Prior Authorization Group Description

FARYDAK

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a hematologist or oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two prior regimens, including Velcade and an immunomodulatory agent (e.g., dexamethasone).

Prior Authorization Group Description

FERRIPROX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to deferoxamine, Exjade or Jadenu.

Prior Authorization Group Description

FIORINAL WITH CODEINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to naproxen and ibuprofen.

Prior Authorization Group Description

FIRAZYR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 18 or greater.

Prescriber Restrictions:

Prescribed by or in consultation with an immunologist, allergist, hematologist or rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Medications known to cause angioedema (i.e., ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate.

Prior Authorization Group Description

FLECTOR

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Cancer-related neuropathic pain.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Acute Pain: 4 weeks. Cancer-related neuropathic pain: Through the end of the Plan contract year.

Other Criteria:

Prior Authorization Group Description

FLUOROURACIL

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

FORTEO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to alendronate.

Prior Authorization Group Description

GANCICLOVIR

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

GATTEX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

MAINTENANCE REQUESTS: Documentation of response to therapy.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

GILENYA

Covered Uses:

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

Exclusion Criteria:

History (in the last 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization or class III/IV heart failure. History or presence of Mobitz II second-degree or third-degree atrioventricular block or sick sinus syndrome, unless patient has a functioning pacemaker. Baseline QTc interval greater than or equal to 500 msec. Concurrent use of Class Ia or Class III anti-arrhythmic drugs.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

GILOTRIF

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation confirming metastatic NSCLC tumors have epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 substitution mutation as detected by a FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Metastatic squamous NSCLC: Disease has progressed following platinum-based chemotherapy (e.g., cisplatin, carboplatin or oxaliplatin).

Prior Authorization Group Description

GLATIRAMER (Copaxone, Glatopa)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

GLYBURIDE (Diabeta, Glynase)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: glimepiride, glipizide or glipizide/metformin combination product.

Prior Authorization Group Description

GLYBURIDE/METFORMIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: glimepiride, glipizide or glipizide/metformin combination product.

Prior Authorization Group Description

GRANIX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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Prior Authorization Group Description

HAEGARDA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial: 6 months. Reauthorization: 12 months.

Other Criteria:

Failure of danazol, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

HARVONI

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Treatment of HCV genotype 1, 4, 5, or 6 with decompensated cirrhosis and sofosbuvir-based treatment failure.

Exclusion Criteria:

Required Medical Information:

Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

8 to 24 weeks based on genotype and prior treatment, cirrhosis, or liver transplant status.

Other Criteria:

Prior Authorization Group Description

HETLIOZ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

HUMAN GROWTH HORMONE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria:

Required Medical Information:

CHILDREN AND ADOLESCENTS WITH GROWTH HORMONE DEFICIENCY, SHOX DEFICIENCY IN CHILDREN: The patient's baseline height must be greater than 2 SD below the mean for gender and age. Growth rate is such that the patient is unlikely to attain an adult height in the normal range - 59 inches for girls and 63 inches for boys. TURNER SYNDROME: Confirmed by karyotype. PRADER-WILLI or NOONAN SYNDROME: The patient's baseline height must be less than the 5th percentile for gender and age or 2 or more SD below the mean measured paternal height. Growth rate is such that the patient is unlikely to attain an adult height in the normal range - 59 inches for girls and 63 inches for boys. REAUTHORIZATION: Continued treatment will be approved with documentation of response to therapy.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Adults: Through the end of the Plan contract year. Children: 6 months.

Other Criteria:

Prior Authorization Group Description

HUMIRA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist. CROHN'S DISEASE, ULCERATIVE COLITIS: Prescribed by or in consultation with a GI specialist. HIDRADENITIS SUPPURATIVA: Prescribed by or in consultation with a rheumatologist, dermatologist or GI specialist.

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PLAQUE PSORIASIS: Failure or clinically significant adverse effects to one of the following: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

HYDROCODONE (Zohydro ER)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Three months initial for non-malignant pain then one year. One year for cancer pain.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: MS Contin, Kadian, Duragesic, Opana ER, Avinza or Oxycontin.

Prior Authorization Group Description

HYDROXYZINE HCL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Oral formulations only: Pruritus: Failure or clinically significant adverse effects to one of the following topical agents: betamethasone, hydrocortisone, triamcinolone, fluticasone, clobetasol, fluocinonide or fluocinolone. Anxiety: Failure or clinically significant adverse effects to one of the following: venlafaxine, buspirone, duloxetine or escitalopram. Oral and injectable formulations: All other FDA approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

HYDROXYZINE PAMOATE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Pruritus: Failure or clinically significant adverse effects to one of the following topical agents: betamethasone, hydrocortisone, triamcinolone, fluticasone, clobetasol, fluocinonide or fluocinolone. Anxiety: Failure or clinically significant adverse effects to one of the following: venlafaxine, buspirone, duloxetine or escitalopram. All other FDA approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

ICLUSIG

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation of T315I mutation status. Acute Lymphoblastic Leukemia: Documentation of Philadelphia chromosome positive (Ph+) disease.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

T315I mutation-negative Chronic Myelogenous Leukemia: Failure of a trial of two tyrosine-kinase inhibitors (e.g., imatinib, nilotinib, dasatinib, bosutinib) used to treat CML, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

IDHIFA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Presence of an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test (e.g., Abbott RealTime IDH2 assay).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Disease has relapsed or is refractory following treatment with a first line chemotherapy regimen (e.g., cytarabine, idarubicin, daunorubicin, cladribine, midostaurin, fludarabine).

Prior Authorization Group Description

ILARIS

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Acute gouty arthritis.

Exclusion Criteria:

Required Medical Information:

Documentation of current weight.

Age Restrictions:

Cryopyrin-Associated Periodic Syndromes: 4 years and older. All other covered indications: 2 years and older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

INTUNIV

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Attention Deficit Hyperactivity Disorder: Failure or clinically significant adverse effects to two of the following: dexmethylphenidate, methylphenidate or mixed amphetamine salts.

Prior Authorization Group Description

JAKAFI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation of current platelet count and complete blood count (CBC). CONTINUATION OF THERAPY: Documentation of reduction in spleen volume or symptom improvement.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

Initial: 6 months. Reauthorization: Through the end of the Plan contract year.

Other Criteria:

Prior Authorization Group Description

JUXTAPID

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Repatha 420 mg (unless contraindicated).

Prior Authorization Group Description

KADCYLA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Kadcyla will be used as a single-agent therapy. Documentation that the patient has either received prior therapy for metastatic disease or developed disease recurrence during or within six months of completing adjuvant therapy.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Previously received trastuzumab and a taxane (e.g., paclitaxel, docetaxel), either separately or in combination.

Prior Authorization Group Description

KALYDECO

Covered Uses:

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

Exclusion Criteria:

Patients with cystic fibrosis who are homozygous for the F508del mutation.

Required Medical Information:

Presence of one mutation in the CFTR gene that is responsive to ivacaftor as detected by an FDA-cleared cystic fibrosis mutation test.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

KAZANO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Tradjenta or Jentadueto AND Failure or clinically significant adverse effects to one of the following: Januvia, Janumet, Janumet XR.

Prior Authorization Group Description

KETOROLAC TROMETHAMINE

Covered Uses:

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

Exclusion Criteria:

Patients with active peptic ulcer disease. Advanced renal impairment or at risk for renal failure due to volume depletion. Suspected or confirmed cerebrovascular bleeding, hemorrhagic diathesis, incomplete hemostasis and those at high risk for bleeding. Patient currently receiving aspirin or NSAIDs (Non-steroidal anti-inflammatory drugs). Patient currently receiving Probenecid or pentoxifylline.

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

5 days

Other Criteria:

Prior Authorization Group Description

KEVZARA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine, or auranofin.

Prior Authorization Group Description

KINERET

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin AND Failure or clinically significant adverse effects to one of the following: Enbrel, Humira, Remicade, Cimzia, Simponi or Simponi Aria.

Prior Authorization Group Description

KISQALI (includes Kisqali Femara Co-Pack)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Will be used in combination with an aromatase inhibitor (e.g., letrozole, anastrozole or exemestane) as initial endocrine-based therapy.

Prior Authorization Group Description

KOMBIGLYZE XR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Tradjenta or Jentadueto AND Failure or clinically significant adverse effects to one of the following: Januvia, Janumet, Janumet XR.

Prior Authorization Group Description

KORLYM

Covered Uses:

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

Exclusion Criteria:

Pregnancy.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

KUVAN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response, demonstrated by a reduction of blood phenylalanine levels from baseline.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial: 2 months. Reauthorization: Through the end of the Plan contract year.

Other Criteria:

Prior Authorization Group Description

KYNAMRO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Repatha 420 mg (unless contraindicated).

Prior Authorization Group Description

LATUDA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Schizophrenia: Failure or clinically significant adverse effects to two of the following generic atypical antipsychotics: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole.

Prior Authorization Group Description

LAZANDA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 18 or greater

Prescriber Restrictions:

Coverage Duration:

Through the end of the Plan contract year.

Other Criteria:

Patient is already taking and is tolerant to around-the-clock opioid therapy. Patients are considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Group Description

LEMTRADA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, Copaxone, Glatopa, Extavia or Rebif.

Prior Authorization Group Description

LENVIMA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Medullary thyroid carcinoma.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Renal Cell Carcinoma: Failure or clinically significant adverse effects to one of the following: Sutent, Nexavar, Votrient, Inlyta, Avastin in combination with Intron-A, Proleukin, Torisel AND Failure or clinically significant adverse effects to Opdivo or Cabometyx AND Must be used in combination with everolimus (Afinitor).

Prior Authorization Group Description

LEUKINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Use Following Induction Chemotherapy in Acute Myelogenous Leukemia, Use in Mobilization and Following Transplantation of Autologous Peripheral Blood Progentior Cells, Use in Myeloid Reconstitution After Autologous or Allogeneic Bone Marrow Transplantation: Failure or clinically significant adverse effects to Neupogen.

Prior Authorization Group Description

LIDODERM

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Diabetic peripheral neuropathy. Cancer-related neuropathic pain.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

LONSURF

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation that the patient does or does not have the KRAS wild type gene. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: 5-fluorouracil, capecitabine, oxaliplatin, irinotecan, Avastin, Cyramza, Zaltrap. If tumor expresses the KRAS wild type gene, failure or clinically significant adverse effects to Erbitux or Vectibix.

Prior Authorization Group Description

LOTRONEX

Covered Uses:

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

Exclusion Criteria:

Male patients.

Required Medical Information:

Female patient with irritable bowel symptoms persisting for at least 6 months.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

LYNPARZA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Treatment of ovarian cancer: Mutations in the BRCA genes as detected by an FDA approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

For maintenance therapy: Completed two or more platinum-based chemotherapy regimens and is in a complete or partial response.

Prior Authorization Group Description

MACRODANTIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Urinary tract infectious disease, Acute treament: Failure or clinically significant adverse effects to ONE of the following: sulfamethoxazole/trimethoprim or ciprofloxacin. Urinary tract infectious disease, Prophylaxis: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

MAVYRET

Covered Uses:

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

Exclusion Criteria:

Treatment-experienced patients with both NS3/4A protease inhibitor and NS5A inhibitor.

Required Medical Information:

If cirrhosis is present, confirmation of Child-Pugh A status. Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

8 to 16 weeks based on genotype, cirrhosis status, prior treatment regimen.

Other Criteria:

If patient has been previously treated with an HCV regimen containing NS5A inhibitor or an NS3/4A protease inhibitor, but not both, member has genotype 1.

Prior Authorization Group Description

MEGACE

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Cachexia associated with cystic fibrosis. Cachexia associated with cancer.

Exclusion Criteria:

Required Medical Information:

Breast Cancer: Megestrol acetate is being used for palliative treatment.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Anorexia and cachexia associated with AIDS: Failure or clinically significant adverse effects to oxandrolone and dronabinol.

Prior Authorization Group Description

MEGACE ES

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Cachexia associated with cystic fibrosis. Cachexia associated with cancer.

Exclusion Criteria:

Required Medical Information:

Breast Cancer: Megestrol acetate is being used for palliative treatment.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Anorexia and cachexia associated with AIDS: Failure or clinically significant adverse effects to oxandrolone and dronabinol.

Prior Authorization Group Description

MEKINIST

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Non-small cell lung cancer.

Exclusion Criteria:

MELANOMA: Monotherapy for patients who have disease progression on prior BRAF inhibitor therapy.

Required Medical Information:

MELANOMA: Positive for the BRAF V600E or V600K mutation detected by an FDA-approved test. NON-SMALL CELL LUNG CANCER: Positive for BRAF V600E mutation.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

NON-SMALL CELL LUNG CANCER: Used in combination with Tafinlar.

Prior Authorization Group Description

MEPERIDINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: codeine, hydromorphone, morphine, oxymorphone, hydrocodone/acetaminophen or oxycodone. Demerol injection only - all other FDA approved indications: patient is continuing on this medication without adverse effects.

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Prior Authorization Group Description

METHAMPHETAMINE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Treatment of obesity.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

METHOCARBAMOL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

METHOTREXATE INJ (Otrexup, Rasuvo)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to generic methotrexate injection.

Prior Authorization Group Description

MIRVASO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Diagnosis of persistent facial erythema of rosacea with papules and pustules of rosacea: Failure or clinically significant adverse effects to topical metronidazole, Finacea or oral doxycycline.

Prior Authorization Group Description

MOZOBIL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation of patient's current weight and absolute neutrophil count (ANC dated within 30 days prior to the request.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Documented failure to reach and/or maintain a target absolute neutrophil count (ANC) with an adequate trial of Neupogen alone. Must be administered in combination with a granulocyte-colony stimulating factor (G-CSF) (i.e., filgrastim, filgrastim-sndz, or tbo-filgrastim).

Prior Authorization Group Description

NAMENDA (includes Namenda XR)

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Vascular dementia.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 59 years and younger. Prior authorization is not required for patients 60 years and older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NATPARA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NERLYNX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months total duration of therapy.

Other Criteria:

Documentation of previous treatment with Herceptin (trastuzumab) as adjuvant therapy.

Prior Authorization Group Description

NESINA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Tradjenta or Jentadueto AND Failure or clinically significant adverse effects to one of the following: Januvia, Janumet, Janumet XR.

Prior Authorization Group Description

NEULASTA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Mobilization of peripheral-blood progenitor cells prior to autologous transplantation.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NEUPOGEN

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Myelodysplastic syndrome. Neutropenia in patients with HIV/AIDS.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NINLARO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one prior therapy [e.g., Velcade (bortezomib), cyclophosphamide (Cytoxan), doxorubicin, Revlimid (lenalidomide), Thalomid (thalidomide), Alkeran (melphalan)]. Ninlaro must be used in combination with dexamethasone.

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Prior Authorization Group Description

NORPACE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NORTHERA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

NUCALA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient has a blood eosinophil count of greater than or equal to 150 cells/mcL within the past 3 months.
CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Patient is 12 years of age or older.

Prescriber Restrictions:

Prescribed by or in consultation with an allergist, pulmonologist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Must be used in combination with ONE inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide) AND must be used in combination with ONE long-acting beta-agonist (e.g., salmeterol, formoterol, vilanterol), unless contraindicated.

Prior Authorization Group Description

NUPLAZID

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

OCALIVA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Must be used in combination with ursodeoxycholic acid unless patient is intolerant to ursodeoxycholic acid.

Prior Authorization Group Description

OCREVUS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Member will not use other disease modifying therapies for MS concurrently. CONTINUATION OF THERAPY: Member is maintained on therapy with positive response (e.g., improved or maintained disease control evidenced by decreased or stabilized Expanded Disability Status Scale (EDSS) score or reduction in relapses or MRI lesions).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a Neurologist.

Coverage Duration:

12 months.

Other Criteria:

Relapsing Forms Of Multiple Sclerosis: Failure or clinically significant adverse effects to one of the following: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, Copaxone, Glatopa, Extavia or Rebif.

Prior Authorization Group Description

ODOMZO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Basal cell carcinoma has recurred following surgery or radiation therapy, or member is not a candidate for surgery or radiation therapy.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

OFEV

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ONGLYZA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Tradjenta or Jentadueto AND Failure or clinically significant adverse effects to one of the following: Januvia, Janumet, Janumet XR.

Prior Authorization Group Description

OPSUMIT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ORENCIA CLICKJECT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PSORIATIC ARTHRITIS: Failure or clinically significant adverse effects to methotrexate unless contraindicated.

Prior Authorization Group Description

ORENCIA IV

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to Remicade AND one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description

ORENCIA SC

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PSORIATIC ARTHRITIS: Failure or clinically significant adverse effects to methotrexate unless contraindicated.

Prior Authorization Group Description

ORKAMBI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Presence of homozygous F508del mutation in an FDA-cleared cystic fibrosis mutation test.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

OSENI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to Tradjenta or Jentadueto AND Failure or clinically significant adverse effects to one of the following: Januvia, Janumet, Janumet XR.

Prior Authorization Group Description

OTEZLA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

PLAQUE PSORIASIS: Failure or clinically significant adverse effects to ONE of the following: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

PARAFON FORTE DSC

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

PHENOBARBITAL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Partial seizures: Failure or clinically significant adverse effects to one of the following: carbamazepine, phenytoin, topiramate, tiagabine, levetiracetam, gabapentin, lamotrigine, oxcarbazepine, primidone or divalproex. Generalized seizures: Failure or clinically significant adverse effects to one of the following: carbamazepine, phenytoin, topiramate, levetiracetam, primidone or lamotrigine. Sedation: patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

PHENTERMINE

Covered Uses:

Short term, 8 to 12 weeks, adjunct in a regimen of weight reduction based on exercise, behavioral modification and caloric restriction in the management of exogenous obesity for patients with an initial body mass index, BMI, greater than or equal to 30 kg per m^2 or greater than or equal 27 kg per m^2 in the presence of other risk factors (e.g., hypertension, diabetes, dyslipidemia).

Exclusion Criteria:

Required Medical Information:

BMI is greater than or equal to 30 kg/m^2 OR BMI is greater than or equal to 27 kg/m^2 with one or more of the following severe co-morbid conditions 1. Coronary artery/heart disease 2. Diabetes 3. Dyslipidemia 4. Hypertension 5. Obstructive sleep apnea.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Three months.

Other Criteria:

Prior Authorization Group Description

PLEGRIDY

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

PRALUENT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Heterozygous Familial Hypercholesterolemia : Documentation (e.g., medical records, chart notes, laboratory values) of LDL level suggestive of a diagnosis of heterozygous familial hypercholesterolemia (e.g., Adults: LDL greater than 190 mg/dL). Hypercholesterolemia: Documentation of an LDL of 100 mg/dL or greater AND documented history of clinical atherosclerotic cardiovascular disease defined as one of the following: Acute coronary syndromes, Myocardial Infarction, Stable or unstable angina, Coronary or other arterial revascularization (e.g., percutaneous coronary intervention or coronary artery bypass graft surgery), Stroke, Peripheral artery disease presumed to be of atherosclerotic origin, Transient ischemic attack (TIA), Clinically significant coronary heart disease (CHD) diagnosed by invasive or noninvasive testing (such as coronary angiography, stress test using treadmill, stress echocardiography, or nuclear imaging), Carotid artery occlusion greater than 50% without symptoms, Renal artery stenosis or renal artery stent procedure. For Praluent 150 mg requests: Failure to achieve LDL less than 70 after 8 weeks of therapy with Praluent 75 mg. Reauthorization requests require documentation of LDL reduction while on Praluent therapy AND, if tolerated, confirmation of continued statin therapy at the maximally tolerated dose.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.

Coverage Duration:

6 months.

Other Criteria:

Clinically significant adverse effect(s), contraindication(s), intolerance or failure to two of the following at maximally tolerated doses: atorvastatin, rosuvastatin, simvastatin, Vytorin, pitavastatin, pravastatin, fluvastatin, or lovastatin.

Prior Authorization Group Description

PROLIA

Covered Uses:

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

Exclusion Criteria:

Hyopcalcemia (unless corrected prior to initiating therapy).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

For men with non-metastatic prostate cancer: Receiving or has received androgen deprivation therapy [i.e. leuprolide (Lupron), bicalutamide (Casodex) or Nilandron]. For women with breast cancer: Receiving or has received adjuvant aromatase inhibitor therapy [i.e. anastrozole (Arimidex), exemestane (Aromasin) or letrozole (Femara)].

Prior Authorization Group Description

PROMACTA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Thrombocytopenia in Chronic Hepatitis C: Documentation of current or planned interferon-based treatment of chronic hepatitis C.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Chronic Immune (Idiopathic) Thrombocytopenia: Failure of a corticosteroid (e.g., oral prednisone, intravenous methylprednisolone or oral dexamethasone), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

PROTOPIC

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Tacrolimus 0.1%: 16 years and older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of two medium to high potency topical corticosteroids (e.g., amcinonide, fluticasone propionate, triamcinolone acetonide, betamethasone valerate, fluocinolone acetonide, hydrocortisone butyrate, mometasone furoate, desoximetasone, fluocinonide or betamethasone dipropionate), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

PROVIGIL

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Multiple sclerosis-related fatigue.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

PURIXAN

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Lymphoblastic lymphoma.

Exclusion Criteria:

Required Medical Information:

Member has a documented swallowing disorder or an inability to swallow tablets or capsules. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to mercaptopurine tablets.

Prior Authorization Group Description

QSYMIA

Covered Uses:

As an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults with an initial body mass index (BMI) of 30 kg/m^2 or greater (obese) or 27 kg/m^2 or greater (overweight) in the presence of at least one weight-related comorbidity such as hypertension, type 2 diabetes mellitus, or dyslipidemia.

Exclusion Criteria:

Required Medical Information:

BMI is greater than or equal to 30 kg/m^2 OR BMI is greater than or equal to 27 kg/m^2 with one or more of the following severe co-morbid conditions 1. Coronary artery/heart disease 2. Diabetes 3. Dyslipidemia 4. Hypertension 5. Obstructive sleep apnea AND Documentation of the patient's baseline weight is required to determine response to therapy. If 3% weight loss is not achieved after 12 weeks on 7.5 mg/46 mg, then dose must be escalated or drug discontinued. If dose is escalated, an additional 12 weeks will be approved. Reauthorization every 6 months for the first year will require documentation of at least 5% weight loss from baseline body weight. Therapy beyond the first year can be authorized every 6 months with documentation of weight maintenance.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial 12 weeks.

Other Criteria:

Prior Authorization Group Description

QUALAQUIN

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Babesiosis. Plasmodium vivax malaria.

Exclusion Criteria:

For the treatment or prevention of nocturnal leg cramps.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Malaria: 7 days. Babesiosis: 7-10 days

Other Criteria:

Plasmodium vivax malaria: Infection is chloroquine-resistant.

Prior Authorization Group Description

RADICAVA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Forced vital capacity greater than or equal to 80%, disease duration of less than or equal to 2 years, functionally retains most activities of daily living (defined as a baseline revised ALS Functional Rating Scale (ALSFRS-R) score with greater than or equal to 2 points in each of the 12 items, meets diagnostic criteria of definite or probable amyotrophic lateral sclerosis (ALS) based on El Escorial revised criteria. CONTINUATION OF THERAPY: Member continues to retain most activities of daily living, forced vital capacity greater than or equal to 80%, and ALSFRS-R score with greater than or equal to 2 points in each of the 12 items.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

6 months.

Other Criteria:

Prescribed in combination with riluzole unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

RANEXA

Covered Uses:

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

Exclusion Criteria:

Patients on strong CYP3A inhibitors (e.g., ketoconazole, HIV protease inhibitors, clarithromycin) or CYP3A inducers (e.g., rifampin, phenobarbital).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

RAYALDEE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient has stage 3 or 4 chronic kidney disease (CKD) and serum total 25-hydroxyvitamin D level less than 30 ng/mL.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

REMICADE

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Wegener's Granulomatosis.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: RHEUMATOID ARTHRITIS and PLAQUE PSORIASIS: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Psoriatic Arthritis/Plaque Psoriasis: Prescribed by or in consultation with a rheumatologist or dermatologist. Crohn's Disease/Ulcerative Colitis: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

12 months.

Other Criteria:

Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. Plaque Psoriasis: Failure or clinically significant adverse effects to one of the following: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

REPATHA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Heterozygous or Homozygous Familial Hypercholesterolemia : Documentation (e.g., medical records, chart notes, laboratory values) of LDL level suggestive of a diagnosis of familial hypercholesterolemia (e.g., Adults: LDL greater than 190 mg/dL). Hypercholesterolemia: Documentation of an LDL of 100 mg/dL or greater AND documented history of clinical atherosclerotic cardiovascular disease defined as one of the following: Acute coronary syndromes, Myocardial Infarction, Stable or unstable angina, Coronary or other arterial revascularization (e.g., percutaneous coronary intervention or coronary artery bypass graft surgery), Stroke, Peripheral artery disease presumed to be of atherosclerotic origin, Transient ischemic attack (TIA), Clinically significant coronary heart disease (CHD) diagnosed by invasive or noninvasive testing (such as coronary angiography, stress test using treadmill, stress echocardiography, or nuclear imaging), Carotid artery occlusion greater than 50% without symptoms, Renal artery stenosis or renal artery stent procedure. Reauthorization requests require documentation of LDL reduction while on Repatha therapy AND, if tolerated, confirmation of continued statin therapy at the maximally tolerated dose.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.

Coverage Duration:

6 months.

Other Criteria:

Clinically significant adverse effect(s), contraindication(s), intolerance or failure to two of the following at maximally tolerated doses: atorvastatin, rosuvastatin, simvastatin, Vytorin, pitavastatin, pravastatin, fluvastatin, or lovastatin.

Prior Authorization Group Description

REVATIO

Covered Uses:

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

Exclusion Criteria:

Patients taking nitrates (e.g., Nitrodur, Nitrobid, Nitrostat, Isordil, Ismo). Patients taking a guanylate cyclase stimulator, such as riociguat (Adempas).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

REVLIMID

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Patients who are pregnant.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Mantle Cell Lymphoma: Failure of maximally tolerated doses of two prior chemo therapies (e.g., CHOP [cyclophosphamide, doxorubicin, vincristine, and prednisone], hyperCVAD [cyclophosphamide, vincristine, doxorubicin, and dexamethasone]) including Velcade unless contraindicated or clinically significant adverse effects are experienced. Multiple Myeloma: Must be used in combination with dexamethasone unless being used as maintenance therapy following autologous hematopoietic stem cell transplantation or as maintenance therapy for active (symptomatic) myeloma responding to primary myeloma therapy.

Prior Authorization Group Description

REXULTI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Schizophrenia: Failure or clinically significant adverse effects to two of the following generic atypical antipsychotics: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole.

Prior Authorization Group Description

RUBRACA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Deleterious or suspected deleterious germline and/or somatic BRCA mutated as detected by an FDA-approved test (e.g., FoundationFocus). CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two or more prior chemotherapy regimens (e.g., cisplatin, carboplatin).

Prior Authorization Group Description

RYDAPT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Acute Myeloid Leukemia: Positive for the FLT3 mutation as detected by an FDA-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay). CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Acute Myeloid Leukemia: Prescribed by or in consultation with an oncologist. Advanced Systemic Mastocytosis: Prescribed by or in consultation with an oncologist, allergist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Acute Myeloid Leukemia: Prescribed in combination with daunorubicin for induction therapy AND in combination with cytarabine for induction and consolidation therapy.

Prior Authorization Group Description

SEROSTIM

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

REAUTHORIZATION: Continued treatment will be approved with documentation of response to therapy.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

6 months.

Other Criteria:

Patient is being treated with concomitant antiretroviral therapy

Prior Authorization Group Description

SILIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following as recommended by the American Academy of Dermatology: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

SIMPONI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist or dermatologist. ULCERATIVE COLITIS: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description

SIMPONI ARIA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description

SKELAXIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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Prior Authorization Group Description

SOMA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is continuing on this medication without adverse effects.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

SOMAVERT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Inadequate response to surgery or radiation therapy, unless surgery or radiation therapy is not appropriate for the patient.

Prior Authorization Group Description

SONATA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: Rozerem, Silenor 6 mg/day or less, trazodone or temazepam.

Prior Authorization Group Description

SOVALDI

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. For the treatment of hepatitis C virus genotypes 5 and 6.

Exclusion Criteria:

Required Medical Information:

Diagnosis of chronic hepatitis C (CHC) and genotype 1, 2, 3, 4, 5 or 6 confirmed by detectable serum hepatitis C virus RNA by quantitative assay OR For treatment of CHC in patients with hepatocellular carcinoma (HCC) meeting Milan criteria (awaiting liver transplantation). Milan criteria is defined as the presence of a tumor 5 cm or less in diameter in patients with single hepatocellular carcinomas and no more than three tumor nodules, each 3 cm or less in diameter in patients with multiple tumors and no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor. Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

GT 1 to 6: 12 to 24 weeks or HCC with CHC: up to 48 weeks or until liver transplantation

Other Criteria:

For Sovaldi in combination with Daklinza for genotype 1: Failure or clinically significant adverse effects to Harvoni (sofosbuvir/ledipasvir). For Sovaldi in combination with Daklinza for genotype 2: Failure or clinically significant adverse effects to sofosbuvir/ribavirin. For patients with hepatocellular carcinoma (HCC) meeting Milan criteria (awaiting liver transplantation): must be used in combination with ribavirin.

Prior Authorization Group Description

SPRITAM

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Medical justification must be provided why patient cannot take generic levetiracetam tablets or liquid.

Prior Authorization Group Description

SPRYCEL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome-positive chronic myeloid leukemia (CML) or Philadelphia chromosome-positive acute lymphoblastic leukemia (ALL): Failure of imatinib, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

STELARA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist. CROHN'S DISEASE: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

12 months.

Other Criteria:

PLAQUE PSORIASIS: Failure or clinically significant adverse effects to ONE of the following: methotrexate, cyclosporine, or acitretin. PSORIATIC ARTHRITIS: Failure or clinically significant adverse effects to methotrexate unless contraindicated.

Prior Authorization Group Description

STELARA IV

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

4 weeks.

Other Criteria:

Prior Authorization Group Description

STIVARGA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

METASTATIC COLORECTAL CANCER: Documentation that the patient does or does not have the RAS wild type gene. Documentation that the patient does or does not have the BRAF V600E mutation. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

METASTATIC COLORECTAL CANCER: If tumor does not have the RAS wild type gene, failure or clinically significant adverse effects to one of the following: 5-fluorouracil, capecitabine, oxaliplatin, irinotecan, Cyramza, Avastin, Zaltrap OR If tumor expresses the RAS wild type gene without the BRAF V600E mutation, failure or clinically significant adverse effects to Erbitux or Vectibix. GASTROINTESTINAL STROMAL TUMOR: Failure or clinically significant adverse effects to one of the following: Gleevec or Sutent.

Prior Authorization Group Description

STRENSIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

SUBSYS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 18 or greater

Prescriber Restrictions:

Coverage Duration:

Through the end of the Plan contract year.

Other Criteria:

Patient is already taking and is tolerant to around-the-clock opioid therapy. Patients are considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Group Description

SUBUTEX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient is pregnant OR Written documentation of intolerance to naloxone.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Non pregnant: 3 months initial. Pregnant patients: 9 months.

Other Criteria:

Prior Authorization Group Description

SURMONTIL

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Irritable bowel syndrome.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Depression: Failure or clinically significant adverse effects to one of the following: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine, or venlafaxine XR.

Prior Authorization Group Description

SYMLINPEN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation that the current HbA1c level is greater than 7%.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Diabetes Type 2: Failure of a metformin-containing regimen, unless contraindicated or clinically significant adverse effects are experienced. Diabetes Type 1: Failure of an insulin-containing regimen, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

TAGRISSO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation that the patient has an EGFR T790M mutation as detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of Tarceva, Iressa, or Gilotrif, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

TALTZ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description

TARCEVA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Non-small cell lung cancer: Documentation that the patient has EGFR exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Pancreatic cancer: Tarceva is being prescribed in combination with gemcitabine.

Prior Authorization Group Description

TASIGNA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Patients with hypokalemia, hypomagnesemia, or long QT syndrome.

Required Medical Information:

Chronic Myelogenous Leukemia (CML), Acute Lymphoblastic Leukemia (ALL): Documentation that the patient has Philadelphia chromosome positive disease. Acute Lymphoblastic Leukemia: Documentation that the patient achieved complete response to induction therapy following allogeneic hematopoietic stem cell transplantation for consolidation OR disease is relapsed/refractory with either the F317L/V/I/C, T315A, or V299L mutations.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Soft Tissue Sarcoma Gastrointestinal Stromal Tumor: Failure to imatinib, sunitinib, or regorafenib, unless contraindicated or clinically significant adverse effects are experienced

Prior Authorization Group Description

TECENTRIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of platinum-containing chemotherapy (e.g., cisplatin or carboplatin), OR the patient is not eligible for cisplatin-containing chemotherapy. Non-small cell lung cancer: If a known epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberration exists, then for ALK+ disease: prior trial of Xalkori or Alecensa OR for EGFR+ disease: prior trial of Tarceva, Gilotrif or Iressa.

Prior Authorization Group Description

TECFIDERA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

TENEX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: amlodipine/benazepril, benazepril, benazepril/hydrochlorothiazide, captopril, captopril/hydrochlorothiazide, fosinopril, fosinopril/hydrochlorothiazide, lisinopril, lisinopril/hydrochlorothiazide, quinapril, quinapril/hydrochlorothiazide, losartan, losartan/hydrochlorothiazide, valsartan, valsartan/hydrochlorothiazide, irbesartan, irbesartan/hydrochlorothiazide, candesartan, candesartan/hydrochlorothiazide, carvedilol, labetalol, acebutolol, atenolol, bisoprolol, bisoprolol/hydrochlorothiazide, timolol, nadolol, propranolol, metoprolol, metoprolol/hydrochlorothiazide, pindolol, nifedipine SR, amlodipine, nicardipine.

Prior Authorization Group Description

TETRABENAZINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

TREMFYA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to ONE of the following as recommended by the American Academy of Dermatology: methotrexate, cyclosporine, or acitretin.

Prior Authorization Group Description

TRIHEXYPHENIDYL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Parkinsons disease/Parkinsonism: Failure or clinically significant adverse effects to two of the following: amantadine, levodopa/carbidopa, entacapone, pramipexole, ropinirole, selegiline. All other FDA-approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description

TYMLOS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response. Tymlos has not been used for more than two years.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of a bisphosphonate (e.g., alendronate) unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

TYSABRI

Covered Uses:

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

Exclusion Criteria:

Patients who have or have had progressive multifocal leukoencephalopathy.

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS: Prescribed by or in consultation with a neurologist. CROHN'S DISEASE: Prescribed by or in consultation with a GI specialist.

Coverage Duration:

12 months.

Other Criteria:

RELAPSING FORMS OF MULTIPLE SCLEROSIS: Failure or clinically significant adverse effects to one of the following: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, Copaxone, Glatopa, Extavia or Rebif. CROHN'S DISEASE: Failure or clinically significant adverse effects to Humira or Remicade.

Prior Authorization Group Description

UPTRAVI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

VALCHLOR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following skin-directed therapies: topical corticosteroids (e.g., clobetasol, triamcinolone), Targretin gel, Tazorac, or imiquimod. FOR CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Prior Authorization Group Description

VANCOCIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, infectious disease specialist or hospitalist.

Coverage Duration:

C. Diff diarrhea: 14 days. Staph enterocolitis: 10 days. Recurrent C. Diff: 10 weeks

Other Criteria:

Prior Authorization Group Description

VENCLEXTA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Chronic Lymphocytic Leukemia without 17p deletion.

Exclusion Criteria:

Required Medical Information:

Documentation of CLL with or without 17p deletion.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of clinically significant adverse effects to one previous therapy (e.g., Imbruvica, Campath, high-dose methylprednisolone with Rituxan).

Prior Authorization Group Description

VERSACLOZ

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Psychotic disorder associated with Parkinson's disease.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of or clinically significant adverse effects to clozapine (Clozaril) or FazaClo.

Prior Authorization Group Description

VERZENIO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of endocrine therapy (e.g., anastrozole, exemestane, tamoxifen). For combination therapy: used in combination with fulvestrant. For monotherapy: failure of chemotherapy (e.g., docetaxel, gemcitabine).

Prior Authorization Group Description

VIBERZI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to loperamide and either diphenoxylate-atropine or dicyclomine, unless patient is 65 years or older.

Prior Authorization Group Description

VINBLASTINE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Documentation that vinblastine is being used as palliative therapy.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

VINCRISTINE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Patients with the demyelinating form of Charcot-Marie-Tooth syndrome.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Hodgkin's disease, non-Hodgkin's malignant lymphomas, rhabdomyosarcoma, neuroblastoma, Wilms' tumor: use in combination with other oncolytic agents.

Prior Authorization Group Description

VOSEVI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

For members with cirrhosis, documentation of Child-Pugh A status. Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

12 weeks.

Other Criteria:

If HCV genotype 1, 2, 3, 4, 5 or 6, member has previously been treated with an HCV regimen containing one of the following NS5A inhibitors: daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir. Alternatively, if HCV genotype is 1a or 3, member has previously been treated with an HCV regimen containing sofosbuvir.

Prior Authorization Group Description

VOTRIENT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

SOFT TISSUE SARCOMA: Member has received prior chemotherapy (e.g., regimens containing doxorubicin or epirubicin).

Prior Authorization Group Description

VRAYLAR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to TWO of the following atypical antipsychotics: aripiprazole, ziprasidone, quetiapine, olanzapine, risperidone.

Prior Authorization Group Description

XALKORI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation that the patient is ALK-positive as detected by an FDA-approved test or that the patient is ROS-1 positive as confirmed by a laboratory-developed break-apart FISH or RT-PCR clinical trial assay.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

XATMEP

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Less than 18 years of age.

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist (for acute lymphoblastic leukemia) or rheumatologist (for polyarticular juvenile idiopathic arthritis).

Coverage Duration:

12 months.

Other Criteria:

Medical justification as to why member cannot use methotrexate tablets.

Prior Authorization Group Description

XELJANZ (includes Xeljanz XR)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to one of the following: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description

XENICAL

Covered Uses:

For obesity management including weight loss and weight maintenance when used in conjunction with a reduced-calorie diet or to reduce the risk for weight regain after prior weight loss in obese patients with an initial body mass index (BMI) of 30 kg/m^2 or greater (obese) or 27 kg/m^2 or greater (overweight) in the presence of at least one weight-related comorbidity such as hypertension, type 2 diabetes mellitus, or dyslipidemia.

Exclusion Criteria:

Required Medical Information:

BMI is greater than or equal to 30 kg/m^2 OR BMI is greater than or equal to 27 kg/m^2 with one or more of the following severe co-morbid conditions 1. Coronary artery/heart disease 2. Diabetes 3. Dyslipidemia 4. Hypertension 5. Obstructive sleep apnea AND Documentation of the patient's baseline weight is required to determine response to therapy. Reauthorization: Documentation of a 5-10 pound weight loss during the previous 6 month period for the first year of treatment and lack of side effects. Therapy beyond the first year can be authorized every 6 months with documentation of weight maintenance and lack of side effects.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial: 6 months.

Other Criteria:

Prior Authorization Group Description

XEOMIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

XERMELO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Prescribed in combination with a somatostatin analog (e.g., octreotide, lanreotide) unless contraindicated or clinically significant adverse effects are experienced. CONTINUATION OF THERAPY: Maintained on therapy with positive response (e.g., reduction in bowel movement frequency, reduction in urinary 5-HIAA levels).

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure to a trial of a somatostatin analog (e.g., octreotide, lanreotide) unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description

XOLAIR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Moderate to severe persistent asthma: Patient has a positive skin test or in vitro reactivity to a perennial aeroallergen AND Patient has a confirmed total serum IgE level greater than 30 IU/ml. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Asthma: Patient is 6 years of age or older. Chronic Idiopathic Urticaria: Patient is 12 years of age or older.

Prescriber Restrictions:

Asthma: Prescribed by or in consultation with a pulmonologist, immunologist, or allergist. Urticaria: Prescribed by or in consultation with an allergist, dermatologist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Moderate to severe persistent asthma: Failure or clinically significant adverse effects to one inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide). Chronic Idiopathic Urticaria: Failure or clinically significant adverse effects to one H1 Antihistamine (e.g., levocetirizine or desloratadine).

Prior Authorization Group Description

XTANDI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

For patients without visceral metastases: failure or clinically significant adverse effects to Zytiga.

Prior Authorization Group Description

YERVOY

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Small cell lung cancer.

Exclusion Criteria:

Required Medical Information:

Small cell lung cancer: Disease relapse within 6 months following complete or partial response or stable disease.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Small cell lung cancer: Disease relapse with initial treatment (e.g., cisplatin, carboplatin containing regimen).

Prior Authorization Group Description

ZALTRAP

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Colorectal cancer is resistant or has progressed following an oxaliplatin-containing regimen AND Zaltrap will be used in combination with 5-fluorouracil, leucovorin, and irinotecan (FOLFIRI).

Prior Authorization Group Description

ZARXIO

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Myelodysplastic syndrome. Neutropenia in patients with HIV/AIDS. Hematopoietic syndrome of acute radiation syndrome.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ZEJULA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Completed two or more platinum-based chemotherapy regimens and are in a complete or partial response.

Prior Authorization Group Description

ZELBORAF

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Non-small cell lung cancer. Hairy Cell Leukemia.

Exclusion Criteria:

MELANOMA: Patients with wild-type BRAF melanoma.

Required Medical Information:

MELANOMA, NON-SMALL CELL LUNG CANCER: Positive for the BRAF V600E mutation detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

HAIRY CELL LEUKEMIA: Condition is non-responsive to purine analog therapy (e.g., pentostatin, cladribine).

Prior Authorization Group Description

ZEPATIER

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

12 to 16 wks based on genotype,presence of NS5A resistance-associated polymorphisms,prior treatment.

Other Criteria:

Prior Authorization Group Description

ZINPLAVA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation of positive Clostridium difficile test.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

4 weeks.

Other Criteria:

Will receive or is currently receiving antibacterial drug treatment for Clostridium difficile infection (e.g., metronidazole, vancomycin, fidaxomicin) concomitantly with Zinplava. Has received appropriate treatment for past CDI recurrences, including a pulsed vancomycin regimen.

Prior Authorization Group Description

ZOLPIDEM

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure or clinically significant adverse effects to two of the following: Rozerem, Silenor 6 mg/day or less, trazodone or temazepam.

Prior Authorization Group Description

ZYDELIG

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. MALT lymphoma (gastric and nongastric). Splenic Marginal Zone Lymphoma. Primary Cutaneous Marginal Zone B-Cell Lymphoma. Nodal Marginal Zone Lymphoma.

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a hematologist or oncologist.

Coverage Duration:

12 months.

Other Criteria:

For relapsed follicular B-cell non-Hodgkin lymphoma (FL) or relapsed small lymphocytic lymphoma (SLL): failure or clinically significant adverse effects to two prior systemic therapies (e.g., For FL: Leukeran, Rituxan, Treanda, R-CHOP, R-CVP, FCMR or for SL: Leukeran, Gazyva, FCR, FR, BR or PCR).

Prior Authorization Group Description

ZYKADIA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Soft tissue sarcoma - inflammatory myofibroblastic tumor.

Exclusion Criteria:

Required Medical Information:

Documentation that the patient does or does not have anaplastic lymphoma kinase (ALK)-positive disease. CONTINUATION OF THERAPY: Maintained on therapy with positive response.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description

ZYTIGA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Must be used in combination with prednisone.