap 15 mg
Amphetamine-Dextroamphetamine ER Oral Cap 20 mg
Amphetamine-Dextroamphetamine ER Oral Cap 25 mg
Amphetamine-Dextroamphetamine ER Oral Cap 30 mg
Dextroamphetamine Sulfate Oral Tab 5 mg
Dextroamphetamine Sulfate Oral Tab 10 mg

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

Exclusion Criteria
None

Required Medical Information
Narcolepsy: Submission of sleep study confirming the diagnosis of narcolepsy

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
Drugs
Advair Diskus 100 – 50 mcg
Advair Diskus 500 – 50 mcg
Advair HFA 41 – 21 mcg
Advair HFA 115 – 21 mcg
Advair HFA 230 – 21 mcg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Treatment associated with rhinovirus/cough associated with common cold, treatment of common cough associated with GERD, treatment of symptoms associated with acute respiratory infection, treatment of acute respiratory infection, treatment of ACE inhibitor-induced cough, Psychogenic cough/habit cough/tic cough. Status asthmaticus or acute episodes of asthma or COPD.

Required Medical Information
Diagnosis

Age Restriction
4 years or older (Advair Diskus), 12 years or older (Advair HFA)

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
AFINITOR

Drugs
Afinitor Oral Tab 2.5mg
Afinitor Oral Tab 5mg
Afinitor Oral Tab 7.5 mg
Afinitor Oral Tab 10 mg
Afinitor Disperz Soluble Tab 2 mg
Afinitor Disperz Soluble Tab 3 mg
Afinitor Disperz Soluble Tab 5 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
Afinitor: 18 years of age or older for advanced hormone receptor breast cancer (HR + BC), Renal cell carcinoma (RCC), Pancreatic neuroendocrine tumors (PNET), and renal angiomyolipoma with tuberous sclerosis syndrome (TSC). AFINITOR and AFINITOR DISPERZ: 1 year of age or older for diagnosis of subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC).

Prescriber Restriction
Hematologist, Oncologist (Follow up prescriptions: Urologist, Hema-Onco)

Coverage Duration
12 months

Other Criteria
None
ALECENSA

Drugs
Alecensa 150 mg Oral Cap.

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
1. Diagnosis: anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC) who has progressed on or are intolerant to crizotinib. 2. Anaplastic lymphoma kinase (ALK)-positive

Age Restriction
18 years of age or older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
None
Drugs
Alimta IV Solution Reconstituted 500 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
CrCL, ANC, PLT

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
6 months

Other Criteria
Subject to B vs D Review.
Drugs
Alunbrig Oral Tab 30 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) who have progressed on or are intolerant to crizotinib.

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
Must be covered by Part D benefit.
**ALZHEIMER DISEASE**

**Drugs**  
Namenda XR 14 mg, 21 mg, 28 mg, 7 mg  
Namenda XR Titration Pack  
Memantine Oral Tab 5 mg, 10 mg  
Memantine Oral Sol 2mg/ml  
Memantine Pack

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

**Exclusion Criteria**  
None

**Required Medical Information**  
Folstein Mini-Mental Status Exam (MMSE)

**Age Restriction**  
18 years or older

**Prescriber Restriction**  
None

**Coverage Duration**  
12 months

**Other Criteria**  
MMSE is based on 30 points. Namenda: approve if MMSE less than or equal to 20 - for moderate to severe Alzheimer disease (AD). Mini mental state evaluation (MMSE) not required for Namenda if the patient has tried donepezil.
AMPYRA

Drugs
Ampyra Oral Tab. 10 mg

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

Exclusion Criteria
History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute). Patient currently using any other forms of 4-aminopyridine.

Required Medical Information
Diagnosis of multiple sclerosis AND patient is ambulatory (able to walk at least 25 feet) AND patient has walking impairment. CrCL

Age Restriction
18 years or older

Prescriber Restriction
Neurologist

Coverage Duration
Initial - 3 months. Renewal - 12 months

Other Criteria
For renewal, walking speed has improved from baseline.
ANABOLIC STEROIDS

Drugs
Oxandrolone Oral Tab 2.5 mg
Oxandrolone Oral Tab 10 mg
Anadrol Oral Tab 50 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Carcinoma of the breast in females with hypercalcemia, carcinoma of the prostate or male breast, hypercalcemia, nephrosis, pregnancy.

Required Medical Information
Serum Calcium

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
6 months

Other Criteria
None
ANDRODERM

Drugs
Androderm Transdermal Patch 2 mg/24 Hr
Androderm Transdermal Patch 4 mg/24 Hr

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Not covered for the treatment of sexual dysfunction.

Required Medical Information
1. Primary hypogonadism: two low total testosterone levels on separate days with elevated LH and FSH.
2. Hypogonadotropic hypogonadism: Two low total testosterone levels on separate days with low to low-normal LH and FSH.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
ANORO ELLIPTA

Drugs
Anoro Ellipta 0.0625 mg/0.025 mg/Actuation

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
ANTINEOPLASTICS

Drugs
Bosulif oral Tab 100 mg, 500 mg
Cometriq Oral Cap 60 mg, 100 mg, 140 mg
Erivedge Oral Cap 150 mg
Gilotrif Oral Tab 20 mg, 30 mg, 40 mg
Inlyta Oral Tab 1 mg & 5 mg
Kadcyla Inj Solution 20 mg /ml
Mekinist Oral Tab. 0.5 mg & 2mg
Pomalyst Oral Cap 1 mg, 2mg, 3 mg, 4 mg
Soltamox Oral Sol. 10 mg/5ml
Stivarga Oral Tab 40 mg
Synribo SubQ 3.5 mg vial
Tafinlar Oral Cap 50 mg & 75 mg
Zaltrap IV 100 mg/4ml vial

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years or older

Prescriber Restriction
Hematologist-Oncologist

Coverage Duration
12 months

Other Criteria
Must meet Part D coverage criteria and not be covered under Part B.
ANTIPSYCHOTICS

Drugs
Geodon Inj. 20 mg/ml
Fanapt Oral Tab 1 mg, 2 mg, 4 mg, 6 mg, 8 mg, 10 mg, 12 mg
Fanapt Titration Pack
Saphris Sublingual Tab 2.5mg, 5 mg, 10 mg
Risperdal Consta 12 mg/ml, 18.8 mg/ml, 6.25 mg/ml
Invega Sustenna 39 mg-0.25ml, 78 mg-0.5 ml, 117 mg – 0.75 ml, 156 mg – ml, 234 mg – 1.5 ml
Invega Trinza 273 mg, 410 mg, 546 mg, 810 mg
Abilify IM Inj 9.75 mg/1.3 ml Vial
Abilify Maintena Inj. 300mg, 400mg
Latuda Oral Tab 20 mg, 40 mg, 60 mg, 80 mg, 120 mg
Rexulti Oral Tab. 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg
Vraylar Oral Cap 1.5 mg, 3 mg, 4.5 mg, 6 mg
Vraylar Therpay Pack 1.5mg/3mg
Aristada Prefilled Syringe 276 mg/ml
Aristada Prefilled Syringe 1064 mg/3.9 ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Not indicated for the treatment of dementia-related psychosis due to an increased risk of death seen in the elderly.

Required Medical Information

Age Restriction
Per FDA approved age

Prescriber Restriction
None

Coverage Duration
12 Months

Other Criteria
None
Drugs
Aptiom 200 mg Oral Tab
Aptiom 400 mg Oral Tab
Aptiom 600 mg Oral Tab
Aptiom 800 mg Oral Tab

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis. For adjunct treatment of partial seizure.

Age Restriction
18 years or older

Prescriber Restriction
Neurologist

Coverage Duration
12 Months

Other Criteria
None
Drugs
Arcalyst SubQ 220 mg vial

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
PPD (-)

Age Restriction
12 years or older

Prescriber Restriction
Rheumatologist, Dermatologist or Immunologist

Coverage Duration
12 months

Other Criteria
None
ARNUITY ELLIPTA

Drugs
Arnuity Ellipta Inhaler 100 mcg
Arnuity Ellipta Inhaler 200 mcg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
12 years of age or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
Drugs
Aubagio Oral Tab 14 mg
Aubagio Oral Tab 7 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Pregnancy or potential for pregnancy without the use of reliable contraception. Severe hepatic impairment.

Required Medical Information
Diagnosis (Multiple sclerosis, Relapsing forms). CBC, including a lymphocyte count. Patient has failed therapy with appropriately dosed trial of at least 1 form of interferon AND glatiramer acetate. Renewal authorizations of Aubagio are dependent on documented improvement in symptoms and lack and/or decrease of relapses. Has patient shown symptomatic improvement and a reduction (or lack) of relapses since initiation of therapy?

Age Restriction
18 years of age or older

Prescriber Restriction
Neurologist

Coverage Duration
12 months

Other Criteria
Obtain a CBC, including a lymphocyte count, prior to therapy initiation, after 6 months of therapy, and every 6 to 12 months thereafter or as clinically indicated.
AVASTIN

Drugs
Avastin IV Soln. 100 mg/4ml
Avastin IV Soln. 25 mg/ml

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

Exclusion Criteria
Gastrointestinal perforation. Wound dehiscence. Serious hemorrhage or recent hemoptysis.

Required Medical Information
Diagnosis of one of the following: 1. Metastatic colorectal cancer, with intravenous 5-fluorouracil based chemotherapy for first- or second-line treatment. 2. Metastatic colorectal cancer, with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in patients who have progressed on a first-line Avastin containing regimen. 3. Non-squamous non-small cell lung cancer, with carboplatin and paclitaxel for first line treatment of unresectable, locally advanced recurrent or metastatic disease. 4. Glioblastoma, as a single agent for adult patients with progressive disease following prior therapy. 5. Metastatic renal cell carcinoma with interferon alfa. 6. Cervical cancer, in combination with paclitaxel and cisplatin or paclitaxel and topotecan in persistent, recurrent, or metastatic disease. 7. Platinum-resistant recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer, in combination with paclitaxel, pegylated liposomal doxorubicin or topotecan.

Age Restriction
None

Prescriber Restriction
Hematologist, oncologist

Coverage Duration
12 months

Other Criteria
Subject to B vs D review.
BANZEL

Drugs
Banzel Oral Susp 40 mg/ml, Banzel Oral Tab 200 mg & 400 mg

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

Exclusion Criteria
None

Required Medical Information
Weight

Age Restriction
1 year or older

Prescriber Restriction
Neurologist

Coverage Duration
12 months

Other Criteria
None
BARACLUDE

**Drugs**
Baraclude Oral Solution 0.05 mg/ml
Entecavir Oral Tab 0.5 mg, 0.1 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
None

**Age Restriction**
Adults and pediatric patients 2 years of age and older.

**Prescriber Restriction**
Gastroenterologist, Hepatologist or infectious disease specialist.

**Coverage Duration**
12 months

**Other Criteria**
None
BAVENCIO

Drugs
Bavencio Inj. 20 mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis:
1. Metastatic Merkell cell carcinoma (MCC)
2. Locally advanced or metastatic urothelial carcinoma (UC) with disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

Age Restriction
1. MCC: 12 years and older.
2. UC: 18 years of age or older.

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
Subject to BvD review.
Drugs
Amitriptyline HCl/ Perphenazine 10 mg-4 mg, 50 mg-4 mg, 10 mg-2 mg, 25 mg-2 mg, 25 mg-4 mg Oral Tab.

Amitriptyline HCL 10 mg, 25 mg, 50 mg, 100 mg, 75 mg, 150 mg Oral Tab.

Benztrapine Mesylate 0.5 mg, 1 mg, 2 mg Oral Tab.

Chlomipramine HCl 25mg, 50 mg 75 mg Oral Cap

Doxepine HCl 10 mg/ml Oral Sol.

Doxepin HCl 10 mg, 25 mg, 50 mg, 75 mg, 100 mg, 150 mg Oral Cap.

Estradiol 0.5 mg, 1 mg, 2 mg Oral Tab.

Estradiol Transdermal Patch 0.25 mg/24 hr, 0.5 mg/24 hr, 0.75 mg/24 hr, 0.1 mg/24 hr, 0.0375 mg/24 hr, 0.06 mg/24 hr.

Estropipate Oral Tab. 0.75 mg, 1.5 mg

Fyavolv Oral Tab 1mg/5mcg, 0.5mg/2.5mcg

Guanfacine 1 mg, 2 mg, 3 mg, 4 mg Oral Tab.

Hydroxyzine HCl Inj. 25 mg/ml, 50 mg/ml

Imipramine Pamoate 75 mg, 100 mg, 125 mg, 150 mg Oral Cap

Imipramine HCl 10 mg, 25 mg, 50 mg Oral Tab.

Megestrol Acetate Oral Susp. 125 mg/ml

Megestrol Acetate 20 mg, 40 mg Oral Tab.

Nitrofurantoin 50 mg, 100 mg Oral Cap

Nitrofurantoin, Macrocrystals Oral cap 100 mg, 25 mg

Nitrofurantoin Macrocrystals 25 mg/ Nitrofurantoin Monohydrate 75 mg

Phenadoz Rectal Supp 12.5 mg

Phenobarbital 15 mg, 30 mg, 60 mg, 100 mg, 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg Oral Tab.

Prempro 0.3 mg/1.5 mg - 28 day Pack

Prempro 0.45 mg/ 1.5 mg – 28 day Pack

Prempro 0.625 mg/ 5 mg – 28 day Pack

Prempro 0.625mg/2.5 mg – 28 day Pack

Promethazine HCl Oral Tab 12.5 mg, 25 mg, 50 mg

Thioridazine 10 mg, 25 mg, 50 mg, 100 mg Oral Tab.

Thiothixene 1 mg, 2 mg, 5 mg, 10 mg Oral Cap.

Transdermal Scop Patch 0.0139 mg/Hr

Trihexyphenidyl HCl 0.4 mg/ml Oral Sol.

Trihexyphenidyl HCl 2 mg, 5 mg Oral Tab.

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
The PA is only required for a specific age range, 65 years old or more. The age range approved without PA is 64 years old or less.

**Prescriber Restriction**
None

**Coverage Duration**
12 months

**Other Criteria**
PA will be approved if medical necessity statement is provided by physician including trial and failure to ONE non high risk medication alternative. Formulary alternative medications per drugs include but are NOT limited to:

1. amitriptyline, imipramine, doxepin
   - Alternative: nortriptyline cap, desipramine tab.
2. estrogen:
3. phenobarbital:
   - Alternative: phenytoin, valproic acid, valproate, carbamazepine
4. thioridazine and thiothixene:
   - Alternative: chlorpromazine, loxapine, prochlorperazine
BELINOSTAT

Drugs
Beleodaq Inj. Solution 50 mg/ml

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

Exclusion Criteria
None

Required Medical Information
Diagnosis of peripheral T-cell lymphoma refractory or relapsing. Prior to the first dose the absolute neutrophil count is 1 x 10(9)/L or greater and platelet count is 50 x 10(9)/l or greater and platelet count is 50 x 10(9)/l or greater.

Age Restriction
18 years or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Subject to B vs D review. Patient has tried and had an inadequate response, intolerance or contraindication to at least one prior therapy (e.g., conventional chemotherapy)
**Drugs**
Benlysta IV Soln. 120 mg
Benlysta IV Soln. 400 mg

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

**Exclusion Criteria**
Receiving other biologic therapy or intravenous cyclophosphamide.

**Required Medical Information**
Diagnosis of active, autoantibody-positive (acceptable assays include ANA, anti-ds-DNA, anti-Sm, etc.) systemic lupus erythematosus AND patient is currently receiving one or more of the following standard therapies: corticosteroids, antimalarials, NSAIDs, immunosuppressants.

**Age Restriction**
18 years or older

**Prescriber Restriction**
None

**Coverage Duration**
12 months

**Other Criteria**
Subject to B vs D review.
BOTOX

**Drugs**
Botox Inj. Soln. 100 units
Botox Inj. Soln. 200 units

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

**Exclusion Criteria**
Cosmetic Use

**Required Medical Information**
FOCAL, PRIMARY AXILLARY HYPERHIDROSIS: Condition creates a significant disruption to patient's daily life and ability to work/function or patient has recurrent or chronic irritations and/or infections, dermatitis, skin macerations. CHRONIC MIGRAINE HEADACHE: Patient has a persistent history of chronic, debilitating migraine headaches with frequent attacks on more than 15 days per month AND there is documentation of significant functional disability.

**Age Restriction**
Strabismus or blepharospasm associated with dystonia including benign essential blepharospasm or VII nerve disorders: Approve for patients 12 years or older. Cervical Distonia: 16 years and older

**Prescriber Restriction**
Chronic migraine headaches: neurologist.

**Coverage Duration**
12 months

**Other Criteria**
Subject to B vs D Review. For Chronic migraine headache: patient has failed or had a clinically significant adverse effects to prophylactic treatment with ONE of the following: divalproex, valproic acid, topiramate, timolol or propranolol AND Patient has failed or had a clinically significant adverse effects to abortive therapy with ONE of the following: sumatriptan, rizatriptan, zolmitriptan, naratriptan, almotriptan, frovatriptan, eletriptan, ergotamine/caffeine or dihydroergotamine.
BRILINTA

Drugs
Brilinta Oral Tab. 90 mg
Brilinta Oral Tab. 60 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Active pathological bleeding or history of intracranial hemorrhage, severe hepatic impairment.

Required Medical Information
Acute coronary syndrome - Thrombosis, Prophylaxis or Percutaneous coronary intervention - Thrombosis, Prophylaxis.

Age Restriction
18 years of age or older

Prescriber Restriction
Cardiologist

Coverage Duration
12 months

Other Criteria
None
**BRIVIACT**

**Drugs**
Briviact Oral Tab 10 mg, 25 mg, 50 mg, 75 mg, 100 mg  
Briviact Oral Sol 10 mg/ml  
Briviact Inj. 10 mg/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**

**Age Restriction**
16 years of age or older

**Prescriber Restriction**
Neurologist

**Coverage Duration**
12 months

**Other Criteria**
Injectable Formulation: Subject to B vs D Review.
Drugs
Sodium Phenylbutyrate Oral Powder

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Acute hyperammonemia (Do not use for emergency management)

Required Medical Information
BSA

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
BYETTA

Drugs
Byetta SubQ 10 mcg Pen
Byetta SubQ 5 mcg Pen
Bydureon Inj. 2 mg
Bydureon pen Injector 3.08 mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Weight loss treatment and Type 1 Diabetes Mellitus or treatment of diabetic ketoacidosis.

Required Medical Information
Glycosylated hemoglobin

Age Restriction
18 years or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
CABOMETYX

Drugs
Cabometyx Oral Tab 20 mg, 40 mg, 60 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
1. Diagnosis: advanced renal cell carcinoma (RCC) who have received prior antiangiogenic therapy AND patient has none of the following: a. Hemorrhage or hemoptysis b. Unmanaged Gastrointestinal perforations or fistulas c. Palmer plantar erythrodysesthesia Grade 2.

Age Restriction
18 years or older

Prescriber Restriction
Oncologist or hematologist

Coverage Duration
12 months

Other Criteria
None
**Drugs**
Carbaglu Oral Suspension 80mg/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Diagnosis of N-acetyl glutamate synthase (NAGS) deficiency AND patient is experiencing either acute or chronic hyperammonemia.

**Age Restriction**
None

**Prescriber Restriction**
None

**Coverage Duration**
12 months

**Other Criteria**
None
CAYSTON

Drugs
Cayston Inhalant Sol. 75 mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis

Age Restriction
Cystic fibrosis: 7 years and older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
CEREZYME

Drugs
Cerezyme 400 units vial

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Tay-Sachs Disease, Gaucher disease Type 2 or 3

Required Medical Information
None

Age Restriction
2 years or older

Prescriber Restriction
Hematologist, physician that specializes in the treatment of inherited metabolic disorders or the patient was referred to a center that specializes in the treatment of Gaucher disease.

Coverage Duration
12 months

Other Criteria
None
CHANTIX

Drugs
Chantix Starting Month 0.5 mg & 1 mg
Chantix Oral Tab 0.5 mg
Chantix Oral Tab 1 mg
Chantix Continuing Month Pack 1 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Evidence of therapeutic failure to bupropion
**Drugs**
Cholbam Oral Cap 250 mg
Cholbam Oral Cap 50 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
Extrahepatic manifestations of bile acid synthesis disorders due to single enzyme defects SEDs or peroxisomal disorders PDs including Zellwegerspectrum disorders.

**Required Medical Information**
1. Diagnosis: Patient must have ONE of the following:
   a. Bile acid synthesis disorder due to single enzyme defects (SEDs) or
   b. Peroxisomal disorder (PD), including Zellweger spectrum disorders, as adjunctive treatment
2. Diagnosis was confirmed by mass spectrometry or other biochemical testing or genetic testing.
3. Baseline results of AST, ALT, GGT, alkaline phosphatase, bilirubin and INR.

**Age Restriction**
3 weeks of age and older

**Prescriber Restriction**
1. Hepatologist
2. Gastroenterologist, or
3. Metabolic or biochemical geneticist physician experienced in treating bile acid synthesis disorder/peroxsomal disorder.

**Coverage Duration**
Initially: 6 month.
Continuation: 12 months

**Other Criteria**
For continuation: Liver function is monitored including AST, ALT, GGT, alkaline phosphatase, bilirubin and INR AND patient did not present symptoms of worsening liver function or develops cholestasis.
Drugs
Cinryze Inj. 500 units/vial

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

Exclusion Criteria
None

Required Medical Information
Diagnosis of hereditary angioedema AND Medication will be used for routine prophylaxis against angioedema.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Subject to B vs D Review.
COPAXONE

**Drugs**
Copaxone SubQ Kit 20 mg/ml
Copaxone SubQ 40 mg/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
Concurrent use of glatiramer acetate with interferon beta-1a (Avonex, Rebif) or interferon beta-1b (Betaseron)

**Required Medical Information**
None

**Age Restriction**
18 years or older

**Prescriber Restriction**
Neurologist or a Multiple Sclerosis specialist

**Coverage Duration**
12 months

**Other Criteria**
None
Drugs
Cotellic 20 mg Oral Tab.

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Wild-type BRAF melanoma

Required Medical Information
1. Diagnosis: unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, in combination with vemurafenib. 2. Genetic Test- presence of BRAF V600E or V600K mutation in tumor specimens. 3. Protocol - combination with vemurafenib

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, oncologist

Coverage Duration
12 months

Other Criteria
None
Drugs
Celecoxib Oral Cap 50 mg, 100 mg, 200 mg, 400 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Treatment of perioperative pain in coronary artery bypass graft (CABG) surgery.

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Patients without previous history of cardiovascular disease or diabetes mellitus: 12 months
Patients with previous history of cardiovascular disease or diabetes mellitus: 3 months, unless medical necessity statement provided by physician

Other Criteria
Require trial-failure to 2 Non-steroidal anti-inflammatory drug (NSAIDs) in the past 180 days
Drugs
Cyclobenzaprine Oral Tab. 5 mg, 10 mg, 7.5 mg

Covered Uses
All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria
None

Required Medical Information
1. Diagnosis 2. Physician attestation that he/she has assessed risk versus benefit in using this High Risk Medication (HRM) and would still like to initiate/continue therapy.

Age Restriction
The prior authorization is only required for a specific age range, 65 years old or more. The age range approved without prior authorization is 64 years old or less.

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
The physician has assessed risk versus benefit in using this High Risk Medication (HRM) and has confirmed/ attested that he/she would still like to initiate/continue therapy.
**Drugs**
Cyramza Inj. 100mg/10ml
Cyramza Inj. 500mg/50ml

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

**Exclusion Criteria**
None

**Required Medical Information**
Indication: 1. As a single agent or in combination with paclitaxel, for treatment of advanced gastric or gastro-esophageal junction adenocarcinoma, with disease progression on or after prior fluoropyrimidine-or platinum-containing chemotherapy OR 2. In combination with docetaxel, for treatment of metastatic non-small cell lung cancer with disease progression on or after platinum-based chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving CYRAMZA OR 3. In combination with FOLFIRI, for the treatment of metastatic colorectal cancer with disease progression on or after prior therapy with bevacizumab, oxaliplatin, and a fluoropyrimide

**Age Restriction**
18 years of age or older

**Prescriber Restriction**
Hematologist, oncologist

**Coverage Duration**
12 months

**Other Criteria**
1. Subject to B vs D. 2. Criteria for continuation of therapy: A. Patient responding to treatment AND B. Patient tolerating treatment AND C. Must not have experienced severe bleeding while on therapy.
DARAPRIM

Drugs
Dara trim Oral Tab 25 mg

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

Exclusion Criteria
Megaloblastic anemia due to folate deficiency.

Required Medical Information
Diagnosis

Age Restriction
None

Prescriber Restriction
Infectologist

Coverage Duration
According to prescribed regimen

Other Criteria
Pyrimethamine is no longer available in the United States as of June, 2015. It is only available through a special access program. If there is a delay in procurement, use alternative drug regimens for the treatment or prophylaxis Toxoplasma encephalitis, Pneumocystis pneumonia, or Isospora infection. In patients without a sulfa allergy, trimethoprim/sulfamethoxazole may be substituted for pyrimethamine in combination with sulfadiazine or clindamycin in patients with suspected or documented toxoplasmosis until pyrimethamine is available.
Drugs
Darzalex Inj. 20 mg/ml

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

Exclusion Criteria
None

Required Medical Information
1. Diagnosis: multiple myeloma who have received at least three prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or who are double-refractory to a PI and an immunomodulatory agent.

Age Restriction
18 years of age or older

Prescriber Restriction
Hematologist, oncologist

Coverage Duration
12 months

Other Criteria
Subject to B vs D Review
Drugs
Demerol 50 mg/ml Inj. Solution
Meperidine HCl 25 mg/ml
Meperidine HCl 50 mg/ml

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

Exclusion Criteria
None

Required Medical Information
Diagnosis, indication for use

Age Restriction
None

Prescriber Restriction
1. For moderate to severe pain management: Anesthesiologist, Pain Management Specialist, Hematologist-Oncologist.
2. Premedication for procedure: Gastroenterologist

Coverage Duration
30 days.

Other Criteria
1. For moderate to severe pain, Tx failure or adverse effect to two (2) available short acting formulary opioid drugs.
2. Max allowed daily dose: 1200 mg /day for moderate to severe acute pain management. 150 mg/day as premedication for procedures. Chronic use not recommended due to an increased risk of neurotoxicity (e.g., seizures) secondary to accumulation of the meperidine metabolite, normeperidine.
DISEASE MODIFYING ANTI-RHEUMATIC DRUGS

Drugs
Humira Kit 20 mg/ 0.4 ml, 40 mg/ 0.8 ml
Humira Pen-Crohns Starter Kit
Hunira Prefilled Syinge
Humira Pen Auto Injector 50 mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
PPD negative

Age Restriction
None

Prescriber Restriction
RA and Ankylosing spondylitis: Rheumatologist
Psoriasis with arthropathy: Rheumatologist or Dermatologist
Crohns disease: Gastroenterologist
Plaque psoriasis: Dermatologist
Juvenile idiopathic arthritis: Rheumatologist

Coverage Duration
12 months

Other Criteria
1. For adults with rheumatoid arthritis: If the patient has tried one Disease-modifying antirheumatic drug DMARD (brand or generic, oral or injectable) for at least 2 months, or is concurrently receiving methotrexate(MTX), then authorization may be given for Humira (adalimumab). Humira (adalimumab) is FDA approved for RA in adults who have had an inadequate response to one or more DMARDs. DMARDs are the following drugs: anakinra, auranofin (Ridaura), aurothioglucose, azathioprine, cyclosporine (various brands, generic), d-penicillamine (Cuprimine), etanercept, gold sodium thiomalate (Aurolate, generic), hydroxychloroquine, infliximab, leflunomide, MTX, or sulfasalazine.

2. Initiating DMARD therapy with Humira (adalimumab), alone should be rare. Most patients will have received initial therapy with an oral DMARD(s) (eg, hydroxychloroquine, sulfasalazine, MTX). If MTX is contraindicated another oral DMARD should be tried. Some patients with unfavorable prognostic factors (eg, early age of disease onset, high titer of rheumatoid factor, increased erythrocyte sedimentation rate, swelling of more or equal than 20 joints, extra-articular manifestations of RA) or with joint erosions may be started early on biologic agents, such as Humira (adalimumab), patients will be evaluated by a pharmacist and/or physician on a case-by-case basis to determine a coverage recommendation for the client.

3. For Crohn’s disease (Moderate to Severe): In patients with an inadequate response to at least two conventional therapies (eg. sulfasalazine, mesalamine-containing drugs such as Asacol, Dipentum, or Pentasa, corticosteroids, Immune System Suppressors).
DPP4

Drugs
Jentadueto Oral Tab 2.5-1000 mg, 2.5-500 mg, 2.5-850 mg
Kombiglyze XR Oral Tab 2.5-1000 mg oral, 5-1000 mg, 5-500 mg oral
Onglyza Oral Tab 2.5 mg, 5 mg
Tradjenta Oral Tab 5 mg
Janumet ER 500-50 mg, Janumet 1000-50 mg, 1000-100 mg
Janumet 500-50 mg, 1000-50 mg
Januvia 50 mg, 25 mg, 100 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
A1c, history of previous drug therapies

Age Restriction
18 years or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Patients must try and fail Metformin or combination with Metformin. If A1c less than = 10, then approve. If A1c greater than 10, then deny for ineffectiveness, require use of Insulin. Approve if history of metformin or metformin combination contraindication, ADR or intolerance and A1c is less than 10.
Drugs
Effient Oral Tab 5 mg, 10 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Active pathological bleeding, including peptic ulcer and intracranial hemorrhage, stroke or TIA, history of, discontinue if stroke or TIA occurs with therapy.

Required Medical Information
Diagnosis

Age Restriction
18 years or older

Prescriber Restriction
Cardiologist

Coverage Duration
12 months

Other Criteria
Prior history of a generic clopidrogel within past 180 day. Members without Prior History of medication in claims, MD shall provide documentation of medical record or pharmacy claims processing thru another benefit to comply with previous utilization. Prasugrel is not recommended to be used in patients age 75 years or older except in high-risk situations such as diabetes mellitus or prior myocardial infarction in this age group. Maximum continuous treatment is 30 months.
ELIQUIS

Drugs
Eliquis Oral Tab 2.5 mg, 5 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Active pathological bleeding

Required Medical Information
Diagnosis, SCr, Weight

Age Restriction
18 years or older

Prescriber Restriction
Cardiologist, Internal Medicine, Orthopedist, Surgeon, Pulmonologist

Coverage Duration
12 months

Other Criteria
None
EMPLICITI

Drugs
Empliciti Inj. 300 mg
Empliciti Inj. 400 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis: In combination with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received one to three prior therapies.

Age Restriction
18 years of age or older

Prescriber Restriction
Hematologist, oncologist

Coverage Duration
12 months

Other Criteria
Subject to B vs D Review
**Drugs**
Entresto Oral Tab. 24mg/26mg
Entresto Oral Tab. 97mg/103mg
Entresto Oral Tab. 49mg/51mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
1. History of angioedema related to previous ACE inhibitor or ARB therapy
2. Concomitant use with ACE inhibitors

**Required Medical Information**
Diagnosis of heart failure. Ejection fraction is less than or equal to 40 percent. Heart failure is classified as NYHA Class II, III or IV. Patient is receiving concomitant therapy with one of the following beta-blockers at a maximally tolerated dose or has a contraindication or intolerance to beta-blocker therapy: bisoprolol, carvedilol or metoprolol succinate.

**Age Restriction**
18 years of age or older

**Prescriber Restriction**
Cardiologist

**Coverage Duration**
12 months

**Other Criteria**
For continuation: documentation of positive clinical response to therapy.
EPCLUSA

Drugs
Epclusa Oral Tab 400 mg/100 mg

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

Exclusion Criteria
None

Required Medical Information
1. Diagnosis
2. Genotype
3. Treatment status of patient (treatment naïve or treatment experienced), AND
4. Cirrhosis status are required.

Age Restriction
18 years or older

Prescriber Restriction
1. Gastroenterologist
2. Hepatologist
3. Infectious Disease Specialist.

Coverage Duration
12 weeks

Other Criteria
Criteria will be applied consistent with current AASLD/IDSA guidance.
ERYTHROID STIMULANTS

Drugs
Procrit Inj Soln 2,000 unit/ml, 3,000 unit/ml, 4,000 unit/ml, 10,000 unit/ml, unit/ml 20,000 unit/ml, 40,000 unit/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D worded as anemia associated with chronic renal failure (CRF), including patients on dialysis and not on dialysis, and worded as anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. Plus anemia in patients with HIV, who are receiving zidovudine. Anemic patients (Hb of 13.0 g/dL or less) at high risk for perioperative transfusions (secondary to significant, anticipated blood loss and are scheduled to undergo elective, noncardiac, nonvascular surgery to reduce the need for allogeneic blood transfusions). Anemia, due to myelodysplastic syndrome (MDS). Anemia associated with use of ribavirin therapy for hepatitis C (in combination with interferon or pegylated interferon alfa 2a/2b products).

Exclusion Criteria
Uncontrolled hypertension

Required Medical Information
CRF anemia. Hemoglobin (Hb) of less than or equal to 10.0 g/dL to start. Hb less than or equal to 12.0 g/dL if previously on epoetin alfa (EA) or Aranesp. Anemia w/myelosuppressive chemotherapy. Hb immediately prior to EA is 10.0 g/dL or less (or hematocrit [Hct] is 30% or less). EA maintenance is starting dose if Hb level remains 10.0 g/dL or less (or Hct remains 30% or less) 4 weeks after start and Hb rise is 1.0 g/dL or more (Hct rise is 3% or more). Patients w/Hb rises less than 1.0 g/dL (Hct rise less than 3%) versus pretreatment baseline over 4 weeks of treatment and Hb is less than 10.0 g/dL after 4 weeks of treatment (Hct is less than 30%), the recommended FDA starting dose may be increased once by 25%.Continued use is not reasonable/necessary if Hb rises less than 1.0 g/dL (Hct rise less than 3%) versus pre-treatment baseline by 8 weeks of treatment. Continued EA is not reasonable/necessary if there is a rapid Hb rise more than 1.0 g/dL (Hct more than 3%) over 2 weeks of treatment unless Hb remains below or subsequently falls to less than 10.0 g/dL (or Hct is less than 30%).Continuation/reinstitution of EA must have dose reduction of 25% of previous dose. MDS, approve if Hb is 12.0 g/dL or less. Previously receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. An additional 6 months allowed after first 6 months if Hb is 12.0 g/dL or less. Anemia in HIV (+ zidovudine), Hb is 10.0 g/dL or less or endogenous erythropoietin levels are 500 m units/mL or less at treatment start. Previously on EA approve if Hb is 12.0 g/dL or less. Anemia due to ribavirin for Hep C, Hb is 10.0 g/dL or less at treatment start. All conditions, deny if Hb exceeds 12.0 g/dL.

Age Restriction
1 month or older

Prescriber Restriction
Hematologist, Oncologist, Gastroenterologist, Infectious Disease Specialist, Nephrologist, Surgeon

Coverage Duration
Chemo course: 8 weeks after last chemotherapy dose.
MDS: 6mo
Hb 12 or less: Additional 6 months,
Transfusion: 3weeks.
Other: 12months
Other Criteria
Part B versus Part D determination will be made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an end-stage renal disease (ESRD)-related condition.
ESBRIET

Drugs
Esbriet Oral Cap 267 mg
Esbriet Oral Cap 801 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis, idiopathic pulmonary fibrosis confirmed by CT scan or biopsy, patient has a forced vital capacity (FVC) greater than or equal to 50%, of predicted AND the patient does not have evidence or suspicion of an alternative interstitial lung disease diagnosis AND baseline liver function tests were performed.

Age Restriction
18 years of age or older

Prescriber Restriction
Pulmonologist

Coverage Duration
12 months

Other Criteria
For continuation, patient has stabilization from baseline or a less than 10 percent decline in force vital capacity AND the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage.
Drugs
Exelon Transdermal Patch 4.6 mg/24 Hr, 9.5 mg/24 Hr, 13.3 mg/24 Hr
Rivastigmine Transdermal Patch 4.6 mg/24 Hr, 9.5 mg/24 Hr, 13.3 mg/24 Hr

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Folstein Mini-Mental Status Exam (MMMSE)

Age Restriction
18 years of age or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
MMSE is based on 30 points. Approve if MMSE less than or equal to 24. MMSE not required if the patient has tried donepezil.
**Drugs**
Exjade Oral Suspension 1.25mg/ml, 2.5 mg/ml, 5 mg/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
Advance malignancies, PLT less than 50 x 10(9)/L, high risk myelodisplastic syndromes, CrCL less than 40mL/min, or SrCr greater than 2 times the age appropriate ULN.

**Required Medical Information**
SCr or CrCL in duplicate, serum transaminase, bilirubin, serum ferritin, and iron levels before initiating therapy

**Age Restriction**
2 years and older

**Prescriber Restriction**
Pneumologist, Hematologist

**Coverage Duration**
12 months

**Other Criteria**
None
FABRAZYME

Drugs
Fabrazyme IV 35 MG vial

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Fabry disease in male patients based on clinical symptoms or by genetic testing. Fabry disease in female patients based on family history and/or genetic testing.

Age Restriction
8 years or older

Prescriber Restriction
Pediatrician, internist, geneticist or metabolic specialist.

Coverage Duration
12 months

Other Criteria
None
FARYDAK

Drugs
Farydak Oral Cap. 10 mg, 15 mg, 20 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis, multiple myeloma and all of the following:
   1. In combination with bortezomib and dexamethasone and
   2. Patient has received at least 2 prior regimens, including bortezomib and an immunomodulatory agent.
      a. (Bortezomib/cyclophosphamide/dexamethasone, Bortezomib/dexamethasone,
         Bortezomib/doxorubicin/dexamethasone, Bortezomib/lenalidomide/dexamethasone,
         Bortezomib/thalidomide/dexamethasone).
      b. Complete Blood Count (CBC). Do not initiate therapy if the baseline platelet count is less than 100 x 10(9)/L or if the baseline absolute neutrophil count is less than 1.5 x 10(9)/L. Hb greater than 10 g/dl.
      c. ECG with interpretation (within one moth of initiation of therapy): Do not initiate if the QTc is more than 450 msec or if there are clinically significant baseline ST-segment or T-wave abnormalities. d. Serum Electrolytes: (K : 3.5 -5.0 mEq/L or 3.5 5.0 mmol/L, Mg: 1.5 2.5mg/dl)

Age Restriction
18 and older

Prescriber Restriction
1. Hematologist
2. Oncologist

Coverage Duration
12 months

Other Criteria
Member should be enrolled in FARYDAK REMS Program.
FENTANYL

Drugs
Fentanyl Transdermal Patch 0.012 mg/hr, 0.1 mg/hr, 0.025 mg/hr, 0.05 mg/hr, 0.075 mg/hr
Fentanyl Oral Lozenge 0.2 mg, 0.4 mg, 0.6 mg, 0.8 mg, 1.2 mg, 1.6 mg
Fentora Buccal Tablet 0.1 mg, 0.2 mg, 0.4 mg, 0.6 mg, 0.8 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Acute or severe bronchial asthma, paralytic ileus, significant respiratory depression. Acute or postoperative pain including use after outpatient or day surgeries, or if analgesia is required for short term period. mild or intermitent pain management.

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
For Fentanyl OTF: Oncologists and Pain Specialists

Coverage Duration
12 months

Other Criteria
A. Fentanyl Patches: For patients that:
   1. Requires continuous, around-the-clock opioid administration for an extended period of time
   2. Cannot be managed by other means such as non-steroidal analgesics, opioid combination products, or immediate-release opioids.
B. Fentanyl Oral transmucosal fentanyl citrate (OTFC), Fentanyl Citrate Lollipop:
   1. Patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting, or
   2. Patient is unable to take other short-acting narcotics (e.g., oxycodone, morphine sulfate, hydromorphone, etc.) secondary to allergy or severe adverse events.
   3. Patient is on or will be on a long-acting narcotic (e.g., Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (e.g., morphine sulfate, hydromorphone, fentanyl citrate).
FERRIPROX

Drugs
Ferriprox Oral Tab. 500 mg
Ferriprox Oral Sol. 100mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis of Iron overload, Transfusional - Thalassemia syndrome. Absolute neutrophil count (ANC)

Age Restriction
18 years of age or older

Prescriber Restriction
Hematologist

Coverage Duration
12 months

Other Criteria
None
**FIRAZYR**

**Drugs**
Firazyr SubQ 30 mg/3ml vial

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
None

**Age Restriction**
18 years or older

**Prescriber Restriction**
Prescribed by, or in consultation with, an Allergist/Immunologist or a physician that specializes in the treatment of hereditary angioedema HAE or related disorders.

**Coverage Duration**
12 months

**Other Criteria**
None
FILGRASTIM

Drugs
Neupogen Syringe 480 mcg/0.8ml (600 mcg/ml), 300 mcg/0.5 ml (600 mcg/ml)
Neupogen Inj Vial 300 mcg/ml, 480 mcg/1.6 ml (300 mcg/ml)
Granix 300 mcg Prefilled Syringe

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
CBC and Platelet count

Age Restriction
None

Prescriber Restriction
Hematologist, Oncologist or Infectious Disease Specialist.

Coverage Duration
Authorization will be for 4 months per PA depending on dx to evaluate laboratory results.

Other Criteria
None
Drugs
Forteo SubQ 600 mcg/2.4ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years or older

Prescriber Restriction
Endocrinologists, Rheumatologists, Orthopedists, Gynecologists

Coverage Duration
12 months

Other Criteria
Forteo be approved for the covered osteoporosis indications if the patient has tried and failed two oral bisphosphonates (eg, alendronate, ibandronate), Prior History of medication in claims, MD shall provide documentation of medical record or pharmacy claims processing thru another benefit to comply with previous utilization. If the patient has severe renal impairment (eg, creatinine clearance less than 30 mL/min) or chronic kidney disease or if the patient has multiple vertebral fractures in the setting of vertebral T-scores less than -2.5.
FYCOMPA

Drugs
Fycompa Oral Tab 2 mg, 4 mg, 6 mg, 8 mg, 10 mg, 12 mg

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

Exclusion Criteria
None

Required Medical Information
Diagnosis: Fycompa is used in combination with at least one other antiepileptic medication.

Age Restriction
12 years of age or older

Prescriber Restriction
Neurologist

Coverage Duration
12 months

Other Criteria
Treatment failure an antiepileptic medications monotherapy. Prior History of medication in claims, MD shall provide documentation of medical record or pharmacy claims processing thru another benefit to comply with previous utilization.
Drugs
Gattex Inj Solution 10 mg/ml

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

Exclusion Criteria
Active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary, pancreatic), colorectal cancer, or small bowel cancer.

Required Medical Information
1. Diagnosis of short bowel syndrome AND patient is receiving specialized nutritional support (i.e. parenteral nutrition).
2. Colonoscopy or alternate imaging with removal of polyps should be done within 6 months prior to initiation of teduglutide.

Age Restriction
18 years or older

Prescriber Restriction
Gastroenterologist

Coverage Duration
Initiation, 6 months
Renewal, 12 months

Other Criteria
For renewal, patient has a reduced need for parenteral support (20% reduction) after at least 6 months of therapy.
Drugs
Gilenya Oral Cap 0.5 mg

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

Exclusion Criteria
Recent (within the last 6 months) myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure, History of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker, Baseline QTc interval =500 msec, Treatment with Class Ia or Class III anti-arrhythmic drugs

Required Medical Information
Diagnosis

Age Restriction
18 years or older

Prescriber Restriction
Neurologist or a Multiple Sclerosis specialist

Coverage Duration
12 months

Other Criteria
None
GLYXAMBI

Drugs
Glyxambi Oral Tab. 10/ 5 mg
Glyxambi Oral Tab. 25/ 5 mg

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

Exclusion Criteria
None

Required Medical Information
A1c, history of previous drug therapies

Age Restriction
18 years or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Patients must have prior utilization of either empagliflozin or linagliptintry plus metformin for 3 consecutive months and A1c is not on target. A1c is less or equal than 10. If A1c greater than 10, then deny for ineffectiveness, require use of Insulin. Approve if history of metformin contraindication, ADR or intolerance, prior utilization of either empagliflozin or linagliptintry for 3 consecutive months and A1c is less or equal than 10.
Drugs
Norditropin FlexPro 10 mg/1.5ml, 15 mg/1.5ml, 5 mg/1.5ml, 30 mg/3ml

Covered Uses
All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria
Acute respiratory failure, active malignancy

Required Medical Information
Children with acquired growth hormone GH deficiency. Documented GH stimulation testing with 1 test (levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon) showing deficiency defined by a diminished serum GH response to stimulation testing of less than 10 ng/mL AND baseline height less than the third percentile for gender and age AND pretreatment height velocity in child less than 3 years of less than 7 cm/year and in child greater than or equal to 3 years of less than 4 cm/year OR child of any age growth velocity less than the tenth percentile for age and gender based on at least 6 months of data. Child who has undergone brain radiation does not have to meet criteria for baseline height. Congenital hypopituitarism does not have to meet criteria for height or growth velocity. Child who has had a hypophysectomy does not have to meet any criteria. Non-GH deficient short stature (idiopathic short stature) in child with open epiphyses, 6 month trial. Baseline height less than third percentile (ie, greater than 2 SD below the mean for gender and age AND pretreatment height velocity in child less than 3 years of less than 7 cm/year and in child greater than or equal to 3 years of less than 4 cm/year OR child of any age growth velocity less than the tenth percentile for age and gender based on at least 6 months of data AND pediatric endocrinologist must certify the child has a condition for which GH is effective (or will possibly be effective during the initial trial of therapy) AND pediatric endocrinologist must certify that based on bone-age x-ray, the predicted adult height is less than the third percentile. The 6-month trial of GH is to establish that the child’s condition responds to GH therapy. Authorization for continued therapy is based on an adequate clinical response defined as an annualized growth rate that doubles in comparison to the previous year.

Age Restriction
None

Prescriber Restriction
Endocrinologist or Nephrologist

Coverage Duration
12 months

Other Criteria
Adult GH def (start) AND adult onset (GH alone or multiple hormone deficiencies/hypopituitarism from pituitary dz, hypothalamic dz, surgery, cranial radiation tx, tumor txment, traumatic brain injury, or subarachnoid hemorrhage) or childhood-onset AND negative response to 1 GH stimulation test (insulin tolerance [peak less than 5 mcg/L], or glucagon [peak less than 3 mcg/L]) [GHRH plus arginine may be used if available], transition adoless off somatropin 1 mo before retesting, OR 3 or more pituitary hormone deficiencies (TSH, ACTH, LH/FSH, or AVP) AND serum IGF-1 84 microg/L or less using the Esoterix ECB RIA or age/gender adjusted serum IGF-1 SDS below the 2.5 percentile.Turners, initial tx, female, and has short stature.SHOX,start, open epiphyses. CRI, start, approve. Prader-Willi, initial tx, approve. SGA/IUGR, initial tx, born SGA, AND no sufficient catch-up growth before age 4 yr, AND age 2 to 8 yrs, if older than 8 yrs, approve 1 yr trial if prepubertal, AND baseline ht less than
3rd percentile for gender/age. Noonan syndrome, initial tx, baseline ht less than 3rd percentile. HIV infection w/wasting or cachexia, HIV-positive AND have 1 of the following, documented unintentional wt loss of greater than or equal to 10% from baseline OR wt less than 90% of the lower limit of ideal body wt OR BMI less than or equal to 20 kg/m2 AND able to consume or be fed via parenteral or enteral feedings 75% or more of maintenance energy requirements based on current body weight AND on antiretroviral tx greater than or equal to 30 days prior to beginning GH tx and will continue antiretroviral tx throughout GH txment. Repeat 12 or 24-wk courses of GH may be authorized after initial 12 or 24-wk GH course for HIV infection w/wasting or cachexia provided that they are off GH for at least 1 mo and meet all of previous HIV criteria. HIV-assoc failure to thrive. Able to consume or be fed via parenteral or enteral feedings 75% or more of maintenance energy requirements based on current body weight AND on antiretroviral tx for greater than or equal to 30 days prior to beginning GH tx and will continue antiretroviral tx. SBS pts eval on case-by-case basis for more than one 4-wk course per yr.
HALAVEN

Drugs
Halaven IV 1 mg/2ml solution

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
None
HARVONI

Drugs
Harvoni Oral Tab 90/400 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
1. Diagnosis
2. Genotype and
3. Treatment status of patient (treatment naive or treatment-experienced) are required.

Age Restriction
12 years of age or older

Prescriber Restriction
1. Gastroenterologist
2. Hepatologist
3. Infectious Disease Specialist.

Coverage Duration
12 to 24 weeks depending on baseline host and viral factors.

Other Criteria
Criteria will be applied consistent with current AASLD/IDSA guidance
**Drugs**
Adefovir Dipivoxil Tab 10 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
None

**Age Restriction**
12 years or older

**Prescriber Restriction**
Gastroenterologist, Hepatologist or infectious disease specialist.

**Coverage Duration**
12 months

**Other Criteria**
None
HETLIOZ

Drugs
Hetlioz 20 mg oral cap.

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis: Non-24 Hour Sleep Wake Disorder (Non-24) AND the patient is totally blind with no perception of light.

Age Restriction
18 years or older

Prescriber Restriction
1. Sleep Disorder Specialist
2. Neurologist

Coverage Duration
12 months

Other Criteria
None
HEXALEN

Drugs
Hexalen Oral Cap 50 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Pre-existing severe bone marrow depression or severe neurologic toxicity.

Required Medical Information
BSA

Age Restriction
18 and older

Prescriber Restriction
Oncologist

Coverage Duration
12 months

Other Criteria
None
HUMULIN R 500

Drugs
Humulin R Pen Injector 500 units/ml (kwikpen)

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis of diabetes mellitus requiring more than 200 units of insulin per day.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
Drugs
Ibrance Oral Cap 100 mg, 125 mg, 75 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with: an aromatase inhibitor as initial endocrine based therapy in postmenopausal women or fulvestrant in women with disease progression following endocrine therapy.

Age Restriction
18 years of age or older

Prescriber Restriction
1) Hematologist
2) Oncologist

Coverage Duration
12 months

Other Criteria
None
Drugs
Iclusig Oral Tab 15 mg
Iclusig Oral Tab 45 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis of:
1) Chronic myeloid leukemia, Chronic, accelerated, or blast phase, for whom no other tyrosine kinase inhibitor therapy is indicated.
2) Chronic myeloid leukemia, T315I-positive, chronic, accelerated, or blast phase.
3) Philadelphia chromosome-positive acute lymphoblastic leukemia, For whom no other tyrosine kinase inhibitor therapy is indicated.
4) Philadelphia chromosome-positive acute lymphoblastic leukemia, T315I-positive.

Age Restriction
18 and older

Prescriber Restriction
3) Hematologist
4) Oncologist

Coverage Duration
12 months

Other Criteria
Must meet Part D coverage criteria and not be covered under Part B.
Drugs
Ilaris Inj. Solution 150 mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Positive TB Test

Required Medical Information
Diagnosis of cryopyrin-associated periodic syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS) OR Diagnosis of active systemic juvenile idiopathic arthritis (sJIA) AND patient has tried and had an inadequate response, contraindication or intolerance to corticosteroids (e.g., prednisone, methylprednisolone) or methotrexate

Age Restriction
CAPS - 4 years of age or older. sJIA - 2 years of age or older

Prescriber Restriction
Prescribed by or in consultation with or recommendation of, an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist.

Coverage Duration
12 months

Other Criteria
For renewal, patient experienced disease stability or improvement. Cryopyrin-associated periodic syndromes: improvement in serum C reactive protein, serum amyloid A levels, and signs and symptoms of cryopyrin-associated periodic syndromes (eg, fever, urticaria-like rash, arthralgia, myalgia, fatigue, and conjunctivitis) may indicate efficacy. Systemic juvenile idiopathic arthritis: improvement in serum C reactive protein and signs and symptoms of systemic juvenile idiopathic arthritis (eg, time between flare-ups and number of joints with active arthritis and limited range of motion) may indicate efficacy.
Drugs
Imatinib 100 mg
Imatinib 400 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis for which Imatinib is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. New patients with CML and ALL which is Ph-positive may receive authorization for Imatinib.

Age Restriction
1 year of age and older

Prescriber Restriction
Hematologist, oncologist

Coverage Duration
Authorization will be for 12 months.

Other Criteria
For CML, new patient must have Ph-positive CML for approval of Imatinib. For ALL, new patient must have Ph-positive ALL for approval of Imatinib.
Drugs
Imbruvica Oral Cap 140 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis

Age Restriction
18 years of age and older

Prescriber Restriction
Oncologist or Hematologist

Coverage Duration
12 months

Other Criteria
None
**Drugs**
Imfinzi IV. Sol. 120 mg/2.4 ml
Imfinzi IV. Sol. 500 mg/10 ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Diagnosis of Locally advanced or metastatic urothelial carcinoma who:
1. Have disease progression during or following platinum-containing chemotherapy OR
2. Have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

**Age Restriction**
18 years or older

**Prescriber Restriction**
Hematologist, Oncologist

**Coverage Duration**
12 months

**Other Criteria**
Subject to BvD
INCRELEX

Drugs
Increlex SubQ 40 mg/4ml vial

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Active or suspected neoplasia

Required Medical Information
Weight

Age Restriction
2-18 years old

Prescriber Restriction
Endocrinologist

Coverage Duration
12 months

Other Criteria
None
Drugs
Incruse Ellipta Inhaler 0.0625/Actuat

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years of age or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
INTERFERON BETA-1B

Drugs
Betaseron SubQ 0.3 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Concurrent use of interferon beta-1b with interferon beta-1a (Avonex, Rebif) or glatiramer acetate (Copaxone)

Required Medical Information
MRI

Age Restriction
18 years or older

Prescriber Restriction
Neurologist or a multiple sclerosis (MS) specialist

Coverage Duration
12 months

Other Criteria
None
**Drugs**
- Intron-A 6,000,000 unit/ml
- Intron-A 10,000,000 unit/ml
- Intron-A 18,000,000 units/ml
- Intron-A 50,000,000 units/ml
- Intron-A 25,000,000 units/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
Autoimmune hepatitis decompensated liver disease.

**Required Medical Information**
None

**Age Restriction**
- Chronic hepatitis B: 1 years or older
- Chronic hepatitis C: 3 years or older
- Other diagnosis: 18 years or older

**Prescriber Restriction**
Gastroenterologist, hematologist, oncologist, infectious disease (ID) specialist

**Coverage Duration**
12 months

**Other Criteria**
Subject to B vs D Review
IRESSA

Drugs
Iressa 250 mg Oral Tab.

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis: Metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, oncologist

Coverage Duration
12 months

Other Criteria
For continuation based on both of the following criteria: (1) Patient has not experienced disease progression AND (2) Patient has not experienced any serious adverse event while on the medication.
Drugs
Jakafi Oral Tab 5 mg, 10 mg, 15 mg, 20 mg, 25 mg

Covered Uses
All FDA approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years or older

Prescriber Restriction
Hematologist-Oncologist

Coverage Duration
Int. treatment limited to 6 months and subsequent 12 months

Other Criteria
Subsequent authorization requires documentation of spleen size reduction or symptomatic improvement.
JUXTAPID

Drugs
Juxtapid oral cap 5 mg, 10 mg, 20 mg, 30 mg, 40 mg, 60 mg

Covered Uses
All FDA approved indications not otherwise excluded from Part D

Exclusion Criteria
Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests. Pregnancy. Concomitant use with strong or moderate CYP3A4 inhibitors.

Required Medical Information
Diagnosis of homozygous familial hypercholesterolemia as evidenced by one of the following: A) genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or autosomal recessive hypercholesterolemia (ARH) adaptor protein gene locus OR B) untreated/pre-treatment LDL greater than 500 mg/dL Patient has tried and had an inadequate response to the maximum tolerated dose of a high potency statin (e.g., atorvastatin, rosuvastatin), unless all statin are contraindicated.

Age Restriction
18 years or older

Prescriber Restriction
Cardiologist, lipidologist, endocrinologist and /or geneticist

Coverage Duration
Initial – 6 months. Renewal – 12 months

Other Criteria
For renewal, patient has responded to therapy with a decrease in LDL levels from baseline AND patient does not have contraindications to therapy.
**KALYDECO**

**Drugs**
Kalydeco Oral Tab 150 mg
Kalydeco Oral Granules 50 mg, 75 mg

**Covered Uses**
All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
1. Diagnosis of cystic fibrosis (CF) who have one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data. If the patient’s genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use.

**Age Restriction**
Oral granules: 2 to 5 years of age. Tablets: 6 years of age and older

**Prescriber Restriction**
Pneumologist

**Coverage Duration**
Initiation, 3 months
Renewal, 6 months

**Other Criteria**
For renewal, patient has experienced benefit from therapy (i.e. improvement in pulmonary lung function [FEV1], decreased number of pulmonary exacerbations)
KANUMA

Drugs
Kanuma Inj 20/10 ml

Covered Uses
All FDA approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
1. Diagnosis of lysosomal acid lipase deficiency (LAL-D) AND
2. Diagnosis was confirmed by an enzymatic blood (e.g., dried blood spot test) or genetic test.

Age Restriction
1 month of age or older

Prescriber Restriction
Gastroenterologist, lipidologist or geneticist.

Coverage Duration
12 months

Other Criteria
Subject to B vs D review
**KEYTRUDA**

**Drugs**
Keytruda Inj. Solution 100 mg/4 ml vial
Keytruda Inj. Solution 50 mg vial

**Covered Uses**
All FDA approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Diagnosis of one of the following:

1. Unrespectable or metastatic melanoma.
2. Non-Small Cell Lung Cancer (NSCLC): a) as a single agent for the first-line treatment of patients with metastatic NSCLC whose tumors have high PD-L1 expression [(Tumor Proportion Score (TPS) ≥50%)] as determined by an FDA-approved test, with no EGFR or ALK genomic tumor aberrations, or b) as a single agent for the treatment of patients with metastatic NSCLC whose tumors express PD-L1 (TPS ≥1%) as determined by an FDA-approved test, with disease progression on or after platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving KEYTRUDA, or c) in combination with pemetrexed and carboplatin, as first-line treatment of patients with metastatic nonsquamous NSCLC.
3. Recurrent or metastatic Head and Neck Squamous Cell Cancer (HNSCC) with disease progression on or after platinum-containing chemotherapy.
4. Classical Hodgkin Lymphoma (cHL) who have relapsed after 3 or more prior lines of therapy.
5. Locally advanced or metastatic Urothelial Carcinoma who are not eligible for cisplatin-containing chemotherapy. OR for the treatment of patients who have locally advanced or metastatic urothelial carcinoma who have disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.
   a. Unresectable or metastatic Microsatellite Instability-High Cancer or mismatch repair deficient: a) solid tumors that have progressed following prior treatment and who have no satisfactory alternative treatment options, or b) colorectal cancer that has progressed following treatment with fluoropyrimidine, oxaliplatin, and irinotecan.

**Age Restriction**
18 years or older

**Prescriber Restriction**
1) Hematologist
2) Oncologist

**Coverage Duration**
12 months

**Other Criteria**
Subject to BvD review
KISQALI

Drugs
Kisqali Dose Pack 200 mg
Kisqali Dose Pack 400 mg
Kisqali Dose Pack 600 mg

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

Exclusion Criteria
None

Required Medical Information
1. Diagnosis
2. To be used in combination with letrozole
3. Before initiating therapy, CBC, liver function tests, and an ECG are performed.

Age Restriction
18 years or older

Prescriber Restriction
1. Hematologist
2. Oncologist

Coverage Duration
12 months

Other Criteria
For renewal, patient has no disease progression or unacceptable toxicity.
**Drugs**
Kisqali / Femara Therapy Pack 200 mg/2.5 mg
Kisqali / Femara Therapy Pack 400 mg/2.5 mg
Kisqali / Femara Therapy Pack 600 mg/2.5 mg

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

**Exclusion Criteria**
None

**Required Medical Information**
1. Diagnosis
2. Before initiating therapy, CBC, liver function test, and an ECG are performed.

**Age Restriction**
18 years or older

**Prescriber Restriction**
Hematologist
Oncologist

**Coverage Duration**
12 months

**Other Criteria**
For renewal, patient has no disease progression or unacceptable toxicity.
KORLYM

Drugs
Korlym Oral Tab 300mg

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

Exclusion Criteria
Pregnancy. Patient requires concomitant treatment with long-term corticosteroids (e.g., immunosuppression for organ transplant). History of unexplained vaginal bleeding. Endometrial hyperplasia with atypia or endometrial carcinoma. Concomitantly taking simvastatin, lovastatin, or a CYP3A substrate with a narrow therapeutic index (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus)

Required Medical Information
1. Diagnosis of endogenous Cushings syndrome AND diagnosis of type 2 diabetes mellitus or glucose intolerance AND Patient has hyperglycemia secondary to hypercortisolism AND patient has failed or is not a candidate for surgery.
2. Member have failed or been intolerant to therapy with adrenal enzyme inhibitors.
3. Member have failed or been intolerant to therapy with oral and injectable agents for type 2 diabetes mellitus.

Age Restriction
18 years of age or older

Prescriber Restriction
Endocrinologist

Coverage Duration
12 months

Other Criteria
None
Drugs
Kuvan Oral Tab 100 mg
Kuvan Oral Solution 500 mg
Kuvan Oral Solution 100 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Weight

Age Restriction
1 month of age or older

Prescriber Restriction
Endocrinologist, hepatologist, geneticist and metabolic specialist.

Coverage Duration
12 months

Other Criteria
None
KYNAMRO

Drugs
Kynamro Prefilled Syringe 200mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests.

Required Medical Information
Diagnosis of homozygous familial hypercholesterolemia as evidenced by one of the following: A) genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or autosomal recessive hypercholesterolemia (ARH) adaptor protein gene locus OR B) untreated/pre-treatment LDL greater than 500 mg/dL with at least one of the following: cutaneous or tendonous xanthoma before age 10 years, history of early vascular disease (men younger than 55 years, women younger than 60 years) on both sides of the family if parenteral LDL levels are unknown, elevated LDL cholesterol levels before lipid-lowering therapy consistent with heterozygous FH in both parents AND Medication will be used as adjunct to other lipid-lowering treatments AND Patient has tried and had an inadequate response to the maximum tolerated dose of a high potency statin (e.g., atorvastatin, rosuvastatin), unless all statin are contraindicated AND tried and failed a statin in combination with other lipid lowering therapies such as ezetimibe, bile acid sequestrant, or niacin.

Age Restriction
18 years of age or older

Prescriber Restriction
Cardiologist or Endocrinologist

Coverage Duration
12 months

Other Criteria
REMS participation
Drugs
Lenvima Pack 10, 14, 20, 24
Lenvima Pack 10 – 4
Lenvima Oral Cap 4 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis, 1. Differentiated Thyroid Cancer (DTC): single agent for patients with locally recurrent or metastatic, progressive, radioactive iodine-refractory DTC, OR 2. Renal Cell Cancer (RCC): in combination with everolimus, for patients with advanced RCC following one prior anti-angiogenic therapy.

Age Restriction
18 years of age or older.

Prescriber Restriction
1. Hematologist
2. Oncologist

Coverage Duration
12 months

Other Criteria
None
Drugs
Letairis Oral Tab 5 mg & 10 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Pregnancy. Idiopathic pulmonary fibrosis.

Required Medical Information
For the FDA-approved indication of pulmonary arterial hypertension, patients not currently on Letairis are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. For the FDA-approved indication of pulmonary arterial hypertension, patients currently on Letairis may continue therapy if they have a diagnosis of PAH.

Age Restriction
18 years or older

Prescriber Restriction
Pulmonologist or Cardiologist

Coverage Duration
Initial - 6 months. Renewal - 12 months

Other Criteria
None
LHRH DRUGS

Drugs
Leuprolide Acetate Kit 1 mg/0.2ml
Lupron Depot Kit 3.75 mg, 7.5 mg, 22.5 mg, 30 mg, 45 mg
Lupron Depot-Ped Kit 11.25 mg, 15 mg
Trelstar Depot Mixject 3.75 mg
Trelstar LA Mixject 11.25 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
Gynecologist, Urologist or Oncologist, Endocrinologist

Coverage Duration
12 months

Other Criteria
Must meet Part D coverage criteria and not be covered under Part B
LIDODERM

Drugs
Lidocaine Patch 5 % External

Covered Uses
All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria
None

Required Medical Information
Postherpetic Neuralgia or Diabetic Neuropathy: The member must have had a failure, adverse reaction, or contraindication to gabapentin.

Age Restriction
18 years or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
LINZESS

Drugs
Linzess Oral Cap 0.145 mg, 0.29 mg, 0.072 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Mechanical gastrointestinal obstruction

Required Medical Information
Diagnosis of irritable bowel syndrome-constipation occurring over at least 6 months and patient has tried and failed increasing fluid and fiber intake and patient has tried and failed or has an intolerance to osmotic laxatives, stimulant laxatives or probiotics OR Diagnosis of chronic idiopathic constipation for at least 3 months and patient has tried and failed increasing fluid and fiber intake and patient has tried and failed or has an intolerance to osmotic laxatives, stimulant laxatives or stool softeners.

Age Restriction
18 years and older

Prescriber Restriction
Gastroenterologist

Coverage Duration
Initial – 3 months. Renewal – 12 months.

Other Criteria
For renewal, the patient has experienced an increase in the number of bowel movements.
Drugs
Alosetron Oral Tab 0.5 mg & 1 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Do not initiate in patients with constipation. History of chronic or severe constipation or sequelae from constipation, intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions. ischemic colitis. impaired intestinal circulation, thrombophlebitis, or hypercoagulable state. Crohns disease or ulcerative colitis. diverticulitis. severe hepatic impairment. Concomitant use of fluvoxamine.

Required Medical Information
None

Age Restriction
18 years and older

Prescriber Restriction
Only prescribers enrolled in the Prometheus Prescribing Program.

Coverage Duration
12 weeks

Other Criteria
None
LOW MOLECULAR WEIGHT HEPARIN

Drugs
Fondaparinux sodium SubQ 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml, 10 mg/0.8ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Active major bleeding, Trombocytopenia

Required Medical Information
None

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, pulmonologist, surgeon, cardiologist or a peripheral vascular disease specialist.

Coverage Duration
1. Fondaparinux, For 5 – 9 days.
   - Extend prophylaxis up to 33 days.
   - For thrombosis of superficial lower limb up to 45 days.

Other Criteria
Fondaparinux: if the drug is to be used for DVT prophylaxis: try and failed therapy with Enoxaparin is required.
LUPANETA

Drugs
Lupaneta Pack 1-Month, Lupaneta Pack 3-Month.

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis, Negative pregnancy test

Age Restriction
18 years or older

Prescriber Restriction
Gynecologist

Coverage Duration
Limitations of Use: Initial treatment course is limited to 6 months and use is not recommended longer than a total of 12 months due to concerns about adverse impact on bone mineral density

Other Criteria
None
LYNPARZA

**Drugs**
Lynparza Oral Cap 50 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Diagnosis: Advanced ovarian cancer AND all of the following:
1. BRCA-positive mutation
2. Prior therapy with 3 or more lines of chemotherapy and
3. No concurrent therapy with other agents for the treatment of ovarian cancer.

**Age Restriction**
18 years or older

**Prescriber Restriction**
   a. Hematologist
   b. Oncologist

**Coverage Duration**
12 months

**Other Criteria**
Must be covered by Part D
MATULANE

Drugs
Matulane Oral Cap 50 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
None
MEPRON

Drugs
Atovaquone Oral Susp 750 mg/5 ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
Infectious Disease specialist

Coverage Duration
12 months

Other Criteria
None
METHOXSALEN

Drugs
Methoxsalen Oral Cap 10 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
History of light sensitive disease states (lupus erythematosus, porphyria, xeroderma pigmentosum, and albinism), history of melanoma, invasive squamous cell carcinomas, aphakia.

Required Medical Information
Diagnosis

Age Restriction
18 years and older

Prescriber Restriction
Dermatologist or Hematologist-Oncologist. Immunologist, Rheumatologist

Coverage Duration
12 months

Other Criteria
None
MODAFINIL

Drugs
Modafinil Oral Tab 100mg
Modafinil Oral Tab 200 mg

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

Exclusion Criteria
None

Required Medical Information
Diagnosis of one of the following: A) excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) and documentation of residual excessive sleepiness OR B) excessive sleepiness associated with narcolepsy confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR C) diagnosis of excessive sleepiness associated with shift work disorder confirmed by sleep lab evaluation and sleep disturbance persisted for at least three months.

Age Restriction
17 years of age or older

Prescriber Restriction
None

Coverage Duration
OSA/hypopnea syndrome - 6 months (initial), 12 months (renewal). Other diagnoses - 12 months.

Other Criteria
None
**MOZOBIL**

### Drugs
Mozobil Inj. 20mg/ml (24 mg vial)

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

### Exclusion Criteria
Pregnant, Breast Feeding

### Required Medical Information
Patient is to undergo autologous stem cell transplantation for the treatment of non-Hodgkins lymphoma or multiple myeloma AND Patient will concomitantly receive a daily dose of a granulocyte colony-stimulating factor (G-CSF) for 4 days prior to the first evening dose of Mozobil and on each day prior to apheresis while using Mozobil.

### Age Restriction
None

### Prescriber Restriction
None

### Coverage Duration
4 days

### Other Criteria
None
Drugs
Natpara Prefilled Syringe 0.25 mg/act, 0.05 mg/act, 0.075 mg/act, 0.1 mg/act.

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

Exclusion Criteria
1. Because of the potential risk of osteosarcoma, recommended only for patients who cannot be well-controlled on calcium supplements and active forms of vitamin D alone. 2. Patients with hypoparathyroidism caused by calcium-sensing receptor mutations. 3. Patients with acute post-surgical hypoparathyroidism

Required Medical Information
1. Diagnosis of hypocalcemia secondary to hypoparathyroidism AND Hypocalcemia is not corrected by calcium supplements and active forms of vitamin D alone AND 2. Serum calcium concentration is greater than 7.5 mg/dL and the 25-hydroxyvitamin D stores are sufficient.

Age Restriction
18 years or older

Prescriber Restriction
Endocrinologist

Coverage Duration
Initiation 3 months, and continuation 6 months.

Other Criteria
Concomitant use with alendronate is not recommended, Member should be enrolled in NATPARA REMS Program. Under this program, only certified healthcare providers can prescribe and only certified pharmacies can dispense Natpara
NEXAVAR

Drugs
Nexavar Oral Tab 200 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Combination with carboplatin and paclitaxel in patients with squamous cell lung cancer.

Required Medical Information
Diagnosis

Age Restriction
18 years and older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
None
NINLARO

Drugs
Ninlaro Oral Cap 2.3 mg, 3 mg, 4 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
1. Diagnosis: Use with lenalidomide and dexamethasone for the treatment of patients with multiple myeloma who have received at least one prior therapy.
2. Previous therapy
3. Protocol – to be use with lenalidomide and dexamethasone

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
None
Drugs
Zolpidem Tartrate Oral Tab. 5mg, 10 mg
Zolpidem Tartrate Oral Tab ER 6.25 mg, 12.5 mg

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

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
The PA is only required for a specific age range, 65 years old or more. The age range approved without PA is 64 years old or less.

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
PA will be approved if medical necessity statement is provided by physician including trial and failure to ONE non high risk medication alternative AND. Formulary Alternative Medications per drugs include but are NOT limited to -(1) Temazepam and Rozerem
NORTHERA

Drugs
Northera Oral Cap 100 mg, 200 mg, 300 mg

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

Exclusion Criteria
None

Required Medical Information
Diagnosis of neurogenic orthostatic hypotension (NOH), caused by primary autonomic failure (e.g. Parkinsons disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy.

Age Restriction
18 years or older

Prescriber Restriction
None

Coverage Duration
3 months

Other Criteria
None
Drugs
Nucala Inj Vial 100 mg

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

Exclusion Criteria
None

Required Medical Information
1. Diagnosis: for add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype. 2. Member had a history of 2 or more exacerbations in the prior year despite regular use of high-dose inhaled corticosteroids plus an additional asthma controller (unless either intolerant or contraindicated). 3. CBC differential, eosinophil blood count of more than 150 cells per mcl.

Age Restriction
12 years or older.

Prescriber Restriction
Pneumologist, Allergist, Immunologist

Coverage Duration
Initial- 6 month, continuation 12 months

Other Criteria
Subject to B vs D review. For continuation: Patient has improve in his condition, demonstrated by a reduction in oral/systemic corticosteroid use.
NULOJIX

Drugs
Nulojix Inj. 250 mg/vial

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

Exclusion Criteria
EBV seronegative or unknown status

Required Medical Information
Medication will be used for the prevention of kidney transplant organ rejection AND the patient is immune to the Epstein-Barr virus (EBV seropositive) AND the patient is prescribed concurrent therapy with mycophenolate and corticosteroids.

Age Restriction
18 years or older.

Prescriber Restriction
Prescriber is experienced in immunosuppressive therapy and management of transplant patients.

Coverage Duration
12 months

Other Criteria
Subject to B vs D Review.
**Drugs**
Nuplazid Oral Tab 17 mg

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

**Exclusion Criteria**
None

**Required Medical Information**
1. Diagnosis: hallucinations and delusions associated with Parkinson’s disease psychosis AND ALL of the following:
   a. Prescribing physician has attempted to adjust Parkinson’s disease medications in order to reduce psychosis without worsening motor symptoms prior to requesting Nuplazid.
   b. Mini-Mental State Examination (MMSE) score Greater than or equal to 21.

**Age Restriction**
18 years or older.

**Prescriber Restriction**
Psychiatrist, neurologist

**Coverage Duration**
12 months

**Other Criteria**
None
Drugs
Armodafinil Oral Tab 50mg, 150 mg, 200 mg, 250 mg

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

Exclusion Criteria
None

Required Medical Information
Diagnosis of one of the following: A) excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) and documentation of residual excessive sleepiness OR B) excessive sleepiness associated with narcolepsy confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR C) diagnosis of excessive sleepiness associated with shift work disorder confirmed by sleep lab evaluation and sleep disturbance persisted for at least three months.

Age Restriction
17 years or older.

Prescriber Restriction
None

Coverage Duration
OSA/hypopnea syndrome - 6 months (initial), 12 months (renewal). Other diagnoses - 12 month

Other Criteria
None
Drugs
Odomzo 200 mg Oral Cap.

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

Exclusion Criteria
Pregnancy

Required Medical Information
Diagnosis: locally advanced basal cell carcinoma (BCC) that has recurred following surgery or radiation therapy, or those who are not candidates for surgery or radiation therapy.

Age Restriction
18 years or older.

Prescriber Restriction
Hematologist, oncologist

Coverage Duration
12 months

Other Criteria
None
**Drugs**
Ofev Oral Cap 100 mg
Ofev Oral Cap 150 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
1. Diagnosis of idiopathic pulmonary fibrosis confirmed by a high resolution CT scan or biopsy AND
2. Patient does not have evidence or suspicion of an alternative interstitial lung disease diagnosis AND
3. Liver function tests have been performed prior to start of therapy AND
4. Patient has a forced vital capacity (FVC) greater or equal to 50% of predicted.

**Age Restriction**
18 years or older

**Prescriber Restriction**
Pulmonologist

**Coverage Duration**
12 months

**Other Criteria**
For continuation, patient has stabilization from baseline or a less than 10 percent decline in force vital capacity AND the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage.
Drugs
Opsumit 10 mg Oral Tab

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Pregnancy

Required Medical Information
Diagnosis of Pulmonary artery hypertension as defined by WHO group 1 and confirmed by right heart catheterization. Pregnancy test in females of reproductive potential prior to initiation.

Age Restriction
18 years or older

Prescriber Restriction
Pulmonologist, Cardiologist

Coverage Duration
12 months

Other Criteria
Participation in REMS Program for females
**ORFADIN**

**Drugs**
Orfadin Oral Tab 10 mg, 2 mg, 5 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Weight

**Age Restriction**
None

**Prescriber Restriction**
Nephrologist, Gastroenterologist, Hematologist, Geneticist, Endocrinologist or Metabolic Specialist.

**Coverage Duration**
12 months

**Other Criteria**
None
**Drugs**
Orkambi Oral Tab 125 mg/ 200 mg, 125 mg/ 100 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Diagnosis of cystic fibrosis AND Patient homozygous for the F508del mutation in the CFTR gene, documented by an FDA-cleared cystic fibrosis-mutation test. FEV1 value.

**Age Restriction**
12 years or older

**Prescriber Restriction**
Pneumologist

**Coverage Duration**
Initiation 3 months. Renewal 6 months.

**Other Criteria**
For renewal, patient has experienced benefit from therapy (i.e. improvement in pulmonary lung function [FEV1], decreased number of pulmonary exacerbations)
OTHER RESPIRATORY DRUGS

Drugs
Zemaira Inj. Sol. 50 mg/ml
Prolastin Inj Sol. 50 mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Lung disease patients in whom congenital alpha 1 -PI deficiency has not been established

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Subject to B vs D review.
METHYLNALTREXONE

**Drugs**
Relistor Inj vial 12/0.6ml  
Relistor Prefilled Syringe 12/0.6ml  
Relistor Prefilled Syringe 8/0.4 ml  

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
Known or suspected gastrointestinal obstruction and patients at an increased risk of recurrent obstruction, gastrointestinal perforation may occur.

**Required Medical Information**
Diagnosis of opioid induced constipation. Trial and Failure of a Laxative in the past 90 days.

**Age Restriction**
18 years and older

**Prescriber Restriction**
Gastroenterologist, Oncologist, hematologist OR Pain management Specialist.

**Coverage Duration**
12 months

**Other Criteria**
None
Drugs
Panretin 0.1 % Topical Gel

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years and older

Prescriber Restriction
Hematologist- Oncologist

Coverage Duration
12 months

Other Criteria
None
Drugs
Pegasys Inj.Sol. 0.18mg/ml
Pegasys Prefilled Syringe 0.36 mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Autoimmune hepatitis. Hepatic decompensation in patients with cirrhosis.

Required Medical Information
Diagnosis, one of the following: 1. Diagnosis of hepatitis HCV genotype: G3, G4, G5 or G6, treatment-naive: sofosbuvir and weight-based RBV plus weekly PEG-IFN for 12 weeks. 2. Diagnosis of hepatitis HCV genotype: G2, G3, G4, G5 or G6, re treatment: sofosbuvir and weight-based RBV plus weekly PEG-IFN for 12 weeks. OR 3. Chronic Hepatitis B.

Age Restriction
HCV: 18 yrs or older if triple therapy (Pegasys+Sovaldi+RBV), else 5 yrs or older.

Prescriber Restriction
Infectious disease physician, gastroenterologist, hepatologist, or a transplant physician

Coverage Duration
Criteria will be applied consistent with current AASLD-IDSA guidance.

Other Criteria
For renewal of HCV, approval is based on the requirements outlined in the FDA-approved labeling, including viral load, presence of cirrhosis, and response to prior therapy.
<table>
<thead>
<tr>
<th>Drugs</th>
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<tbody>
<tr>
<td>Abelcet intravenous suspension 5 mg/ml</td>
</tr>
<tr>
<td>Acetylcysteine inhalation solution 10 %, 20 %</td>
</tr>
<tr>
<td>Acyclovir sodium intravenous solution 50 mg/ml</td>
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<tr>
<td>Adagen intramuscular solution 250 unit/ml</td>
</tr>
<tr>
<td>Albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml</td>
</tr>
<tr>
<td>Aldurazyme intravenous solution 2.9 mg/5ml</td>
</tr>
<tr>
<td>Ambisome intravenous suspension reconstituted 50 mg</td>
</tr>
<tr>
<td>Aminosyn ii intravenous solution 10 %, 7 %, 8.5 %</td>
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<tr>
<td>Aminosyn ii/electrolytes intravenous solution 8.5 %</td>
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<tr>
<td>Aminosyn/electrolytes intravenous solution 7 %</td>
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<tr>
<td>Aminosyn/electrolytes intravenous solution 8.5 %</td>
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<tr>
<td>Aminosyn-hbc intravenous solution 7 %</td>
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<tr>
<td>Aminosyn-pf intravenous solution 10 %, 7 %</td>
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<tr>
<td>Aminosyn-rf intravenous solution 5.2 %</td>
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<tr>
<td>Amphotericin b injection solution reconstituted 50 mg</td>
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<tr>
<td>Ampicillin sodium injection solution reconstituted 1 gm, 125 mg</td>
</tr>
<tr>
<td>Ampicillin sodium intravenous solution reconstituted 10 gm</td>
</tr>
<tr>
<td>Ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm</td>
</tr>
<tr>
<td>Ampicillin-sulbactam sodium injection solution reconstituted 3 (2-1) gm</td>
</tr>
<tr>
<td>Ampicillin-sulbactam sodium intravenous solution reconstituted 15 (10-5) gm</td>
</tr>
<tr>
<td>Aprepitant oral capsule 125 mg, 40 mg, 80 &amp; 125 mg, 80 mg</td>
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<tr>
<td>Azacitidine injection suspension reconstituted 100 mg</td>
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<tr>
<td>Azathioprine oral tablet 50 mg</td>
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<tr>
<td>Azathioprine sodium injection solution reconstituted 100 mg</td>
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<tr>
<td>Bicnu intravenous solution reconstituted 100 mg</td>
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<tr>
<td>Bivigam intravenous solution 10 gm/100ml</td>
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<tr>
<td>Bleomycin sulfate injection solution reconstituted 30 unit</td>
</tr>
<tr>
<td>Budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml</td>
</tr>
<tr>
<td>Busulfex intravenous solution 6 mg/ml</td>
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<tr>
<td>Busulfan Intravenous solution 6 mg/ml</td>
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<tr>
<td>Calcitriol oral solution 1 mcg/ml</td>
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<tr>
<td>Cancidas intravenous solution reconstituted 50 mg, 70 mg</td>
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<tr>
<td>Carboplatin intravenous solution 150 mg/15ml</td>
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<tr>
<td>Cefoxitin sodium injection solution reconstituted 10 gm</td>
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<tr>
<td>Cefoxitin sodium intravenous solution reconstituted 1 gm, 2 gm</td>
</tr>
<tr>
<td>Ceftriaxone sodium injection solution reconstituted 250 mg, 500 mg</td>
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<tr>
<td>Ceftriaxone sodium intravenous solution reconstituted 1 gm, 10 gm, 2 gm</td>
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<tr>
<td>Cefuroxime sodium injection solution reconstituted 1.5 gm, 7.5 gm, 750 mg</td>
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<tr>
<td>Chloramphenicol sod succinate intravenous solution reconstituted 1 gm</td>
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<tr>
<td>Cisplatin intravenous solution 100 mg/100ml</td>
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<tr>
<td>Cladribine intravenous solution 10 mg/10ml</td>
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<tr>
<td>Clinimix/dextrose (2.75/5) intravenous solution 2.75 %</td>
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<tr>
<td>Clinimix/dextrose (4.25/10) intravenous solution 4.25 %</td>
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<tr>
<td>Clinimix/dextrose (4.25/20) intravenous solution 4.25 %</td>
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<tr>
<td>Clinimix/dextrose (4.25/25) intravenous solution 4.25 %</td>
</tr>
</tbody>
</table>
Clinimix/dextrose (4.25/5) intravenous solution 4.25 %
Clinimix/dextrose (5/15) intravenous solution 5 %
Clinimix/dextrose (5/20) intravenous solution 5 %
Clinimix/dextrose (5/25) intravenous solution 5 %
Colistimethate sodium injection solution reconstituted 150 mg
Cromolyn sodium inhalation nebulization solution 20 mg/2ml
Cyclophosphamide oral capsule 25 mg, 50 mg
Cyclosporine intravenous solution 50 mg/ml
Cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg
Cyclosporine modified oral solution 100 mg/ml
Cyclosporine oral capsule 100 mg, 25 mg
Cytarabine injection solution 20 mg/ml
Dacarbazine intravenous solution reconstituted 200 mg
Daptomycin intravenous solution reconstituted 500 mg
Daunorubicin hcl intravenous injectable 5 mg/ml
Depo-provera intramuscular suspension 400 mg/ml
Desmopressin acetate injection solution 4 mcg/ml
Dexrazoxane intravenous solution reconstituted 250 mg
Diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml
Docetaxel intravenous concentrate 80 mg/4ml
Docetaxel intravenous solution 80 mg/8ml
Doxorubicin hcl intravenous solution 2 mg/ml
Doxorubicin hcl liposomal intravenous injectable 2 mg/ml
Dronabinol oral capsule 10 mg, 2.5 mg, 5 mg
Duramorph injection solution 0.5 mg/ml, 1 mg/ml
Elitek intravenous solution reconstituted 1.5 mg, 7.5 mg
Emend intravenous solution reconstituted 150 mg
Emend oral suspension reconstituted 125 mg
Engerix-b injection suspension 10 mcg/0.5ml, 20 mcg/ml
Epirubicin hcl intravenous solution 200 mg/100ml
Erythrocin lactobionate intravenous solution reconstituted 500 mg
Etoposide intravenous solution 500 mg/25ml
Faslodex intramuscular solution 250 mg/5ml
Fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%
Fluconazole in sodium chloride intravenous solution 400-0.9 mg/200ml-%
Fludarabine phosphate intravenous solution reconstituted 50 mg
Fluorouracil intravenous solution 2.5 gm/50ml
Freamine hbc intravenous solution 6.9 %
Gamastan s/d intramuscular injectable
Gammagard injection solution 2.5 gm/25ml
Gammmagard s/d less iga intravenous solution reconstituted 10 gm, 5 gm
Gammaplex intravenous solution 10 gm/200ml
Gammaplex intravenous solution 10 gm/100ml
Gammaplex intravenous solution 10 gm/50ml
Gamunex-c injection solution 1 gm/10ml
Ganciclovir sodium intravenous solution reconstituted 500 mg
Gemcitabine hcl intravenous solution reconstituted 1 gm
Gengraf oral capsule 100 mg, 25 mg, 50 mg
Gengraf oral solution 100 mg/ml
Granisetron hcl intravenous solution 1 mg/ml, 4 mg/4ml
Granisetron hcl oral tablet 1 mg
Heparin (porcine) in d5w intravenous solution 40-5 unit/ml-%, 50-5 unit/ml-%
Heparin sod (porcine) in d5w intravenous solution 100 unit/ml
Heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml
Hepatamine intravenous solution 8%
Herceptin intravenous solution reconstituted 440 mg
Hydromorphone hcl pf injection solution 10 mg/ml, 50 mg/5ml
Idarubicin hcl intravenous solution 10 mg/10ml
Ifosfamide intravenous solution reconstituted 1 gm
Imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg
Intralipid intravenous emulsion 20%
Intralipid intravenous emulsion 30%
Invanz injection solution reconstituted 1 gm
Ipratropium bromide inhalation solution 0.02%
Ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml
Irinotecan hcl intravenous solution 100 mg/5ml
Istodax (overfill) intravenous solution reconstituted 10 mg
Kyprolis intravenous solution reconstituted 30 mg, 60 mg
Lartruvo intravenous solution 500 mg/50ml
Leucovorin calcium injection solution reconstituted 100 mg, 350 mg
Levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml
Levocarnitine oral solution 1 gm/10ml
Lidocaine hcl (pf) injection solution 0.5 %
Lidocaine hcl injection solution 2 %
Lidocaine hcl Inj. 10 mg/ml
Lumizyme intravenous solution reconstituted 50 mg
Melphalan hcl intravenous solution reconstituted 50 mg
Meropenem intravenous solution reconstituted 500 mg
Mesna intravenous solution 100 mg/ml
Methotrexate oral tablet 2.5 mg
Methotrexate sodium (pf) injection solution 1 gm/40ml
Methotrexate sodium injection solution 50 mg/2ml
Methotrexate sodium injection solution reconstituted 1 gm
Mitomycin intravenous solution reconstituted 20 mg
Mitoxantrone hcl intravenous concentrate 25 mg/12.5ml
Morphine sulfate (pf) intravenous solution 10 mg/ml, 2 mg/ml, 4 mg/ml, 8 mg/ml
Mustargen injection solution reconstituted 10 mg
Mycamine intravenous solution reconstituted 100 mg, 50 mg
Mycophenolate mofetil hcl intravenous solution reconstituted 500 mg
Mycophenolate mofetil oral capsule 250 mg
Mycophenolate mofetil oral suspension reconstituted 200 mg/ml
Mycophenolate mofetil oral tablet 500 mg
Mycophenolate sodium oral tablet delayed release 180 mg, 360 mg
Nafcillin sodium injection solution reconstituted 1 gm, 10 gm
Naglazyme intravenous solution 1 mg/ml
Nebupent inhalation solution reconstituted 300 mg
Neoral oral capsule 100 mg, 25 mg

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Neoral oral solution 100 mg/ml  
Nephramine intravenous solution 5.4 %  
Nipent intravenous solution reconstituted 10 mg  
Nutrilipid intravenous emulsion 20 %  
Octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml  
Ondansetron hcl oral solution 4 mg/5ml  
Ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg  
Ondansetron oral tablet dispersible 4 mg, 8 mg  
Opdivo intravenous solution 40 mg/4ml  
Oxaliplatin intravenous solution 100 mg/20ml  
Paclitaxel intravenous concentrate 300 mg/50ml  
Pamidronate disodium intravenous solution 30 mg/10ml, 6 mg/ml, 90 mg/10ml  
Paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg  
Pentam injection solution reconstituted 300 mg  
Perforomist inhalation nebulization solution 20 mcg/2ml  
Premasol intravenous solution 10 %  
Premasol intravenous solution 6 %  
Privigen intravenous solution 20 gm/200ml  
Procalamine intravenous solution 3 %  
Prograf oral capsule 0.5 mg, 1 mg, 5 mg  
Proleukin intravenous solution reconstituted 22000000 unit  
Prosol intravenous solution 20 %  
Pulmozyme inhalation solution 1 mg/ml  
Rapamune oral solution 1 mg/ml  
Recombivax hb injection suspension 10 mcg/ml, 40 mcg/ml, 5 mcg/0.5ml  
Rituxan intravenous solution 500 mg/50ml  
Sandimmune oral solution 100 mg/ml  
Sandostatin lar depot intramuscular kit 10 mg, 20 mg, 30 mg  
Sirolimus oral tablet 0.5 mg, 1 mg  
Sirolimus oral tablet 2 mg  
Somatuline depot subcutaneous solution 120 mg/0.5ml, 60 mg/0.2ml, 90 mg/0.3ml  
Tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg  
Teflaro intravenous solution reconstituted 400 mg, 600 mg  
Tenivac intramuscular injectable 5-2 lfu  
Tetanus-diphtheria toxoids td intramuscular suspension 2-2 lfu/0.5ml  
Tobramycin inhalation nebulization solution 300 mg/5ml  
Tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml  
Toposar intravenous solution 1 gm/50ml  
Topotecan hcl intravenous solution reconstituted 4 mg  
Tpn electrolytes intravenous solution  
Travasol intravenous solution 10 %  
Treanda intravenous solution reconstituted 100 mg  
Trisenox intravenous solution 10 mg/10ml  
Trohamine intravenous solution 10 %  
Vancomycin hcl intravenous solution reconstituted 10 gm, 1000 mg, 500 mg  
Vinblastine sulfate intravenous solution 1 mg/ml  
Vincasar pfs intravenous solution 1 mg/ml  
Vincristine sulfate intravenous solution 1 mg/ml  
Vinorelbine tartrate intravenous solution 50 mg/5ml
Yondelis intravenous solution reconstituted 1 mg
Zanosar intravenous solution reconstituted 1 gm
Zoledronic acid intravenous concentrate 4 mg/5ml
Zoledronic acid intravenous solution 5 mg/100ml
Zortress oral tablet 0.25 mg, 0.5 mg, 0.75 mg

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

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
None

Other Criteria
None
PHOSPHODIESTERASE-5 INHIBITORS FOR PAH

Drugs
Revatio Oral Suspension 10 mg / ml
Sildenafil Citrate Oral Tab 20 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
1. Use for erectile dysfunction
2. Patients taking nitrates

Required Medical Information
Diagnosis of pulmonary artery hypertension as defined by WHO group 1 and confirmed by right heart catheterization.

Age Restriction
18 years of age or older

Prescriber Restriction
Pulmonologist, Cardiologist

Coverage Duration
12 months

Other Criteria
None
PRADAXA

Drugs
Pradaxa Oral Cap 75 mg, 110 mg, 150 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Mechanical Prosthetic Heart Valve, active pathological bleeding.

Required Medical Information
None

Age Restriction
18 years or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Authorize use of Pradaxa if the patient has tried and failed warfarin
PROLIA

Drugs
Prolia Inj. 60 mg/ml

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

Exclusion Criteria
Pregnancy

Required Medical Information
Patient is at high risk for fracture defined as one of the following: Personal history of low-trauma fractures as an adult, History of osteoporotic fracture in a first degree relative, Concurrent use of systemic corticosteroids (avg dose more than 5 mg of prednisone per day), Concurrent cigarette smoking, Low body weight less than 127 pounds, Low bone mineral density (T-score of -2.5 or lower) AND Diagnosis of one of the following: Patient is female and is receiving adjuvant aromatase inhibitor therapy for breast cancer, Patient is male and is receiving androgen deprivation therapy for non-metastatic prostate cancer, Patient is a male or postmenopausal female with a diagnosis of osteoporosis AND Patient has a documented trial and failure with a bisphosphonate (failure is defined as new fractures in compliant patients) or contraindication or intolerance to bisphosphonate therapy or is unable to comply with appropriate administration recommendations for oral or injectable bisphosphonate therapy AND patient will have pre-existing hypocalcemia and vitamin D deficiency corrected prior to administration of the medication.

Age Restriction
None

Prescriber Restriction
Endocrinologist
Rheumatologist
Gynecologist
Oncologist

Coverage Duration
12 months

Other Criteria
Subject to B v D Review
Drugs
Promacta Oral Tab 12.5 mg, 25 mg, 50 mg, 75 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. Thrombocytopenia due to hepatitis C virus (HCV)-related cirrhosis.

Exclusion Criteria
None

Required Medical Information
Diagnosis of 1) Chronic immune (idiopathic) thrombocytopenia (ITP) who have had an insufficient response to corticosteroids, immunoglobulins, or splenectomy OR 2) Thrombocytopenia in patients with chronic hepatitis C to allow the initiation and maintenance of interferon-based therapy OR 3) Severe aplastic anemia who have had an insufficient response to immunosuppressive therapy.

Age Restriction
6 years or older

Prescriber Restriction
Treatment of thrombocytopenia due to chronic immune (idiopathic) thrombocytopenic purpura (ITP), approve if prescribed by, or after consultation with, a hematologist. Treatment of thrombocytopenia due to HCV-related cirrhosis, approve if prescribed by, or after consultation with, either a hematologist, gastroenterologist, hepatologist or a physician who specializes in infectious disease.

Coverage Duration
Authorization will be for 12 months

Other Criteria
For treatment of thrombocytopenia due to HCV-related cirrhosis, approve to allow for initiation of antiviral therapy.
QUETIAPINE

Drugs
Quetiapine Fumarate Oral Tab 25 mg, 50 mg
Quetiapine XR 50mg, 150mg, 200mg, 300mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Dementia-related psychosis

Required Medical Information
Diagnosis of schizophrenia; bipolar disorder, or depressive episodes

Age Restriction
10 years or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Quetiapine ER: documented trial and failure to IR quetiapine. For Prior History of medication in claims, MD shall provide documentation of medical record or pharmacy claims processing thru another benefit to comply with previous utilization. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. There is an increased risk of suicidal thoughts and behavior in children, adolescents and young adults taking antidepressants. Monitor patients.
Drugs
Ranexa Oral Tab Extended Release 12 HR 500 mg & 1000 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Concurrent use of CYP3A inducers and strong CYP3A inhibitors. Liver cirrhosis.

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
Cardiologist or internal medicine practitioner

Coverage Duration
12 months

Other Criteria
None
RAVICTI

**Drugs**
Ravicti Oral Sol. 1100 mg/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
Contraindicated in patients less than 2 months of age.

**Required Medical Information**
Diagnosis: for use as a nitrogen binding agent for chronic management of adult and pediatric patients more than 2 years of age with urea cycle disorders (UCDs).

**Age Restriction**
2 years of older

**Prescriber Restriction**
Specialist in urea cycle disorder (UCD)

**Coverage Duration**
12 months

**Other Criteria**
None
Drugs
Regranex 0.1% External

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
1. Prevention of ulcers/wounds.
2. First-line therapy for the treatment of Stage II ulcers/wounds. Standard ulcer/wound care should be used first-line.
3. Treatment of wounds/ulcers classified as Stage I.
4. Neoplasm at application site.

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Becaplermin gel 0.01% should be used as an adjunct to, and not a substitute for good ulcer/wound care practices including initial sharp debridement, pressure relief, and infection control.
**Drugs**
Remodulin Inj Soln 1 mg/ml, 2.5 mg/ml, 5 mg/ml, 10 mg/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
For the FDA-approved indication of pulmonary arterial hypertension, patients not currently on Remodulin are required to have had a right-heart catheterization to confirm the diagnosis of pulmonary artery hypertension (PAH) to ensure appropriate medical assessment. For the FDA-approved indication of pulmonary arterial hypertension, patients currently on Remodulin may continue therapy if they have a diagnosis of PAH.

**Age Restriction**
18 years or older

**Prescriber Restriction**
For treatment of pulmonary arterial hypertension, Remodulin must be prescribed by or in consultation with a cardiologist or a pulmonologist.

**Coverage Duration**
Authorization will be for 12 months.

**Other Criteria**
Subject to B vs D Review
**Drugs**

Repatha Prefilled Syringe 140 mg/ml  
Repatha Authoinjector 140 mg/ml  
Repatha Cartridge 120 mg/ml

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**

Monotherapy

**Required Medical Information**

1. **Diagnosis**
   1) Familial hypercholesterolemia - homozygous AND has a concurrent claim for other lipid-lowering therapies (statins or ezetimibe).  
   2) Primary heterozygous familial hypercholesterolemia AND has a concurrent claim for other maximally tolerated statin (rosuvastatin or atorvastatin).  
   3) Primary hypercholesterolemia, Atherosclerotic cardiovascular disease, AND has a concurrent claim for other maximally tolerated statin (rosuvastatin or atorvastatin), AND does the patient have at least 90 consecutive days of maximun tolerate dose of atorvastatin or rosuvastatin and 90 consecutive days of ezetimibe therapy in the last 180 Days.
   
   Intolerance to a statin: medical records of documentation with ONE of the following:  
   1) Intolerable and persistent (ie: more than 2 weeks) muscle symptoms (eg., muscle pain, weakness, cramps) with ALL of the following: a. Patient has taken at least ONE high intensity statin in combination with Zetia (ezetimibe) and ONE low to moderate intensity statin in combination with Zetia (ezetimibe): with documented reappearance of the muscle symptoms b. Documentation provided indicated creatinine kinase (CK) levels greater than 10 times upper normal limit and/or rhabdomyolysis with CK levels greater than 10,000 IU/L).  
   2) Intolerable and persistent hepatotoxicity with ALL of the following: a. Documentation indicating persistent elevations (>3 times the upper limit of normal occurring on 2 more occasions) of serum transaminases or the presence of jaundice. b. Secondary causes of elevations in hepatic transaminase levels have been ruled out (eg., infection, medications, herbal supplements).  

2. **LDL**.

**Age Restriction**

13 years or older

**Prescriber Restriction**

Cardiologist, Endocrinologist

**Coverage Duration**

Initial-3 months, Continuation 6 months.

**Other Criteria**

For continuation of therapy. Patient has to show clinical response with lowering of LDL-C since initiation of PCSK9 inhibitor therapy.
**Drugs**
Restasis Ophthalmic Susp. 0.5 mg/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Diagnosis of Keratoconjunctivitis Sicca (KCS)

**Age Restriction**
None

**Prescriber Restriction**
Ophthalmologist

**Coverage Duration**
12 months

**Other Criteria**
None
**Drugs**
Revlimid Oral Cap 2.5 mg, 5 mg, 10 mg, 15 mg, 20 mg, 25 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
Pregnancy. Treatment of patients with Chronic lymphocytic leukemia (CLL).

**Required Medical Information**
Myelodysplastic Syndrome: Diagnosis of transfusion-dependent anemia due to myelodysplastic syndrome associated with the 5q-deletion cytogenetic abnormality. Multiple Myeloma: Diagnosis of Multiple Myeloma and Revlimid is being used in combination with dexamethasone and the member has received and failed to respond to at least one prior therapy. 2 negative pregnancy test prior to starting treatment for females on child bearing ages.

**Age Restriction**
18 years and older

**Prescriber Restriction**
Hematologist, Oncologist, ID specialist

**Coverage Duration**
12 months

**Other Criteria**
Revlimid REMS
RIBAVIRIN

**Drugs**
Ribavirin Oral Cap. 200 mg
Ribavirin Oral Tab 200 mg
Ribasphere Oral Cap. 200 mg
Ribasphere Oral Tab 200 mg, 400 mg, 600 mg
Ribasphere Ribapak 200 mg/400 mg
Ribasphere Ribapak 800 mg, 1000 mg, 1200 mg
Moderiba Oral Tab 200 mg
Moderiba 800 Dose Pack
Rebetol Oral Solution 40 mg/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
Coadministration with didanosine, hemoglobinopathy, pregnancy, pancreatitis, CrCL less than 50 ml/min

**Required Medical Information**
To be used in combination and not monotherapy. For continuation of therapy: CBC, negative pregnancy test prior to starting treatment for females on child bearing ages.

**Age Restriction**
3 years and older

**Prescriber Restriction**
Gastroenterologist, Hepatologist, Infectious Disease specialist

**Coverage Duration**
12 months

**Other Criteria**
None
RILUTEK

**Drugs**
Riluzole Oral Tab 50 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
None

**Age Restriction**
18 years and older

**Prescriber Restriction**
Neurologist

**Coverage Duration**
12 months

**Other Criteria**
None
Drugs
Rubraca Oral Tab 200 mg, 300 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
1. Monotherapy for the treatment of patients with deleterious BRCA mutation (germline and/or somatic) associated advanced ovarian cancer who have been treated with two or more chemotherapies.
2. BRCA mutation as detected by an approved FDA laboratory test.
3. Women of reproductive potential: Use of effective contraception during therapy.

Age Restriction
18 years of age or older.

Prescriber Restriction
Hematologist - Oncologist

Coverage Duration
12 months

Other Criteria
Must be covered by Part D.
**Drugs**
Rydapt Oral Capsule 25 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Diagnosis of one the following:
1. Newly diagnosed acute myeloid leukemia (AML) that is FLT3 mutation positive as detected by an FDA-approved test, in combination with standard cytarabine and daunorubicin induction and cytarabine Consolidation, OR
2. Aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).

**Age Restriction**
18 years or older.

**Prescriber Restriction**
Hematologist, Oncologist

**Coverage Duration**
12 months

**Other Criteria**
Must be covered by Part D benefit. RYDAPT is not indicated as a single-agent induction therapy for the treatment of patients with AML.
Drugs
Sabril Oral Sol. 50 mg / ml
Sabril Oral Tab 500 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
Neurologist

Coverage Duration
12 months

Other Criteria
None
SAVELLA

Drugs
Savella Oral Tab 12.5 mg, 25 mg, 50 mg, 100 mg
Savella 4 week Titration Pack

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Concomitant use of MAOI

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
**Drugs**
Serevent Diskus Aerosol Powder 50 mcg/dose

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
None

**Age Restriction**
4 years or older

**Prescriber Restriction**
None

**Coverage Duration**
12 months

**Other Criteria**
Because of this risk, use of Serevent Diskus for the treatment of asthma without concomitant use of a long-term asthma control medication, such as an inhaled corticosteroid, is contraindicated. Use Serevent Diskus only as additional therapy for patients with asthma who are currently taking but are inadequately controlled on a long-term asthma control medication, such as an inhaled corticosteroid. Do not use Serevent Diskus for patients whose asthma is adequately controlled on low- or medium-dose inhaled corticosteroids.
**SGLT2 INHIBITORS**

**Drugs**
- Farxiga Oral Tab 5 mg, 10 mg
- Xigduo ER 5 / 500 mg, 5 / 1000 mg, 10 / 500 mg, 10 / 1000 mg
- Invokana Oral Tab 100 mg, 300 mg
- Invokamet Oral Tab 50 / 500 mg, 50 / 1000 mg, 150 / 500 mg, 150 / 1000 mg
- Jardiance Oral Tab 10 mg, 25 mg
- Invokamet ER Oral Tab 50 / 500 mg, 50 / 1000 mg, 150 / 500 mg, 150 / 1000 mg
- Synjardy Oral Tab 12.5 mg / 1000 mg, 12.5 mg / 500 mg, 5 mg / 1000 mg, 5 mg / 500 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
A1c, history of previous drug therapies.

**Age Restriction**
None

**Prescriber Restriction**
None

**Coverage Duration**
12 months

**Other Criteria**
Patients must try and fail Metformin or combination with Metformin. If A1c less than = 10, then approve. If A1c greater than 10, then deny for ineffectiveness, require use of Insulin. Approve if history of metformin or metformin combination contraindication, ADR or intolerance and A1c is less than 10.
Drugs
Signifor Inj. Sol. 0.3 mg / ml, 0.6 mg / ml, 0.9 mg / ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
1. Diagnosis of (pituitary) Cushings disease AND pituitary surgery is not an option or has not been curative.
2. Baseline 24-hour urine free cortisol level equal or higher than 1.5 x upper limit of normal.
3. Failure of at least one prior agent used in the treatment of Cushings disease (ketoconazole, mitotane, or metyrapone) or contraindication to all agents.

Age Restriction
18 years or older

Prescriber Restriction
Endocrinologist

Coverage Duration
12 months

Other Criteria
For continuation: 24-hour urine free cortisol level is less than 1.5 x upper limit of normal AND clinically meaningful reduction in 24-hour urinary free cortisol AND patient is tolerating treatment.
Drugs
Signifor Inj. Susp 10 mg / ml, 20 mg / ml, 30 mg / ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Patient has a diagnosis of acromegaly and patient had an inadequate response to surgery or patient is not a candidate for surgery

Age Restriction
18 years or older

Prescriber Restriction
Endocrinologist

Coverage Duration
3 months initial. 12 months renewal.

Other Criteria
For renewal, patients growth hormone level or insulin-like growth factor 1 (IGF-1) level for age and gender has normalized/improved.
SIRTURO

Drugs
Sirturo Oral Tab 100 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis of Multi-drug resistant tuberculosis, In combination with at least 3 other agents. Monitor ECGs and Liver function Prior to initiating Treatment.

Age Restriction
None

Prescriber Restriction
Infectious Disease TB Specialist

Coverage Duration
24 weeks

Other Criteria
Bedaquiline fumarate is not recommended for the treatment of drug-sensitive TB, latent infection due to Mycobacterium TB, for the treatment of extrapulmonary TB (eg, CNS), or for the treatment of non-tuberculous mycobacterial infections.
SIVEXTRO

Drugs
Sivextro Oral Tab 200 mg
Sivextro Inj Sol 50 mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Culture

Age Restriction
18 years or older

Prescriber Restriction
1) Infectious disease physician
2) Dermatologist
3) Hematologist-Oncologist

Coverage Duration
6 days

Other Criteria
To allow continuation of therapy:
1) Approved if patient started in hospital, other inpatient facility, or as an outpatient on intravenous (IV) Sivextro and is now being changed to oral Sivextro.
2) Approve if patient started in hospital or other inpatient facility on oral Sivextro. This does not include patients started on oral Sivextro as outpatients unless they meet other exceptions listed.
3) Sivextro ORAL - Patient started in hospital, other inpatient facility, or as an outpatient on IV vancomycin.
4) For Sivextro IV-patient must have difficult to swallow oral Sivextro, if Vancomycin was started in hospital, continuation of Vancomycin at discharge is recommended.
5) Subject to B vs D Review.
SOMAVER slow

Drugs
Somavert SubQ Soln 10 mg, 15 mg, 20 mg, 25 mg, 30 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
Endocrinologist

Coverage Duration
12 months

Other Criteria
Patients who have had an inadequate response to surgery and/or radiation therapy; and/or other medical therapies, or for whom these therapies are not appropriate. The goal of treatment is to normalize serum IGF-I levels.
SOVALDI

Drugs
Sovaldi 400 mg Oral Tab

Covered Uses
All medically-accepted indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis and genotype. For hepatocellular carcinoma, meets Milan criteria for liver transplant (i.e. a single HCC nodule with a maximum size of 5 cm or as many as 3 nodules with the largest not exceeding 3 cm and no macrovascular invasion).

Age Restriction
12 years or older

Prescriber Restriction
Gastroenterologist, Hepatologist, Infectious Disease Specialist

Coverage Duration
12 to 48 weeks depending on tx regimen, liver transplantation status and decompensation.

Other Criteria
Criteria will be applied consistent with current AASLD/IDSA guidance
Drugs
Sprycel Oral Tab 20 mg, 50 mg, 70 mg, 80 mg, 100 mg, 140 mg

Covered Uses
All medically-accepted indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis for which Sprycel is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. New patients with CML and ALL which is Ph-positive may receive authorization for Sprycel.

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
Authorization will be for 12 months.

Other Criteria
For CML, new patient must have Ph-positive CML for approval of Sprycel. For ALL, new patient must have Ph-positive ALL for approval of Sprycel.
Drugs
Stiolto Metered Dose Inh.

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

Exclusion Criteria
None

Required Medical Information
Diagnosis

Age Restriction
18 years of age or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
Drugs
Strattera Oral Cap 10mg 18 mg, 25mg, 40 mg, 60 mg, 80 mg, 100 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
MAOI within 2 weeks

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Therapeutic failure to methylphenidate product, either immediate-release or sustained-release (eg, Ritalin, Ritalin SR, Metadate CD, Metadate ER, Methylin ER, Concerta), or Focalin, or an amphetamine (Adderall/Adderall XR, or Dexedrine, Desoxyn). OR Patient has a history of stimulant drug abuse or other substance abuse.
Drugs
Buprenorphine HCl-Naloxone HCl Tab. SL 2-0.5 mg
Buprenorphine HCl-Naloxone HCl Tab. SL 8-2 mg
Suboxone Oral Strip 2 mg / 0.5 mg, 4 mg / 1 mg, 8 mg / 2 mg, 12 mg / 3 mg

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

Exclusion Criteria
None

Required Medical Information
Patient has a diagnosis of opioid dependence

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Initial - 3 months. Renewal - 9 months.

Other Criteria
None
Drugs
Sutent Oral Cap 12.5 mg, 25 mg, 50 mg, 37.5 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years and older

Prescriber Restriction
Hematologist - Oncologist

Coverage Duration
12 months

Other Criteria
None
SYLATRON

Drugs
Sylatron SubQ KIT 296 mcg, 444 mcg, 888 mcg

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

Exclusion Criteria
Severe liver Damage, autoimmune hepatitis

Required Medical Information
Diagnosis

Age Restriction
18 years or older

Prescriber Restriction
Hematologist-Oncologist, Gastroenterologist, or Infectious disease physician

Coverage Duration
12 month

Other Criteria
None
**SYMLIN**

**Drugs**
SymlinPen 120 SubQ Soln 2700 mcg/2.7ml
SymlinPen 60 SubQ Soln 1500 mcg/1.5ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
Confirmed gastropareses

**Required Medical Information**
A1c

**Age Restriction**
18 years or older

**Prescriber Restriction**
None

**Coverage Duration**
12 months

**Other Criteria**
Approve if patient meet all of the following criteria: are currently on mealtime insulin, have an HbA1c less or = 9%, have failed to achieve adequate control of blood glucose levels despite individualized management of their insulin therapy, have adherence to current insulin regimen. Nutritionist consultation.
SYNAGIS

Drugs
Synagis IM Soln. 50 mg/ 0.5 ml

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

Exclusion Criteria
None

Required Medical Information
Coverage of Synagis (palivizumab) will require documentation for chronic lung disease, pre-maturity, immunodeficiency, or congenital heart disease. During the RSV Season.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
5 months

Other Criteria
The beginning of the RSV season is defined as November 1st. The first dose must be administered after October 15th and the last dose before March 31st. Drug may be subject to B vs D coverage determination.
**Drugs**
Synarel Nasal Soln 2 mg/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
Pregnancy, breast feeding, abnormal vaginal bleeding.

**Required Medical Information**
None

**Age Restriction**
None

**Prescriber Restriction**
Gynecologist, Endocrinologist

**Coverage Duration**
6 months

**Other Criteria**
None
Drugs
Synercid Inj. (150 mg/350 mg)/10 ml

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

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
Infectious Disease specialist

Coverage Duration
6 months

Other Criteria
Subject to B vs D Review
Drugs
Tagrisso Oral Tab 40 mg, 80 mg

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

Exclusion Criteria
None

Required Medical Information
Diagnosis: metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC), as detected by an FDA-approved test, who have progressed on or after EGFR TKI therapy. 2. Genetic Test-presence of T790M mutation. 3. Previous treatments. TKIs in use or in clinical trials include: Afatinib (Giotrif),Axitinib (Inlyta),Bosutinib (Bosulif),Crizotinib (Xalkori),Dasatinib (Sprycel),Erlotinib (Tarceva),Gefitinib (Iressa),Imatinib (Glivec),Lapatinib (Tyverb),Nilotinib,(Tasigna),Pazopanib (Votrient),Regorafenib (Stivarga),Sorafenib (Nexavar),Sunitinib (Sutent)

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
None
Drugs
Tarceva Oral Tab 25 mg, 100 mg, 150 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years and older

Prescriber Restriction
Hematologist- Oncologist

Coverage Duration
12 months

Other Criteria
None
TARGRETIN

Drugs
Targetin Topical gel 0.01 mg
Bexarotene Oral Cap 75 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis of cutaneous T-cell lymphoma (CTCL) and patient is not a candidate for or had an inadequate response, is intolerant to, or has a contraindication to at least one prior systemic therapy (e.g., corticosteroids) for cutaneous manifestations of CTCL.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Female patient of child-bearing bearing potential have a documented negative pregnancy test one week prior to the initiation of therapy. For renewal, Patient has not had disease progression while on therapy and female patients of child-bearing potential are not pregnant and are continuing to use adequate birth-control measures during therapy.
TASIGNA

Drugs
Tasigna Oral Cap 150 mg, 200 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Hyokalemia, hypomagnesemia, long QT syndrome

Required Medical Information
Diagnosis for which Tasigna is being used. For indication of CML, the Philadelphia chromosome (Ph) status of the leukemia must be reported. New patients with CML which is Ph-positive may receive authorization for Tasigna. Blood potassium and magnesium values.

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
Authorization will be for 12 months

Other Criteria
For CML, new patient must have Ph-positive CML for approval of Tasigna.
TAZORAC

Drugs
Tazorac External 0.05 %, 0.1 %
Tazarotene  External 0.1%

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Pregnancy

Required Medical Information
Diagnosis of acne vulgaris and patient has tried an adequate trial (at least two weeks) with at least one other topical acne product (e.g., benzoyl peroxide, salicylic acid, clindamycin, erythromycin, adapalene, azelaic acid, and/or tretinoin) OR Diagnosis of stable moderate to severe plaque psoriasis and 20% or less body surface area involvement and patient has a contraindication or tried adequate trial (at least 2 weeks) with at least one other topical psoriasis product (e.g., medium to high potency corticosteroid and/or vitamin D analogs) AND females of child-bearing potential are using adequate birth control measures during therapy.

Age Restriction
12 years or older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
TECENTRIQ

Drugs
Tecentriq Inj. 60 mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis of: 1. Locally advanced or metastatic urothelial carcinoma who: a) are not eligible for cisplatin-containing chemotherapy, or b) have disease progression during or following any platinum-containing chemotherapy, or within 12 months of neoadjuvant or adjuvant chemotherapy. OR 2. Metastatic non-small cell lung cancer who have disease progression during or following platinum-containing chemotherapy. Patients with EGFR or ALK genomic tumor aberrations should have disease progression on FDA approved therapy for these aberrations prior to receiving TECENTRIQ.

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
Subject to BvsD review.
Drugs
Tecfidera Oral Cap DR 120 mg
Tecfidera Oral Cap DR 240 mg
Tecfidera Pack

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis (Multiple sclerosis, Relapsing forms). CBC, including a lymphocyte count. Renewal authorizations of Tecfidera are dependent on documented improvement in symptoms and lack and/or decrease of relapses. Has patient shown symptomatic improvement and a reduction (or lack) of relapses since initiation of therapy?

Age Restriction
18 years and older

Prescriber Restriction
Neurologist

Coverage Duration
12 months

Other Criteria
Obtain a CBC, including a lymphocyte count, prior to therapy initiation, after 6 months of therapy, and every 6 to 12 months thereafter or as clinically indicated. Orphan drug designation: Treatment of Friedreich ataxia
Drugs
Thalomid Oral Cap 50 mg, 100 mg, 150 mg, 200mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Pregnancy

Required Medical Information
Pregnancy Test
1) 10-14 days prior to initiation of Tx,
2) 24 hours prior to initiation of Tx.

Age Restriction
12 years and older

Prescriber Restriction
Hematologist - Oncologist

Coverage Duration
12 months

Other Criteria
Only available thru a restricted distribution program, THALOMID REMS.
TOPICAL IMMUNOMODULATORS

Drugs
Tacrolimus Topical Ointment

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

Exclusion Criteria
None

Required Medical Information
Diagnosis. Prior use of Topical corticosteroid

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
3 months, if patient required additional fills, case will be re-evaluated.

Other Criteria
Prior history of at least TWO generic topical corticosteroids within past 180 day. Members without Prior History of medication in claims, MD shall provide documentation of medical record or pharmacy claims processing thru another benefit to comply with previous utilization.
TRETINOIN

Drugs
Adapalene Topical gel
Adapalene Topical Cream
Avita Topical Cream
Tretinoin Topical Cream
Tretinoin Topical Gel

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
1. Liver spots
2. Stretch marks
3. Scarring from acne
4. Solar elastosis
5. Premature aging and treatment of photo-aged or photo-damaged skin (eg, solar lentigines, skin roughness, mottled hyperpigmentation or age spots
6. Wrinkles
7. Geographic tongue
8. Hyperpigmentation (postinflammatory) caused by folliculitis, acne and eczema
9. Melasma/cholasma
10. Alopecia androgenetic
11. Alopecia areata
12. Seborrheic keratosis
13. Confluent and reticulated papillomatosis
14. Dermatitis
15. Dowling Degos disease. One case series reported topical tretinoin to be ineffective in treating this condition
16. Dysplastic nevi
17. Folliculitis
18. Milia. There is only one case report showing topical tretinoin to be effective in treating milia.
19. Necrobiosis lipoidica diabeticorum
20. Perforating collagenosis
21. Psoriasis
22. Systemic sclerosis
23. Keratosis pilaris
24. Sebaceous hyperplasia, Sebaceous cyst
25. Skin cancer (melanoma, basal cell carcinoma)

Required Medical Information
None

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months
Other Criteria
None
TYGACIL

**Drugs**
Tygacil IV Soln 50 mg
Tigecycline Inj. Soln 50 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
None

**Age Restriction**
18 yrs and older

**Prescriber Restriction**
ID Specialist, Dermatologist, Pneumologist, Gastroenterologist

**Coverage Duration**
14 days

**Other Criteria**
Subject to B vs D review.
TYKERB

Drugs
Tykerb Oral Tab 250 mg

Covered Uses
All medically-accepted indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis for which Tykerb is being used. For indication of breast cancer, the HER2 status must be reported. New patients with breast cancer which is HER2-positive may receive authorization for Tykerb.

Age Restriction
18 years or older

Prescriber Restriction
Oncologist

Coverage Duration
Authorization will be for 12 months

Other Criteria
For breast cancer, new patient must have HER2-positive breast cancer for approval of Tykerb
Drugs
Tysabri Inj. Soln. 300 mg/ 15 ml

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

Exclusion Criteria
History of progressive multifocal leukoencephalopathy. Not approved in conjunction with other medications for the treatment of progressive multiple sclerosis (Betaseron, Avonex, Rebif or Copaxone) or when used in conjunction with other medications (corticosteroids, 5-aminosalicylates, 6-mercaptopurine and/or azathioprine, methotrexate or Humira)

Required Medical Information
Diagnosis of relapsing form of multiple sclerosis and medication will be used as monotherapy and patient had an inadequate response, intolerance, or contraindication to conventional therapy with one of the following: An interferon beta product, Copaxone, Gilenya OR Diagnosis of moderate to severe active Crohn's disease and medication will not be used in combination with immunosuppressants or inhibitors of tumor necrosis factor-alfa and patient had an inadequate response, intolerance, or contraindication to any of the following: Humira, Remicade, or Cimzia.

Age Restriction
18 years or older.

Prescriber Restriction
1. For multiple sclerosis: Neurologist
2. For Crohn's disease: Gastroenterologist

Coverage Duration
Initial authorization is 6 month, re-authorization in 6 month increments.

Other Criteria
Patient and physician are registered in the TOUCH prescribing program. For Crohn's Disease, the member must have all of the following: 1. A documented diagnosis of Crohn's Disease. 2. Demonstrated an inadequate response to an appropriate trial with two (2) or more of the following agents: Corticosteroids (e.g., prednisone, prednisolone, methylprednisolone), 5-Aminosalicylates (e.g., sulfasalazine, Azulfidine, Asacol, Pentasa, Rowasa, Dipentum, Colazal), 6-mercaptopurine (6-MP, Purinethol) and/or azathioprine, and/or methotrexate. 3. The Member has demonstrated an inadequate response to an appropriate trial with at least one of the following TNF-inhibitors: Cimzia, Humira or Remicade. Subject to B vs D Review.
UPTRAVI

Drugs
Uptravi Oral Tab 200 mcg
Uptravi Oral Tab 400 mcg
Uptravi Oral Tab 600 mcg
Uptravi Oral Tab 800 mcg
Uptravi Oral Tab 1000 mcg
Uptravi Oral Tab 1400 mcg
Uptravi Oral Tab 1600 mcg
Uptravi Oral Tab 200/800 mcg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
1. Initial Tx, Diagnosis of pulmonary arterial hypertension (PAH, WHO Group I) evidenced by a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment
2. Continuation of Tx, the patient shows documented beneficial response from Uptravi (including any of the following, reduce pulmonary vascular resistance and/or pressure, improved symptoms, improved patient activity and/or longevity)

Age Restriction
18 years and older

Prescriber Restriction
Pneumologist, Cardiologist

Coverage Duration
Initial: 3 months. Continuation: 12 months

Other Criteria
Initial treatment should be 200 mcg po twice daily
VALCHLOR

**Drugs**
Valchlor Topical Gel 0.00016 mg/mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Diagnosis: Topical treatment of stage 1a or 1b mycosis fungoides-type cutaneous t-cell lymphoma in patients who have received prior skin-directed therapy.

**Age Restriction**
18 years and older

**Prescriber Restriction**
Hematologist-Oncologist

**Coverage Duration**
12 months

**Other Criteria**
None
**VELCADE**

**Drugs**
Velcade IV Soln 3.5 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
None

**Age Restriction**
18 years or older

**Prescriber Restriction**
Hematologist, Oncologist

**Coverage Duration**
12 months

**Other Criteria**
Subject to B vs D review.
VENCLEXTA

Drugs
Venclexta Oral Tab 10 mg
Venclexta Oral Tab 50 mg
Venclexta Oral Tab 100 mg
Venclexta Oral Pack 10/50/100

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Strong inhibitor of CYP3A at initiation and during ramp-up phase is contraindicated.

Required Medical Information
1. Diagnosis: Chronic lymphocytic leukemia (CLL) with 17p deletion, as detected by an FDA approved test, who have received at least one prior therapy.
2. Assessment of risk for Tumor Lysis Syndrome.
3. Concomitant use of allopurinol is required.

Age Restriction
18 years or older

Prescriber Restriction
Oncologist or hematologist

Coverage Duration
12 months

Other Criteria
For renewal, patient has no disease progression or unacceptable toxicity.
Drugs
Ventavis Inhalant Sol. 0.01 mg/ml
Ventavis Inhalant Sol. 0.02 mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis of pulmonary arterial hypertension WHO Group I with New York Heart Association (NYHA) functional class III of IV that was confirmed by right heart catheterization

Age Restriction
18 years or older

Prescriber Restriction
Cardiologist or a pulmonologist

Coverage Duration
Initial – 6 months. Renewal – 12 months

Other Criteria
Coverage Determination for B vs D Required.
VOTRIENT

Drugs
Votrient Oral Tab 200 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years or older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
None
**Drugs**
Vpriv Inj. Sol. 100 units/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Diagnosis of type 1 Non-neuropathic Gaucher's disease, chronic.

**Age Restriction**
4 years or older

**Prescriber Restriction**
Hematologist or specialist in the treatment of inherited metabolic disorders.

**Coverage Duration**
Initiation 3 months
Renewal 6 months

**Other Criteria**
Renewal, Normalization of hemoglobin and platelet counts as indication of efficacy, or documentation of reduction in liver and spleen enlargement. Subject to B vs D review.
Drugs
Xalkori Oral Cap 200 mg, 250 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
ALK-positive or ROS1-Positive Metastatic NSCLC.

Age Restriction
18 years or older

Prescriber Restriction
Hematologist-Oncologist

Coverage Duration
12 months

Other Criteria
None
XARELTO

Drugs
Xarelto Oral Tab 10 mg
Xarelto Oral Tab 15 mg
Xarelto Oral Tab 20 mg
Xarelto Pack

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Prophylaxis: Acute coronary syndrome; recent: Cardiovascular event risk

Required Medical Information
CrCL

Age Restriction
18 years or older

Prescriber Restriction
Internal Medicine, Cardiologist, Orthopedist, Surgeon, Pulmonologist or Hematologist.

Coverage Duration
12 months

Other Criteria
Warfarin is considered first line drug for atrial fibrillation, non-valvular - Cerebrovascular accident, Prophylaxis - Embolism, Systemic, Prophylaxis
Drugs
Xeljanz Oral Tab ER 11 mg
Xeljanz Oral Tab 5mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Active serious infection (including tuberculosis). Combined use with a biologic disease-modifying anti-rheumatic drugs or potent immunosuppressant (e.g., azathioprine or cyclosporine).

Required Medical Information
Diagnosis of moderately to severely active rheumatoid arthritis AND patient tried and had an inadequate response, intolerance or contraindication to methotrexate or other non-biologic disease modifying anti-rheumatic drugs for at least 3 consecutive months AND patient has been tested for tuberculosis (TB) infection in the past year and latent TB has been ruled out or is being treated per guidelines.

Age Restriction
18 years or older

Prescriber Restriction
Rheumatologist

Coverage Duration
12 months

Other Criteria
For renewal, patient has stable disease or has improved while on therapy (e.g., improvement in tender/swollen joint count, improvement in ACR scoring)
Drugs
Tetrabenazine Oral Tab 12.5 mg, 25 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Primary hyperkinetic dystonia. Hemiballism.

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years of age

Prescriber Restriction
For treatment of chorea associated with Huntingtons disease, Tourette syndrome or related tic disorders, primary hyperkinetic dystonia, or hemiballism, Xenazine (tetrabenazine) must be prescribed by or after consultation with a neurologist. For TD, Xenazine (tetrabenazine) must be prescribed by or after consultation with a neurologist or psychiatrist.

Coverage Duration
12 month

Other Criteria
None
XGEVA

Drugs
Xgeva SC Inj. 70 mg/ml (120 mg/1.7 ml vial)

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

Exclusion Criteria
Hypocalcemia (calcium less than 8.0 mg/dL).

Required Medical Information
Diagnosis of a solid tumor (e.g., breast cancer, castrate-resistant prostate cancer, thyroid carcinoma, kidney, or non-small cell lung cancer) AND patient has bone metastases AND Medication will be used for the prevention of skeletal-related events (e.g., spinal cord compression, hypercalcemia, bone pain or lesions requiring radiation or surgery) OR Patient has a diagnosis of giant cell tumor of bone AND Tumor is unresectable or surgical resection is likely to result in severe morbidity OR patient has diagnosis of hypercalcemia of malignancy refractory to bisphosphonate therapy.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
Subject to B vs D Review.
XIFAXAN

Drugs
Xifaxan Oral Tab 200 mg, 550 mg

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

Exclusion Criteria
None

Required Medical Information
Diagnosis

Age Restriction
Traveler’s 12 years or older

Prescriber Restriction
Gastroenterologist, Hepatologist or Infectious Disease Specialist.

Coverage Duration
Authorization will be for 12 months. Approval for Travelers Diarrhea will be as requested.

Other Criteria
For hepatic encephalopathy, Trial of a 30 day supply of the following: Lactulose. Step 2: Xifaxan 550MG. Prior History of medication in claims, MD shall provide documentation of medical record or pharmacy claims processing thru another benefit to comply with previous utilization. For a diagnosis of Travelers diarrhea, Noninvasive strains of E coli, Xifaxan 200MG will be approved first line.
**Drugs**
Xolair SubQ Soln 150 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Moderate to severe persistent asthma and SAR/PAR, baseline IgE level of at least 30 IU/ML. For asthma, patient has a positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay (eg, immunoCAP, ELISA) or the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds). For SAR/PAR, patient has positive skin testing (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach) and/or positive in vitro testing (ie, a blood test for allergen-specific IgE antibodies) for one or more relevant allergens (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach). Chronic idiopathic urticaria - must have urticaria for more than 6 weeks, with symptoms present more than 3 days/wk. despite daily non-sedating H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine).

**Age Restriction**
None

**Prescriber Restriction**
Allergist, Immunologist, Pulmonologist or Dermatologist

**Coverage Duration**
12 months

**Other Criteria**
Moderate to severe persistent asthma must meet all criteria patient's asthma symptoms have not been adequately controlled by concomitant use of at least 3 months of inhaled corticosteroid and a long-acting beta-agonist (LABA) or LABA alternative, if LABA contraindicated or pt has intolerance then alternatives include sustained-release theophylline or a leukotriene modifier (eg, montelukast), AND inadequate control demonstrated by hospitalization for asthma, requirement for systemic corticosteroids to control asthma exacerbation(s), or increasing need (eg, more than 4 times a day) for short-acting inhaled beta2 agonists for symptoms (excluding preventative use for exercise-induced asthma).
**Drugs**
Xtandi Oral Cap 40 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Diagnosis of metastatic castration-resistant prostate cancer AND patient had prior chemotherapy that included docetaxel AND the patient has tried and had an inadequate response, contraindication or intolerance to Zytiga.

**Age Restriction**
None

**Prescriber Restriction**
None

**Coverage Duration**
12 months

**Other Criteria**
None
Drugs
Xyrem Oral Sol. 500 mg/ml

Covered Uses
All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria
Concomitant treatment with sedative hypnotic agents. Succinic semialdehyde dehydrogenase deficiency.

Required Medical Information
Diagnosis of one of the following: A) narcolepsy with excessive daytime sleepiness, cataplexy or both confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) and for patients with excessive daytime sleepiness, patient has had a previous trial with or has a contraindication, intolerance, or allergy to modafinil, armodafinil, methylphenidate, dextroamphetamine, or mixed amphetamine salts B) fibromyalgia syndrome and patient had a previous trial (of at least 30 days) with, or has a contraindication, intolerance, or allergy to two of the following: duloxetine, milnacipran, or pregabalin.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
6 months (initial), 12 months (renewal).

Other Criteria
For renewal, the patient had a positive response to the medication (increased sleep quality for patients with narcolepsy). Patient and physician are enrolled in Xyrem REMS.
**YERVOY**

**Drugs**
Yervoy Inj Sol 5 mg/ml

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**
None

**Required Medical Information**
Diagnosis of: 1) unresectable or metastatic melanoma (Stage III/IV) AND If the request is for re-induction, the patient had no significant toxicity with the prior course of Yervoy AND the patient experienced progression after having stable disease for longer than three months or relapse after having a clinical response to therapy. OR 2) Adjuvant treatment of patients with cutaneous melanoma with pathologic involvement of regional lymph nodes of more than 1 mm who have undergone complete resection, including total lymphadenectomy. Must submit baseline TSH, AST, ALT, Total bilirubin.

**Age Restriction**
None

**Prescriber Restriction**
Hematologist, Oncologist

**Coverage Duration**
16 weeks

**Other Criteria**
Subject to BvD review. Member is enrolled on Yervoy REMS program.
ZAVESCA

Drugs
Zavesca Oral Cap 100 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
Not covered for Type 2 or 3 Gauchers Disease

Required Medical Information
Diagnosis of Type 1 Gaucher Disease and cannot be treated with enzyme replacement therapy (e.g. cerezyme)

Age Restriction
18 years and older

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria
None
ZEJULA

Drugs
Zejula Oral Capsule 100 mg

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

Exclusion Criteria
None

Required Medical Information
Diagnosis:
Maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy.

Age Restriction
18 years or older

Prescriber Restriction
1. Hematologist
2. Oncologist

Coverage Duration
12 months

Other Criteria
Must be covered by Part D benefit.
Drugs
Zelboraf Oral Tablet 240 mg

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

Exclusion Criteria
None

Required Medical Information
Baseline: electrocardiogram, electrolytes, liver enzymes, and bilirubin. Confirmation of BRAF V600E mutation-positive melanoma by an FDA-approved test (cobas (R) 4800 BRAF V600 Mutation Test).

Age Restriction
18 years or older

Prescriber Restriction
Hematologist-Oncologist

Coverage Duration
12 months

Other Criteria
None
ZINBRYTA

Drugs
Zinbryta Prefilled Syringe 150 mg/ml

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
1. Concurrent use of glatiramer acetate with interferon beta-1a (Avonex, Rebif) or interferon beta-1b (Betaseron).
2. Pre-existing hepatic disease or hepatic impairment, including ALT or AST at least 2 times the ULN.
3. History of autoimmune hepatitis or other autoimmune condition involving the liver.

Required Medical Information
1. Diagnosis: Relapsing Multiple Sclerosis (MS) AND Inadequate response to two or more MS drugs.

Age Restriction
17 years and older

Prescriber Restriction
Neurologist or a Multiple Sclerosis-specialist.

Coverage Duration
12 months

Other Criteria
Physician and patient enrolled in the Zinbryta REMS Program.
Drugs
Zolinza Oral Cap 100 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years and older

Prescriber Restriction
Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
None
ZYDELIG

Drugs
Zydelig Oral Tab. 100 mg, 150 mg

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
1) For Relapsed chronic lymphocytic leukemia (CLL):
   a. Patient must have a current prior authorization for Rituxan (rituximab),
   b. Must be used in combination with Rituxan (rituximab).
2) For Relapsed follicular B-cell non-Hodgkin lymphoma (FL):
   a. Patient has received two prior systemic therapies.
3) Relapsed small lymphocytic lymphoma (SLL):
   a. Patient has received two prior systemic therapies.

Age Restriction
18 years and older

Prescriber Restriction
1) Hematologist
2) Oncologist

Coverage Duration
12 months

Other Criteria
Participation in REMS Program.
Drugs
Zykadia 150 mg oral cap.

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Diagnosis, confirmation of ALK-positive mutation as detected by an FDA-approved test, AND documentation of previous treatment with or intolerance to crizotinib (Xalkori®).

Age Restriction
18 years of age or older

Prescriber Restriction
Oncologist or Hematologist

Coverage Duration
12 month

Other Criteria
None
Drugs
Zytiga Oral Tab  250 mg

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

Exclusion Criteria
None

Required Medical Information
None

Age Restriction
18 years or older

Prescriber Restriction
Urologist, Hematologist, Oncologist

Coverage Duration
12 months

Other Criteria
None
ZYVOX

Drugs
Linezolid Inj 2mg/ml
Linezolid Oral Tab 600 mg
Linezolid Oral Susp

Covered Uses
All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Culture

Age Restriction
None

Prescriber Restriction
Infectious disease physician, Pulmonary specialist, or Dermatologist

Coverage Duration
10-14 days (Vancomycin-resistant Enterococcus faecium infection-14-28 days)

Other Criteria
To allow continuation of therapy:
1. Approve if patient started in hospital, other inpatient facility, or as an outpatient on intravenous (IV) Zyvox and is now being changed to oral Zyvox.
2. Approve if patient started in hospital or other inpatient facility on oral Zyvox. This does not include patients started on oral Zyvox as outpatients unless they meet other exceptions listed.
3. Zyvox ORAL - Patient started in hospital, other inpatient facility, or as an outpatient on IV vancomycin.
4. For Zyvox IV-patient must have difficult to swallow oral Zyvox, if Vancomycin was started in hospital; continuation of Vancomycin at discharge is recommended.
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<td>Sylatron KIT 888 MCG</td>
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<td>SynmlinPen 60 SOLUTION 1500 MCG/1.5ML</td>
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<td>Synarel SOLUTION 2</td>
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<tr>
<td>Synribo SOLUTION</td>
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