OneCare (HMO SNP)

2020 Prior Authorization Criteria

(Requirements for approval for certain drugs)

Please read: This document contains information about the drugs we cover in this plan.

OneCare (HMO SNP)

Criterios de autorización previa para 2020

(Requisitos para la aprobación de ciertos medicamentos)

Favor de leer: Este documento contiene información sobre los medicamentos cubiertos en este plan.

Chương Trình OneCare (HMO SNP)

Các Tiêu Chuẩn Về Sự Chấp Thuận Trước Trong Năm 2020

(Những yêu cầu để được chấp thuận cho các loại thuốc nhất định)

Vui lòng đọc: Tài liệu này gồm có các thông tin về các loại thuốc chúng tôi đài thọ trong chương trình này.

ABSSSI 2 WEEK

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DALVANCE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Labs with culture and sensitivity information.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 weeks

OTHER CRITERIA
Medical justification specifying that oral antibiotics and IV vancomycin have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

ABSSSI 6 DAY

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SIVEXTRO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Labs with culture and sensitivity information.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 days

OTHER CRITERIA
Medical justification specifying that IV vancomycin has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

ACTEMRA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ACTEMRA, ACTEMRA ACTPEN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a rheumatologist

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: For rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (PJIA), previous trial of or contraindication to both of the following preferred agents: Humira, Enbrel.

ADHD

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DAYTRANA, DEXTROAMPHETAMINE 10 MG TAB, DEXTROAMPHETAMINE 5 MG TAB, DEXTROAMPHETAMINE SULFATE ER, DEXTROAMPHETAMINE-AMPHET ER, DEXTROAMPHETAMINE-AMPHETAMINE, METHYLPHENIDATE ER 10 MG TAB, METHYLPHENIDATE ER 18 MG TAB, METHYLPHENIDATE ER 20 MG TAB, METHYLPHENIDATE ER 27 MG TAB, METHYLPHENIDATE ER 36 MG TAB, METHYLPHENIDATE ER 54 MG TAB, METHYLPHENIDATE ER 72 MG TAB, METHYLPHENIDATE ER (LA), METHYLPHENIDATE 10 MG TABLET, METHYLPHENIDATE 10 MG/5 ML SOL, METHYLPHENIDATE 20 MG TABLET, METHYLPHENIDATE 5 MG TABLET, METHYLPHENIDATE 5 MG/5 ML SOLN, METHYLPHENIDATE HCL CD, METHYLPHENIDATE HCL ER (CD), METHYLPHENIDATE LA, METHYLPHENIDATE SR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
If the patient is receiving concomitant sedatives (ramelteon, zaleplon, zolpidem) or benzodiazepines (alprazolam, chlordiazepoxide, clobazam, clonazepam, diazepam, estazolam, flurazepam, lorazepam, oxazepam, quazepam, temazepam, triazolam), justification as to why both agents are medically necessary.

AEMCOLO

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AEMCOLO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 days

OTHER CRITERIA
Medical justification that two formulary alternatives (Azithromycin, Ciprofloxacin, Levofloxacin) have been tried and failed or are contraindicated,or would not be medically appropriate for the patient.

ALPHA-ADRENERGIC AGONISTS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MIDODRINE HCL

EXCLUSION CRITERIA
Use of midodrine in combination with antihypertensive or peripheral vasodilating medications.

REQUIRED MEDICAL INFORMATION
For new requests and continuation of therapy (previous favorable coverage determination within the past 12 months or paid pharmacy claim within the past 6 months), blood pressure reading within the past month.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
For new requests: (1) Medical justification is required specifying that fludrocortisone has been tried and failed, is contraindicated, or would not be medically appropriate for the patient. And (2) Documentation of low blood pressure readings (less than 90 mmHg systolic or less than 60 mmHg diastolic), tilt table test results, or chart notes documenting symptoms of orthostatic hypotension upon postural change or prolonged standing (i.e. generalized weakness, dizziness, lightheadedness, visual blurring, leg buckling, loss of consciousness, cognitive slowing). Maximum dose of 10mg TID.

ALUNBRIG

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ALUNBRIG

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
1 year

OTHER CRITERIA
Member is intolerant to or has progressed on crizotinib (Xalkori)

AMIKACIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ARIKAYCE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Labs with culture and sensitivity information.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infectious Disease, Hospitalists

COVERAGE DURATION
6 months

OTHER CRITERIA
Documented failure with a multidrug background regimen therapy.

ANADROL

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ANADROL-50

EXCLUSION CRITERIA
Anadrol 50 may not be used to not replace other supportive measures for anemia such as transfusion, correction of iron, folic acid, B12 or pyridoxine deficiency, antibacterial therapy, or the appropriate use of corticosteroids. Other exclusions: Use to enhance athletic ability, Carcinoma of the breast in females with hypercalcemia, Carcinoma of the prostate or breast in male patients, Pregnancy, Nephrosis or the nephrotic phase of nephritis, Severe hepatic dysfunction.

REQUIRED MEDICAL INFORMATION
Cachexia associated with AIDS: member is on an anti-retroviral therapy. Other Indications: Hgb less than 10g/dL, normal serum testosterone level (male recipients).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
Individual has a diagnosis of a deficient red cell production-associated anemia, such as but not limited to acquired aplastic anemia, congenital aplastic anemia, myelofibrosis, or myelotoxic drug-associated hypoplastic anemia. For anemia, approved dose is 1 to 5 mg/kg daily.

ANDROGENS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ANDRODERM, ANDROGEL 1.62% GEL PUMP, ANDROGEL 1.62%(1.25G) GEL PCKT, ANDROGEL 1.62%(2.5G) GEL PCKT, METHYLTESTOSTERONE, TESTOSTERONE 1% (25MG/2.5G) PK, TESTOSTERONE 1% (50 MG/5 G) PK, TESTOSTERONE 1.62% (2.5 G) PKT, TESTOSTERONE 1.62% GEL PUMP, TESTOSTERONE 1.62%(1.25 G) PKT, TESTOSTERONE 10 MG GEL PUMP, TESTOSTERONE 12.5 MG/1.25 GRAM, TESTOSTERONE 25 MG/2.5 GM PKT, TESTOSTERONE 30 MG/1.5 ML PUMP, TESTOSTERONE 50 MG/5 GRAM GEL, TESTOSTERONE 50 MG/5 GRAM PKT, TESTOSTERON CYP 1,000 MG/10 ML, TESTOSTERON CYP 2,000 MG/10 ML, TESTOSTERONE CYP 1,000 MG/5 ML, TESTOSTERONE CYP 100 MG/ML, TESTOSTERONE CYP 200 MG/ML, TESTOSTERONE CYP 500 MG/2.5 ML, TESTOSTERONE CYP 500 MG/5 ML, TESTOSTERONE CYP 6,000 MG/30ML, TESTOSTERONE ENANTHATE

EXCLUSION CRITERIA
Testosterone levels within normal range (range for the lab doing the testing). Female patients (except for palliation of inoperable metastatic (skeletal) mammary cancer). Men with carcinoma of the breast or suspected carcinoma of the prostate. Use to enhance athletic ability.

REQUIRED MEDICAL INFORMATION
For patients initiating testosterone replacement therapy: Testosterone levels (total or free) within the previous 3 months. Require either ONE low total testosterone level OR ONE low free testosterone level. (normal ranges as provided by office or clinic performing labs).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved until end of plan year.

OTHER CRITERIA
Maximum recommended daily dosage. For brand-name testosterone products, medical justification

must be provided documenting why generic testosterone products cannot be used.

ANTIBACTERIALS, OTHER BROAD-SPECTRUM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DAPTOMYCIN, ERTAPENEM, LINEZOLID, LINEZOLID-D5W, MEROPENEM, TIGECYCLINE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Labs with culture and sensitivity information.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 weeks

OTHER CRITERIA
Medical justification specifying that one applicable formulary antibacterial has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

ANTICGRP

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AIMOVIG AUTOINJECTOR, AJOVY AUTOINJECTOR, AJOVY SYRINGE, EMGALITY PEN, EMGALITY SYRINGE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient must have at least 4 migraine days per month. Patient must have an inadequate response, contraindication, or intolerance to two different migraine prevention therapies from different classes such as antiepileptics (divalproex, topiramate, valproate, gabapentin, carbamazepine), beta blockers (propranolol, metoprolol, timolol, atenolol, nadolol), antidepressants (amitriptyline, nortriptyline, venlafaxine), calcium channel blocker (nicardipine, verapamil), angiotensin receptor II blockers ARB/Angiotensin-converting enzyme inhibitors (ACEIs) (candesartan, lisinopril) or antihistamine (cyproheptadine). For treatment of episodic cluster headache, patient must have an inadequate response, contraindication, or intolerance to at least one triptan (subcutaneous or intranasal sumatriptan) and dihydroergotamine.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist or pain specialist

COVERAGE DURATION
Initial therapy: 3 months. Continuation therapy: 1 year

OTHER CRITERIA
N/A

ANTIFUNGAL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ABELCET, AMBISOME, CASPOFUNGIN ACETATE, ERAXIS (WATER DILUENT), MICAFUNGIN, MYCAMINE, NOXAFIL 40 MG/ML SUSPENSION, NOXAFIL DR 100 MG TABLET, POSACONAZOLE DR 100 MG TABLET, VORICONAZOLE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Medical justification specifying that one applicable formulary alternative (Oral Clotrimazole, Oral Fluconazole, Oral Flucytosine, Griseofulvin, Oral Itraconazole, Oral Ketoconazole, Oral Nystatin, or Oral Terbinafine) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

ANTINAUSEA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
APREPITANT, GRANISETRON HCL 1 MG TABLET, PALONOSETRON 0.25 MG/2 ML VIAL, PALONOSETRON 0.25 MG/5 ML VIAL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Medical justification specifying that one applicable formulary alternative (Metoclopramide, Ondansetron, Tetrahydrocannabinol [Dronabinol]) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

ANTINEOPLASTICS

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ABIRATERONE ACETATE, ADCETRIS, AFINITOR 10 MG TABLET, AFINITOR 2.5 MG TABLET, AFINITOR 5 MG TABLET, AFINITOR DISPERZ, ALECENSA, AYVAKIT, BALVERSA, BOSULIF, BRAFTOVI 75 MG CAPSULE, BRUKINSA, CABOMETYX, CALQUENCE, COMETRIQ, COPIKTRA, COTELLIC, DARZALEX FASPRO, DAURISMO, DOCETAXEL 80 MG/8 ML VIAL, ENHERTU, ERLEADA, ERLOTINIB HCL, EVEROLIMUS 2.5 MG TABLET, EVEROLIMUS 5 MG TABLET, EVEROLIMUS 7.5 MG TABLET, FARESTON, FARYDAK 10 MG CAPSULE, FARYDAK 20 MG CAPSULE, FIRMAGON, FLUOROURACIL 0.5% CREAM, FLUOROURACIL 2% TOPICAL SOLN, FLUOROURACIL 5% TOPICAL SOLN, GEMCITABINE HCL 1 GRAM VIAL, GILOTRIF, GLEOSTINE 10 MG CAPSULE, GLEOSTINE 100 MG CAPSULE, GLEOSTINE 40 MG CAPSULE, HERZUMA, IBRANCE, ICLUSIG, IDHIFA, IMATINIB MESYLATE, IMBRUVICA, INLYTA, INREBIC, IRESSA, IRINOTECAN HCL 300 MG/15 ML VL, JAKAFI, KANJINTI, KISQALI, KISQALI FEMARA CO-PACK, KOSELUGO, LAPATINIB, LENVIMA, LONSURF, LORBRENA, LYNPARZA 100 MG TABLET, LYNPARZA 150 MG TABLET, MEKINIST, MEKTOVI, NERLYNX, NEXAVAR, NINLARO, NUBEQA, ODOMZO, OGIVRI, ONTRUZANT, PADCEV, PEMAZYRE, PIQRAY, REVLIMID, ROZLYTREK, RUBRACA, SARCLISA, SPRYCEL, STIVARGA, SUTENT, SYNRIBO, TAFINLAR, TAGRISSO, TALZENNA, TASIGNA, TAZVERIK, THALOMID, THIOTEPA 100 MG VIAL, TIBSOVO, TRAZIMERA, TURALIO, TYKERB, VALCHLOR, VENCLEXTA, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VINBLASTINE SULFATE, VITRAKVI, VIZIMPRO, VOTRIENT, XALKORI, XOSPATA, XPOVIO, XTANDI, YONSA, ZEJULA, ZELBORAF, ZYDELIG, ZYKADIA 150 MG TABLET, ZYTIGA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

ANTINEOPLASTICS-ONC

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
GAVRETO, INQOVI, QINLOCK, RETEVMO, TABRECTA, TUKYSA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

APTIOM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
APTIOM

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification must be received why Formulary Alternatives carbamazepine or oxcarbazepine cannot be used.

ATYPICALS

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
CAPLYTA, FANAPT, LATUDA, REXULTI, SAPHRIS, SECUADO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical justification specifying that two formulary alternatives (aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

AURYXIA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AURYXIA

EXCLUSION CRITERIA
Iron overload syndromes, Normal phosphorus level for new starts, PTH is not elevated for new starts.

REQUIRED MEDICAL INFORMATION
Labs including Calcium, Phosphate, Albumin drawn within the past 30 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Nephrology

COVERAGE DURATION
3 months

OTHER CRITERIA
Justification why calcium acetate cannot be used.

AVASTIN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
MVASI, ZIRABEV

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology, Ophthalmology

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
N/A

AVYCAZ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VABOMERE, ZERBAXA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Labs with culture and sensitivity information.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infectious Disease, Urology, Nephrology, Hospitalist

COVERAGE DURATION
2 weeks

OTHER CRITERIA
N/A

AZITHROMYCIN 600 MG ORAL TABLET

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AZITHROMYCIN 600 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification why other strengths cannot be used if the diagnosis is not treatment or prophylaxis of Mycobacterium avium complex (MAC). Up to 1200mg per week for prophylaxis or 600mg per day for treatment.

BAXDELA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BAXDELA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Labs with culture and sensitivity information.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infectious Disease

COVERAGE DURATION
14 days

OTHER CRITERIA
Medical justification specifying that two applicable formulary antibacterials has been tried and failed, is contraindicated, or would not be medically appropriate for the patient, or upon hospital discharge.

BENZNIDAZOLE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BENZNIDAZOLE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of one of the following: (1) Detection of circulating T. cruzi tryomastigotes on microscopy, (2) Detection of T. cruzi DNA by polymerase chain reaction assay, or (3) Two positive diagnosis serologic tests using different techniques (e.g., enzyme-linked immunoassay, indirect fluorescent antibody) and antigens (e.g., whole-parasite lysate, recombinant antigens) showing IgG antibodies to T. cruzi.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infectious Disease

COVERAGE DURATION
3 months

OTHER CRITERIA
Dose (weight-based) does not exceed 400mg/day.

BRONCHODILATORS, SYMPATHOMIMETIC

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
BROVANA, LEVALBUTEROL CONCENTRATE, LEVALBUTEROL 0.31 MG/3 ML SOL, LEVALBUTEROL 0.63 MG/3 ML SOL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification why a beta agonist inhaler cannot be used.

BUTALBITAL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BUTALBITAL-ACETAMINOPHEN-CAFFEINE 50-325-40 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
For enrollees age 65 and over, the prescriber must acknowledge that medication benefits outweigh potential risks. For continuation of care beyond the initial 3 months: Butalbital-acetaminophen-caffeine is not recommended for extended and repeated use. Please provide a medical justification statement as to the need for continued therapy.

CABLIVI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CABLIVI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: (1) Diagnosis of aTTP confirmed with a PLASMIC score of 6 to 7, (2) Prescribed in combination with plasma exchange therapy (PEX), and (3) Prescribed in combination with immunosuppressive therapy (i.e., glucocorticoids, rituximab). COC: (1A) If request is for a new treatment cycle, member has experienced no more than two recurrences while taking Cablivi, and prescribed in combination with plasma exchange and immunosuppressive therapy (i.e., glucocorticoids, rituximab), or (1B) If request is for treatment extension, chart notes documenting positive clinical response to therapy (e.g. improvement in any of the following: increase in platelet counts, reduction in neurological symptoms, or improvements in organ-damage markers [lactate dehydrogenase, cardiac troponin I, and serum creatinine]).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology

COVERAGE DURATION
3 months

OTHER CRITERIA
Member cannot receive more than 58 days of Cablivi therapy after completion of plasma exchange therapy.

CALCIFEDIOL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
RAYALDEE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification for why formulary alternative calcitriol or paricalcitol cannot be used.

CANNABIDIOL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
EPIDIOLEX

EXCLUSION CRITERIA
Age less than 2 years old

REQUIRED MEDICAL INFORMATION
Chart notes documenting the following: (1) a diagnosis of Lennox-Gastuat syndrome or Dravet syndrome, (2) patient will continue treatment with at least one other antiepileptic drug, (3) patient's weight and labs including AST/ALT and bilirubin levels within the past 30 days, and (4) patient does not have a history of cannabis substance abuse.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
3 months

OTHER CRITERIA
Dose does not exceed 20mg/kg/day.

CARBAGLU

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CARBAGLU

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Laboratory results which confirm the diagnosis, such as enzyme analysis of liver biopsy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

CAROSPIR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CAROSPIR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying why spironolactone oral tablet cannot be used.

CENEGERMIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OXERVATE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: Clinical information to support diagnosis of neurotrophic keratitis. COC: clinical information to indicate complete or improved corneal healing.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Ophthalmologist

COVERAGE DURATION
8 weeks

OTHER CRITERIA
Dose does not exceed 1 vial per affected eye per day.

CHOLBAM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CHOLBAM

EXCLUSION CRITERIA
Used to treat extrahepatic manifestations (such as but not limited to neurologic symptoms) of single enzyme defect-associated bile acid synthesis disorders or peroximal disorders.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
For therapy initiation: Hepatology, Gastroenterology, Geneticist, or Metabolic Specialist

COVERAGE DURATION
Initial Therapy: 3 months. Continuation Therapy: 1 year

OTHER CRITERIA
For initial therapy: (A) Diagnosis of bile acid synthesis disorders (BASDs) due to single enzyme defects (SEDs) including but not limited to 3 beta-hydroxy-delta 5-C27-steroid oxidoreductase defects OR (B) Diagnosis of peroximal disorders (PDs) including but not limited to Zellweger spectrum disorders AND (C) Individual has one of the following: (a) Manifestations of liver disease (for example, jaundice, hepatomegaly) (b) steatorrhea (c) Complications from decreased fat soluble vitamin (such as but not limited to vitamin D and K) absorption (for example, rickets, hypocalcemia, bleeding). For maintenance therapy: Meets the initial request criteria AND has had a clinical improvement (symptoms, lab values) in liver function and/or cholestasis AND has not developed a complete biliary obstruction.

CIMZIA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CIMZIA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Rheumatoid arthritis/ankylosing spondylitis/non-radiographic axial spondyloarthritis: prescribed by or in consultation with a rheumatologist. Psoriatic arthritis: prescribed by or in consultation with a dermatologist or rheumatologist. Crohn's disease: prescribed by or in consultation with a gastroenterologist. Plaque psoriasis: prescribed by or in consultation with a dermatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Rheumatoid arthritis: previous trial of or contraindication to both of the following preferred agents: Humira, Enbrel. Psoriatic arthritis, plaque psoriasis: previous trial of or contraindication to any two of the following preferred agents: Humira, Enbrel, Stelara, Cosentyx. Ankylosing spondylitis: previous trial of or contraindication to any two of the following preferred agents: Humira, Cosentyx, Enbrel. Crohns disease: previous trial of or contraindication to Humira and Stelara. Patients who are pregnant, breastfeeding, or trying to become pregnant are excluded from step criteria for all indications.

CORLANOR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CORLANOR

EXCLUSION CRITERIA
Individual has a heart rate maintained exclusively by a pacemaker. Individual has severe hypotension (blood pressure less than 90/50 mmgHg). Individual has severe hepatic impairment (Child-Pugh Class C).

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiology

COVERAGE DURATION
1 year

OTHER CRITERIA
Individual is using for the treatment of New York Heart Association (NYHA) class II, III or IV heart failure symptoms

CORTICOTROPIN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ACTHAR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For all indications except infantile spasms, documentation of limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (e.g. IV methylprednisolone, IV dexamethasone, or high dose oral steroids).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist for infantile spasm

COVERAGE DURATION
Multiple sclerosis: 21 days. Other approved indications: 28 days.

OTHER CRITERIA
For acute exacerbations of multiple sclerosis (MS), patients must be receiving concurrent immunomodulator therapy (e.g. interferon beta 1a, glatiramer acetate, dimethyl fumarate, fingolimod, or teriflunomide). For proteinuria in nephrotic syndrome, trial/failure or contraindication to calcineurin inhibitors (e.g. cyclosporine or tacrolimus) must be documented. For gout, an intolerance or contraindication to at least two first-line gout therapies (e.g. allopurinol, probenecid, or colchicine) must be documented. For continuation of care beyond the initial 28 days, medical documentation is required demonstrating positive effectiveness.

COSENTYX

COVERED USES
All FDA-Approved Indications

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Plaque psoriasis: prescribed by or in consultation with a dermatologist. Psoriatic arthritis: prescribed by or in consultation with a rheumatologist or a dermatologist. Ankylosing spondylitis: prescribed by or in consultation with a rheumatologist

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial for plaque psoriasis: previous trial of or contraindication to at least one conventional therapy such as PUVA (phototherapy ultraviolet light A), UVB (ultraviolet light B), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. Psoriatic arthritis: previous trial of or contraindication to at least one DMARD (disease-modifying anti-rheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. The quantity will be limited to 10 pens or syringes for the first 28 days of therapy. For maintenance therapy, the quantity will be limited to 2 pens or syringes per 28 days. Medical justification is required to exceed the quantity limits.

CROFELEMER

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MYTESI

EXCLUSION CRITERIA
Infectious diarrhea

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
Medical justification specifying why a formulary alternatives loperamide or diphenoxylate-atropine cannot be used.

CSF

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
FULPHILA, LEUKINE, NEULASTA, NEULASTA ONPRO, NEUPOGEN, NIVESTYM, UDENYCA, ZARXIO, ZIEXTENZO

EXCLUSION CRITERIA
Neutrophil count higher than 100,000/mm3.

REQUIRED MEDICAL INFORMATION
Patient's weight, CBC with differential drawn within the past 2 weeks.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
If any of the following is true, CSFs will be covered only if additional medical documentation establishes medical necessity in the individual case: (1) the neutrophil count is higher than 1,000/mm3 in patients with neutropenia other than chemotherapy-induced, (2) the neutrophil count is higher than 5,000/mm3 in patients receiving myelosuppressive chemotherapy, or (3) Filgrastim: dosing exceeds 10mcg/kg.

DAE

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ACTIVELLA 1 MG-0.5 MG TABLET, AMABELZ, AMITRIPTYLINE HCL, ANGELIQ, BENZTROPINE MES 0.5 MG TAB, BENZTROPINE MES 1 MG TABLET, BENZTROPINE MES 2 MG TABLET, CARISOPRODOL 350 MG TABLET, CHLORDIAZEPOXIDE HCL, CLIMARA PRO, CLOMIPRAMINE HCL, COMBIPATCH, CYCLOBENZAPRINE 10 MG TABLET, CYCLOBENZAPRINE 5 MG TABLET, CYPROHEPTADINE HCL, DEPO-ESTRADIOL, DESIPRAMINE HCL, DIAZEPAM 10 MG TABLET, DIAZEPAM 2 MG TABLET, DIAZEPAM 5 MG TABLET, DIAZEPAM 5 MG/5 ML SOLUTION, DIAZEPAM 5 MG/ML ORAL CONC, DICYCLOMINE 10 MG CAPSULE, DICYCLOMINE 10 MG/5 ML SOLN, DICYCLOMINE 20 MG TABLET, DIPHENHYDRAMINE 50 MG/ML VIAL, DIPHENOXYLATE-ATROPINE, DIPYRIDAMOLE 25 MG TABLET, DIPYRIDAMOLE 50 MG TABLET, DIPYRIDAMOLE 75 MG TABLET, DOTTI, DOXEPIN 10 MG CAPSULE, DOXEPIN 10 MG/ML ORAL CONC, DOXEPIN 100 MG CAPSULE, DOXEPIN 150 MG CAPSULE, DOXEPIN 25 MG CAPSULE, DOXEPIN 50 MG CAPSULE, DOXEPIN 75 MG CAPSULE, DUAVEE, ESTRADIOL 0.025 MG PATCH, ESTRADIOL 0.0375 MG PATCH, ESTRADIOL 0.05 MG PATCH, ESTRADIOL 0.075 MG PATCH, ESTRADIOL 0.1 MG PATCH, ESTRADIOL 0.5 MG TABLET, ESTRADIOL 1 MG TABLET, ESTRADIOL 2 MG TABLET, ESTRADIOL (ONCE WEEKLY), ESTRADIOL (TWICE WEEKLY), ESTRADIOL-NORETHINDRONE ACETAT, FLURAZEPAM HCL, FYAVOLV, GUANFACINE HCL, HYDROXYZINE 10 MG/5 ML SOLN, HYDROXYZINE 10 MG/5 ML SYRUP, HYDROXYZINE 50 MG/25 ML SYRUP, HYDROXYZINE HCL 10 MG TABLET, HYDROXYZINE HCL 25 MG TABLET, HYDROXYZINE HCL 50 MG TABLET, HYDROXYZINE PAMOATE, IMIPRAMINE HCL, INDOMETHACIN 25 MG CAPSULE, INDOMETHACIN 50 MG CAPSULE, JINTELI, LOPREEZA, MECLIZINE 12.5 MG TABLET, MECLIZINE 25 MG TABLET, MENEST 0.3 MG TABLET, MENEST 0.625 MG TABLET, MENEST 1.25 MG TABLET, MENOSTAR, MEPROBAMATE, METHOCARBAMOL 500 MG TABLET, METHOCARBAMOL 750 MG TABLET, METHYLDOPA, METHYLDOPA-HCTZ 250-25 MG TAB, MIMVEY, NIFEDIPINE, NORETHIN-ETH ESTRAD 1 MG-5 MCG, NORETHIND-ETH ESTRAD 0.5-2.5, NORTRIPTYLINE HCL, ORPHENADRINE CITRATE ER, PAROXETINE HCL, PAXIL 10 MG/5 ML SUSPENSION, PERPHENAZINE-AMITRIPTYLINE, PHENOBARBITAL, PREFEST, PREMARIN 0.3 MG TABLET, PREMARIN 0.45 MG TABLET, PREMARIN 0.625 MG TABLET, PREMARIN 0.9 MG TABLET, PREMARIN 1.25 MG TABLET, PREMPHASE, PREMPRO, PROMETHAZINE 12.5 MG SUPPOS, PROMETHAZINE 12.5 MG TABLET, PROMETHAZINE 25 MG SUPPOSITORY, PROMETHAZINE 25 MG TABLET, PROMETHAZINE 50 MG TABLET, PROMETHAZINE 6.25 MG/5 ML SOLN, PROMETHAZINE 6.25 MG/5 ML SYRP, PROTRIPTYLINE HCL, SCOPOLAMINE,

THIORIDAZINE HCL, TRIHEXYPHENIDYL HCL, TRIMETHOBENZAMIDE HCL

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

AGE RESTRICTION

PA required for enrollees age 65 and over. No PA required for enrollees under age 65.

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Approved until end of plan year.

OTHER CRITERIA

Medical justification specifying that two formulary alternatives without age restrictions have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

DAE SFU

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GLIMEPIRIDE, GLYBURIDE, GLYBURIDE-METFORMIN HCL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

AGE RESTRICTION
PA required for enrollees age 65 and over. No PA required for enrollees under age 65.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved until end of plan year.

OTHER CRITERIA
Medical justification specifying that at least two formulary alternatives without age restrictions (glipizide or non-sulfonylurea agents) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

DAE SLEEP DRUGS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ESZOPICLONE, ZALEPLON, ZOLPIDEM TARTRATE 10 MG TABLET, ZOLPIDEM TARTRATE 5 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

AGE RESTRICTION
PA required for enrollees age 65 and over. No PA required for enrollees under age 65.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved until end of plan year.

OTHER CRITERIA
Medical justification specifying that at least two formulary alternatives without age restrictions (Ramelteon, Trazodone, Lorazepam, Oxazepam) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

DALIRESP

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DALIRESP

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Individual is currently or will be concomitantly using with a long-acting bronchodilator.

DEMECLOCYCLINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
DEMECLOCYCLINE HCL

EXCLUSION CRITERIA
Drug-induced SIADH.

REQUIRED MEDICAL INFORMATION
Labs including BUN, SCr, serum uric acid, serum osmolality, serum sodium, urine osmolality and urine sodium drawn within the past 30 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Drug-induced SIADH should be treated by withdrawal of the offending drug and fluid restriction. Medical justification criteria must be provided including why a formulary alternative such as furosemide cannot be used.

DERMATITIS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PIMECROLIMUS, TACROLIMUS 0.03% OINTMENT, TACROLIMUS 0.1% OINTMENT

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Medical justification as to why topical corticosteroids cannot be used.

DERMATOLOGICAL AGENTS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DICLOFENAC SODIUM 3% GEL, DOXEPIN 5% CREAM, FLUOROURACIL 5% CREAM, TAZAROTENE, TAZORAC 0.05% CREAM, TAZORAC 0.05% GEL, TAZORAC 0.1% GEL, TRETINOIN 0.01% GEL, TRETINOIN 0.025% CREAM, TRETINOIN 0.025% GEL, TRETINOIN 0.05% CREAM, TRETINOIN 0.05% GEL, TRETINOIN 0.1% CREAM

EXCLUSION CRITERIA
Cosmetic use.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatology, Allergy, Pediatrician

COVERAGE DURATION
3 months

OTHER CRITERIA
N/A

DIAGNOSTIC USE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ATROPINE 1% EYE DROPS

EXCLUSION CRITERIA
Diagnostic use

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

DIALYSIS-PTH

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FOSRENOL 1,000 MG POWDER PACK, FOSRENOL 750 MG POWDER PACKET, LANTHANUM CARBONATE

EXCLUSION CRITERIA
Normal phosphorus level for new starts, patient is not receiving dialysis, PTH is not elevated for new starts.

REQUIRED MEDICAL INFORMATION
Labs including Calcium, Phosphate, Albumin drawn within the past 30 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Nephrology

COVERAGE DURATION
3 months

OTHER CRITERIA
Justification why calcium acetate cannot be used.

DICLOFENAC

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DICLOFENAC EPOLAMINE, PENNSAID 2% PUMP, PENNSAID 2% SOLUTION PACKET

EXCLUSION CRITERIA
Myocardial infarction (MI) or coronary artery bypass graft (CABG) in the previous year.

REQUIRED MEDICAL INFORMATION
Documentation that one formulary oral NSAID AND diclofenac 1% gel has been tried and failed within the previous 6 months, as evidenced by a previous paid claim under the prescription benefit or by physician documented use.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
Statement of medical justification for concomitant therapy with another nonsteroidal anti-inflammatory drug (NSAID). For continued therapy beyond 6 months, documented evaluation for gastrointestinal (GI) adverse events.

DIRECT RENIN INHIBITOR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ALISKIREN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying that two applicable formulary angiotensin II receptor antagonists (ARBs) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

DOPTELET

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
DOPTELET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Platelet Count (Drawn within last 30 days) indicating platelets less than 50 x 10^9/L.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hepatology, Gastroenterology, Cardiology, Hematology/ Oncology

COVERAGE DURATION
3 months

OTHER CRITERIA
For treatment of thrombocytopenia in patients with chronic liver disease: chart notes are required confirming member has a planned medical or dental procedure within 10-13 days after starting Doptelet. This requirement does not apply for the treatment of other approved indications.

DRIZALMA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DRIZALMA SPRINKLE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Clinical information that the member requires administration of the requested drug via nasogastric tube or is unable to swallow an intact capsule.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

DRY EYE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
RESTASIS, RESTASIS MULTIDOSE, XIIDRA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation is provided indicating an abnormal result or response to one or more of the following dry eye disease diagnostic/assessment methods (AAO, 2013): (a) Tear break-up time (less than 10 seconds) OR (b) Ocular surface dye staining using fluorescein, rose bengal, or lissamine green dyes OR (c) Schirmer test (aqueous tear production of less than or equal to 10 mm of strip wetting in 5 minutes) OR (d) Fluorescein clearance test/tear function index OR (e)Tear osmolarity (indicating tear film instability) OR (f) Tear lactoferrin concentrations in the lacrimal gland (decreased).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Ophthalmology, Optometry, Rheumatology, Internist or Family Medicine.

COVERAGE DURATION
1 year

OTHER CRITERIA
Individual is using to treat moderate to severe dry eye disease (AAO 2013).

DUPIXENT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DUPIXENT PEN, DUPIXENT SYRINGE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For treatment of atopic dermatitis: Body surface area (BSA) involvement equal to or greater than 10 percent OR Eczema Area and Severity Index (EASI) score of 16 or greater OR affecting crucial body areas such as the hands, feet, face, or genitals. For renewal to continue treating atopic dermatitis: Member's condition is stable or showing clinical improvement. These requirements do not apply for the treatment of other approved indications.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Allergy, Immunology, Dermatology, ENT Specialist

COVERAGE DURATION
New: 3 months. Continuation: 1 year.

OTHER CRITERIA
For treatment of atopic dermatitis: Member must have tried and failed or have a contraindication or intolerance to a generic formulary topical corticosteroid and generic topical tacrolimus. Renewal for treatment of all FDA approved indications, the medication quantity is limited to 2 syringes per 28 days.

EGRIFTA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
EGRIFTA, EGRIFTA SV

EXCLUSION CRITERIA
1. Active malignancy. 2. Disruption of the hypothalamic-pituitary axis (due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, head irradiation or trauma). 3. Pregnancy. 4. Weight loss management

REQUIRED MEDICAL INFORMATION
Documentation of active antiretroviral therapy (at least 8 weeks). Baseline visceral adipose tissue (VAT), waist circumference, waist to hip ratio, fasting blood glucose, and body mass index (BMI) are required. For continuation therapy, current VAT is also required.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infectious Disease, Endocrinologist, HIV Specialist

COVERAGE DURATION
Initial: 3 months. Continuation: 6 months.

OTHER CRITERIA
For initial therapy: Waist circumference greater than or equal to 37 inches (94 cm), waist to hip ratio greater than or equal to 0.94 for men or 0.88 for women, fasting blood glucose less than 150 mg/dL, and BMI greater than 20 kg/m2. For continuation, individual must demonstrate there is a clear response in reduction of visceral adipose tissue measured by waist circumference or computed tomography (CT) scan.

EMFLAZA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
EMFLAZA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation indicating a diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with Neurology

COVERAGE DURATION
Initial Therapy: 6 months, Continuation Therapy: 1 year

OTHER CRITERIA
Member must have tried and failed or have a contraindication or intolerance to Prednisone. Requested dose does not exceed 0.9mg/kg/day. For continuation: documentation of positive response to therapy (i.e. improved muscle strength or pulmonary function).

ENBREL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ENBREL, ENBREL MINI, ENBREL SURECLICK

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, ankylosing spondylitis: prescribed by or in consultation with a rheumatologist. Psoriatic arthritis: prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis: prescribed by or in consultation with a dermatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Rheumatoid arthritis: previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine.

ENTRESTO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ENTRESTO

EXCLUSION CRITERIA
History of angioedema related to previous ACE inhibitor or ARB therapy. Concomitant use of ACE inhibitors. Concomitant use of aliskiren (Tekturna) in patients with diabetes.

REQUIRED MEDICAL INFORMATION
Heart failure with reduced ejection fraction (Left Ventricular Ejection Fraction = 40 percent or less), an elevated natriuretic peptide level or hospitalization for Heart failure in the past 12 months, and a systolic blood pressure of at least 100 mmHg.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

ENZYME REPLACEMENTS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CYSTAGON, KUVAN 100 MG TABLET, KUVAN 500 MG POWDER PACKET, MIGLUSTAT, RAVICTI, SAPROPTERIN 100 MG TABLET, SAPROPTERIN 500 MG POWDER PKT, SODIUM PHENYLBUTYRATE POWDER

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
FDA-approved duration.

OTHER CRITERIA
N/A

EPCLUSA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SOFOSBUVIR-VELPATASVIR

EXCLUSION CRITERIA
Patients concurrently using any of the following medications not recommended by the manufacturer: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, efavirenz (e.g. ATRIPLA, SUSTIVA), rosuvastatin at doses greater than 10mg daily, tipranavir/ritonavir, or topotecan. Patients with severe renal impairment, ESRD or who require hemodialysis.

REQUIRED MEDICAL INFORMATION
HCV RNA level within past 6 months. Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (hepatologist), or a specially trained group such as ECHO (extension for community healthcare outcomes) model

COVERAGE DURATION
Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance. HCV RNA level within the past 6 months. Combination therapy with ribavirin is required for patients with decompensated cirrhosis, unless the patient is ribavirin ineligible.

EPO

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ARANESP 10 MCG/0.4 ML SYRINGE, ARANESP 100 MCG/0.5 ML SYRINGE, ARANESP 100 MCG/ML VIAL, ARANESP 150 MCG/0.3 ML SYRINGE, ARANESP 200 MCG/0.4 ML SYRINGE, ARANESP 200 MCG/ML VIAL, ARANESP 25 MCG/0.42 ML SYRING, ARANESP 25 MCG/ML VIAL, ARANESP 300 MCG/0.6 ML SYRINGE, ARANESP 300 MCG/ML VIAL, ARANESP 40 MCG/0.4 ML SYRINGE, ARANESP 40 MCG/ML VIAL, ARANESP 500 MCG/1 ML SYRINGE, ARANESP 60 MCG/0.3 ML SYRINGE, ARANESP 60 MCG/ML VIAL, EPOGEN, PROCRIT, RETACRIT

EXCLUSION CRITERIA
For initiation of therapy, coverage is excluded if pretreatment Hgb is greater than 10 g/dL.

REQUIRED MEDICAL INFORMATION
Labs including Hgb, Hct, serum ferritin, serum transferrin saturation drawn within the past 60 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Dose reduction or interruption is required if hemoglobin exceeds 10 g/dL (adult CKD not on dialysis, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD).

EXJADE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DEFERASIROX 125 MG TB FOR SUSP, DEFERASIROX 250 MG TB FOR SUSP, DEFERASIROX 500 MG TB FOR SUSP, DEFERIPRONE, FERRIPROX, FERRIPROX

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Current weight, lab values for serum ferritin, SCr, ALT/AST drawn within the past 30 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
3 months

OTHER CRITERIA
Dose cannot exceed 99mg/kg/day for deferiprone or 40mg/kg/day for deferasirox. For transfusional iron overload: serum ferritin must consistently be greater than 1000 mcg/L.

FASENRA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FASENRA, FASENRA PEN

EXCLUSION CRITERIA
Current respiratory disease other than asthma. On dual therapy with another monoclonal antibody for the treatment of asthma. Excluded under Part D if meets coverage criteria under Part B.

REQUIRED MEDICAL INFORMATION
Blood eosinophil at least 150 cells/uL within 4 weeks. Chart notes within the past year documenting persistent airflow obstruction as indicated by 1) pre-bronchodilator FEV1 less than 80% predicted, and 2) FEV1 reversibility of at least 12% and 200 mL after albuterol administration. Member has had 1 or more asthma exacerbations in the past 12 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Allergy, Immunology, Pulmonology

COVERAGE DURATION
Initial Therapy: 3 months. Continuation Therapy: 1 year

OTHER CRITERIA
N/A

FENOFIBRATE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FENOFIBRATE 120 MG TABLET, FENOFIBRATE 150 MG CAPSULE, FENOFIBRATE 40 MG TABLET, FENOFIBRATE 50 MG CAPSULE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying that an alternative fenofibrate of similar strength without prior authorization restrictions (43 mg, 67 mg, 130 mg, 134 mg, 200 mg capsule, or 48 mg, 54 mg, 145 mg, 160 mg tablet, or 45 mg, 135 mg delayed release capsule) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient. Concurrent therapy with a statin is required or medical justification specifying that a statin is contraindicated or would not be medically appropriate for the patient.

FOSAPREPITANT

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
FOSAPREPITANT DIMEGLUMINE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 6-month increments.

OTHER CRITERIA
For non-carboplatin based moderate emetic risk chemotherapy regimens: medical justification specifying that a 5HT3 antagonist (ondansetron or granisetron) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

GALAFOLD

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GALAFOLD

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: Documentation of in vitro assay data indicating an amenable galactosidase alpha gene (GLA) variant, or (for males) Biochemical assay of alpha-galactosidase (GLA) enzyme activity in leukocytes of less than 20% of normal activity COC: Chart notes documenting disease stability or improvement in symptoms.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Geneticist, Metabolic specialist, Specialist related to the diagnosis.

COVERAGE DURATION
New: Approved for 3 months. COC: 1 year

OTHER CRITERIA
Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta).

GNRH

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ELIGARD, LEUPROLIDE ACETATE, LUPRON DEPOT, LUPRON DEPOT (LUPANETA), LUPRON DEPOT-PED 11.25 MG 3MO, LUPRON DEPOT-PED 7.5 MG KIT, SYNAREL, TRELSTAR

EXCLUSION CRITERIA

Infertility treatment.

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

GROWTH HORMONE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GENOTROPIN, HUMATROPE, INCRELEX, NORDITROPIN FLEXPRO, NORDITROPIN NORDIFLEX, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN 5 MG VIAL, SAIZEN 8.8 MG CLICK.EASY CARTG, SAIZEN-SAIZENPREP, SEROSTIM 5 MG VIAL, ZOMACTON

EXCLUSION CRITERIA
Coverage is excluded for adults without demonstrated GH deficiency. Coverage is excluded for use to enhance body mass or strength for professional, recreational or social reasons.

REQUIRED MEDICAL INFORMATION
Copies of recent results (within 3 months) from at least one GH stimulation test: Insulin tolerance test or Arginine plus GHRH. Copies of labs with: Dehydroepiandrosterone (DHEA), Thyroid-stimulating hormone (TSH), Thyroid (free T3 and free T4), Follicle-stimulating hormone (FSH), Luteinizing hormone (LH), Insulin-like growth factor (IGF-1), Hemoglobin A1c level, For males: testosterone levels (total and free), For females: estradiol levels. Patient weight.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinology or Nephrology

COVERAGE DURATION
3 months

OTHER CRITERIA
Maximum recommended daily dose. For initiation of treatment of growth hormone (GH) deficiency in adults, GH deficiency must be demonstrated with at least one of the following: (1) insulin tolerance test (ITT) with serum GH less than 5.1ng/mL, or (2) IGF-I level less than the age-specific lower limit.

GROWTH HORMONE ANTAGONISTS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SOMAVERT

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Serum IGF-I level drawn within the past 30 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Maximum recommended daily dose. Diagnosis of acromegaly AND a prescriber affirmation statement that member has had an inadequate response to surgery and/or radiation OR that surgery and/or radiation therapy are not an option (such as but not limited to, individual is an inappropriate candidate for surgical or radiation-based therapy).

HAE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
HAEGARDA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical chart notes documenting history of frequent or severe HAE attacks (such as more than one event per month or disabled more than 5 days per month or history of recurrent laryngeal attacks).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Allergist, Immunologist, Otolaryngologist

COVERAGE DURATION
6 months

OTHER CRITERIA
Medical justification that danazol has been tried and failed, is contraindicated, or would not be medically appropriate for the patient. Dose does not exceed FDA approved dosage.

HARVONI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
LEDIPASVIR-SOFOSBUVIR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HCV RNA level within past 6 months. Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (hepatologist), or a specially trained group such as ECHO (extension for community healthcare outcomes) model

COVERAGE DURATION
Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance. No approval for requests where provider attests that patient has life expectancy less than 12 months due to non-liver related comorbid conditions (per AASLD/IDSA treatment guideline recommendation). Patient is not concurrently taking any of the following: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, rosuvastatin, sofosbuvir (as a single agent), or tipranavir/ritonavir.

HBV

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ADEFOVIR DIPIVOXIL, BARACLUDE 0.05 MG/ML SOLUTION, ENTECAVIR, EPIVIR HBV 25 MG/5 ML SOLN, LAMIVUDINE 100 MG TABLET, LAMIVUDINE HBV, VEMLIDY

EXCLUSION CRITERIA
Antiviral treatment is not indicated in patients with inactive chronic hepatitis B (CHB), defined as: HBV DNA undetectable AND EITHER (1) HBsAg negative for greater than 6 months OR (2) HBsAg positive, HBeAg negative, anti-HBe positive and normal ALT.

REQUIRED MEDICAL INFORMATION
For new requests: baseline HBsAg (greater than 6 months ago) AND HBV DNA, HBsAg, HBeAg, and LFT within 6 months. For continuation: anti-HBe (HBeAb), HBV DNA, HBsAg, HBeAg, and LFT within 6 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
PREFERRED DRUGS: Must have a history of failure, contraindication, or intolerance to entecavir or adefovir before lamivudine HBV is approved. Must have a history of failure, contraindication, or intolerance to Viread (tenofovir) before Vemlidy is approved. Combination therapy may be approved with documented resistance. SPECIAL POPULATIONS: Criteria will be applied consistent with AASLD guidelines. This includes hepatitis D virus, coinfection with HIV or HCV, concomitant immunosuppressive therapy, concomitant cytotoxic therapy, virologic failure, transplant (liver or nonliver solid organ), pregnancy, or pediatric. SYMPTOMATIC ACUTE HEPATITIS (HBsAg positive for less than 6 months): antiviral treatment is only indicated in patients with acute liver failure or protracted severe course (defined by total bilirubin greater than 3 mg/dL, direct bilirubin greater than 1.5 mg/dL,

INR greater than 1.5, encephalopathy, or ascites). CHRONIC HEPATITIS B (CHB) TREATMENT DURATION: [1] HBeAg-negative at baseline, treat indefinitely. [2] CHB with cirrhosis, treat indefinitely. [3] For patients with HBeAg positive infection without cirrhosis, discontinue therapy after HBsAg loss or after treatment consolidation (treat persistently normal ALT and undetectable HBV DNA for 12 months or longer after seroconversion to anti-HBe). [4] For continued therapy beyond the recommended duration, medical justification is required documenting the benefit of continued treatment outweighs the risk of discontinuation. CHB TREATMENT INDICATIONS (HBsAg positive for at least 6 months, without cirrhosis): [A] HBeAg positive, ALT at least 2XULN (ULN for ALT is 35 U/L for males and 25 U/L for females), HBV DNA greater than 20,000 IU/mL, treat. [B] HBeAg positive, ALT at least 2XULN, HBV DNA between 2,000-20,000 IU/mL, evaluate ALT. [C] HBeAg positive, ALT above ULN but below 2XULN, HBV DNA above 2,000 IU/mL, evaluate ALT. [D] HBeAg positive, ALT below ULN, HBV DNA above 20,000 IU/mL, do not treat. [E] HBeAg positive, ALT below ULN, HBV DNA between 2,000-20,000 IU/mL, consider treatment discontinuation. [F] HBeAg negative, ALT at least 2XULN, HBV DNA at least 2,000 IU/mL, treat. [F] HBeAg negative, ALT at least 2XULN, HBV DNA below 2,000 IU/mL, evaluate ALT. [G] HBeAg negative, ALT above ULN but below 2XULN, HBV DNA above or below 2,000 IU/mL, evaluate ALT. [H] HBeAg negative, ALT below ULN, HBV DNA above 2,000 IU/mL, monitor. [I] HBeAg negative, ALT below ULN, HBV DNA below 2,000 IU/mL, do not treat. EVALUATE ALT: Rule out other causes of ALT elevation and treat if age is greater than 40 years old OR evidence of liver necroinflammation (A3 or higher) or fibrosis (F2 or higher) is identified via noninvasive testing or biopsy.

HIGH POTENCY ER OPIOID

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
KADIAN ER 200 MG CAPSULE, MORPHINE SULF ER 100 MG TABLET, MORPHINE SULF ER 200 MG TABLET, MORPHINE SULFATE ER 100 MG CAP, MORPHINE SULFATE ER 120 MG CAP, OXYCODONE HCL ER 60 MG TABLET, OXYCODONE HCL ER 80 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Oncology, Palliative Care, Pain Specialist

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying that pain is intractable (constant and debilitating pain, potent enough to interfere with sleep, and not controlled on other treatments).

HIGH POTENCY OXYCONTIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OXYCONTIN ER 60 MG TABLET, OXYCONTIN ER 80 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Oncology, Palliative Care, Pain Specialist or Consultation

COVERAGE DURATION
3-months

OTHER CRITERIA
Medical justification specifying that pain is intractable (constant and debilitating pain, potent enough to interfere with sleep, and not controlled on other treatments). Requests will be covered for patients who have contraindications or intolerance to generic extended release oxycodone, or when generic extended release oxycodone is not available.

HOFH

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
JUXTAPID 10 MG CAPSULE, JUXTAPID 20 MG CAPSULE, JUXTAPID 30 MG CAPSULE, JUXTAPID 5 MG CAPSULE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Lipid panel, ALT, AST drawn within the past 30 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiology, Gastroenterology, Endocrinology

COVERAGE DURATION
3 months

OTHER CRITERIA
Must currently take a statin (unless contraindicated) or provide a medical justification as to why its usage would not be medically appropriate (e.g. statin intolerance) for the patient. For lomitapide, must first try and fail mipomersen.

HUMIRA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
HUMIRA, HUMIRA PEDIATRIC CROHN'S, HUMIRA PEN, HUMIRA PEN CROHN'S-UC-HS, HUMIRA PEN PSOR-UVEITS-ADOL HS, HUMIRA(CF), HUMIRA(CF) PEDIATRIC CROHN'S, HUMIRA(CF) PEN, HUMIRA(CF) PEN CROHN'S-UC-HS, HUMIRA(CF) PEN PSOR-UV-ADOL HS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, ankylosing spondylitis: prescribed by or in consultation with a rheumatologist. Psoriatic arthritis: prescribed by or in consultation with a dermatologist or rheumatologist. Psoriasis: prescribed by or in consultation with a dermatologist. Crohn's disease/ulcerative colitis: prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, and psoriatic arthritis: previous trial of or contraindication to one DMARD (disease modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. Ankylosing spondylitis: previous trial of formulary agents not required. Plaque psoriasis: previous trial of or contraindication to one conventional therapy such as PUVA (phototherapy ultraviolet light A), UBV (ultraviolet light B), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. Crohn's disease and ulcerative colitis: previous trial of or contraindication to one conventional therapy such as a corticosteroid (i.e., budesonide,

methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine.

HYPERLIPIDEMIA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OMEGA-3 ACID ETHYL ESTERS, VASCEPA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Lipid panel, ALT, AST drawn within the past 30 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification that formulary statins and fibric acid derivatives have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

IBS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AMITIZA, MOVANTIK, TRULANCE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Medical justification for the concomitant use of antidiarrheals or non-opioid constipating medications.
Medical justification as why bulk or osmotic laxatives are not appropriate.

ILUMYA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ILUMYA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Plaque psoriasis: previous trial of or contraindication to any two of the following preferred agents: Humira, Cosentyx, Stelara, Enbrel.

INGREZZA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
INGREZZA, INGREZZA INITIATION PACK

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For initial therapy: Baseline Abnormal Involuntary Movement Scale (AIMS) scores (items 1-7). For continuation therapy: documentation of the current AIMS score showing improvement as compared to baseline AIMS score (decreased number).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

INTERFERON ALFA-2B

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
INTRON A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hepatitis C: gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (e.g. hepatologist). No requirement for other FDA approved indications.

COVERAGE DURATION
6 months

OTHER CRITERIA
Limited to 1 year of therapy except 18 months for follicular lymphoma. Hepatitis C genotype 1, 2, 3, 4, 5, or 6: requires a trial of or contraindication to peginterferon alfa-2a or peginterferon alfa-2b used in combination with ribavirin unless contraindicated.

INTRAROSA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
INTRAROSA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved until end of plan year.

OTHER CRITERIA
Medical justification specifying that formulary alternatives without age restrictions (e.g. estradiol 0.01% cream, or estradiol/yuvafem vaginal tablet) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

ISTURISA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ISTURISA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: (1) Clinical information indicating pituitary surgery is not an option or has not been curative and (2) baseline 24-hour urinary free cortisol (UFC) level. COC: Labs within past 30 days documenting 24-hour urinary free cortisol (UFC) level has decreased from baseline.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinology

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying that pasireotide has been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

IVIG

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ASCENIV, BIVIGAM, FLEBOGAMMA DIF 10% VIAL, GAMMAGARD LIQUID, GAMMAGARD S-D, GAMMAKED 1 GRAM/10 ML VIAL, GAMMAPLEX, GAMUNEX-C 1 GRAM/10 ML VIAL, HIZENTRA 1 GRAM/5 ML VIAL, HIZENTRA 10 GRAM/50 ML VIAL, HIZENTRA 2 GRAM/10 ML VIAL, HIZENTRA 4 GRAM/20 ML VIAL, OCTAGAM, PANZYGA, PRIVIGEN, XEMBIFY

EXCLUSION CRITERIA
Excluded under Part D if meets coverage criteria under Part B (primary immunodeficiency disease).

REQUIRED MEDICAL INFORMATION
Prescribed dose and dosing frequency. Patient's weight and weight-based dose.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Medical justification must be provided to support the prescribed dosage if it exceeds the FDA-approved maximum daily dose.

JADENU

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
DEFERASIROX 180 MG TABLET, DEFERASIROX 360 MG TABLET, DEFERASIROX 90 MG TABLET, JADENU

EXCLUSION CRITERIA
Dosing not to exceed the 28 mg/kg/day recommendations. Jadenu is contraindicated in patients with serum creatinine greater than 2 times the age-appropriate ULN or ClCr less than 40 mL/min, poor performance status, high-risk myelodysplastic syndromes, advanced malignancies, and platelet counts less than 50 x 10^9/L.

REQUIRED MEDICAL INFORMATION
Current weight, lab values drawn within the past 30 days for serum ferritin level, CPT score/class, serum creatinine, platelet count, and ALT/AST. For transfusional iron overload (transfusional hemosiderosis), also provide the length of time on blood transfusions, and date of last blood transfusion. For non-transfusion dependent thalassemia syndromes, also provide liver iron concentration (LIC).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
6 months

OTHER CRITERIA
Medical justification as to why one formulary alternative (deferasirox [generic Exjade] or Ferriprox) cannot be used. Serum ferritin must consistently be greater than 1000 mcg/L for transfusional iron overload. Serum ferritin must consistently be greater than 300 mcg/L for non-transfusion-dependent thalassemia syndromes. Dose cannot exceed 28mg/kg/day.

JYNARQUE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
JYNARQUE, TOLVAPTAN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Jynarque-New: Medical chart notes documenting a diagnosis of ADPKD, labs including LFTs and bilirubin in the past 30 days and presence of at least 2 risk factors associated with rapidly progressing disease such as a total kidney volume (TKV) of 750 mL or more, hypertension, presence of PKD1 gene, onset of ADPKD symptoms before the age of 30, presence of proteinuria as indicated by labs, high urinary sodium excretion as indicated by labs or increased fibroblast growth factor (FGF) 23. COC: Labs including LFTs and bilirubin in the past 90 days. Tolvaptan (generic Samsca): Treatment of clinically significant hypervolemic and euvolemic hyponatremia (serum sodium less than 125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction), including patients with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Jynarque: Nephrologist

COVERAGE DURATION
3 months

OTHER CRITERIA
N/A

KALYDECO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
KALYDECO

EXCLUSION CRITERIA
Patients who are homozygous for the F508del mutation in the CFTR gene

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pulmonology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

KEVZARA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
KEVZARA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: previous trial of or contraindication to at least one DMARD (disease-modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine

KINERET

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
KINERET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Rheumatoid arthritis: prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Rheumatoid arthritis: previous trial of or contraindication to both of the following preferred agents: Humira, Enbrel.

KORLYM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
KORLYM

EXCLUSION CRITERIA
Pregnancy

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

KRISTALOSE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
KRISTALOSE, LACTULOSE 10 GM PACKET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Medical justification why lactulose solution cannot be used.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
N/A

LEPTIN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
MYALEPT

EXCLUSION CRITERIA
1) HIV related lipodystrophy. 2) Metabolic disease, without concurrent evidence of generalized lipodystrophy. 3) General obesity.

REQUIRED MEDICAL INFORMATION
Chart notes documenting congenital or acquired generalized lipodystrophy. Weight and height, or BMI.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinology

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

LMWH

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FONDAPARINUX SODIUM

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
30 days pending therapeutic INR with warfarin, or for 1 year when warfarin is contraindicated.

OTHER CRITERIA
N/A

LOFEXIDINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
LUCEMYRA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) Diagnosis of opioid use disorder as per DSM-5 criteria, (2) statement from the prescriber that the patient is currently undergoing abrupt opioid discontinuation within the next 7 days, (3) medical justification supporting why an opioid taper with buprenorphine could not be used, and (4) medical records or statement from the prescriber indicating patient will not be using opioid medications during withdrawal period.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Emergency medicine, hospitalist, pain management or addiction psychiatry

COVERAGE DURATION
Approved for 14 days of treatment.

OTHER CRITERIA
One of the following must be provided: (1) lofexidine has already been initiated in an inpatient/ER setting or (2) medical justification for why clonidine could not be used. Maximum dosage does not exceed 16 tablets (2.88 mg) daily.

LYRICA

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
LYRICA CR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
For neuropathic pain associated with diabetic peripheral neuropathy (DPN), individual had a trial of one of the following: (1) SNRI (such as, Cymbalta (duloxetine HCl) or venlafaxine, (2) Tricyclic antidepressants (such as, amitriptyline, clomipramine, desipramine, nortriptyline), OR (3) Gabapentin. For post herpetic neuralgia, member had a trial of one of the following: (1) Gabapentin (2) Lidocaine patch (Lidoderm) or (3) Tricyclic antidepressants (such as, amitriptyline, desipramine, nortriptyline). For Fibromyalgia, individual had a trial of and insufficient response or intolerance to TWO of the following: (1) Savella (milnacipran) (2) Cymbalta (duloxetine HCl) (3) Gabapentin (4) Tricyclic antidepressants (5) Cyclobenzaprine OR (6) Fluoxetine.

MAVENCLAD

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
MAVENCLAD

EXCLUSION CRITERIA
1) Current malignancy, 2) Pregnant women, 3) HIV infection, 4) Active chronic infections (e.g. hepatitis or tuberculosis).

REQUIRED MEDICAL INFORMATION
First treatment course: Baseline liver function test (LFTs) and complete blood count (CBC) with differential, including lymphocyte counts within normal limits must be provided. Second treatment course: Member has received one course treatment (1.75mg/kg) with Mavenclad 12 months ago, Liver function test (LFTs) and complete blood count (CBC) with differential, including lymphocyte counts of at least 800 cells/microliter must be provided.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology, Rheumatology, Gastroenterology

COVERAGE DURATION
3 months

OTHER CRITERIA
N/A

MAVYRET

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MAVYRET

EXCLUSION CRITERIA
Moderate or severe hepatic impairment (Child Pugh B or C)

REQUIRED MEDICAL INFORMATION
HCV RNA level within past 6 months

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (hepatologist), or a specially trained group such as ECHO (extension for community healthcare outcomes) model

COVERAGE DURATION
Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance. Patient is not concurrently taking any of the following medications not recommended or contraindicated by the manufacturer: carbamazepine, rifampin, ethinyl estradiol-containing medication, atazanavir, darunavir, lopinavir, ritonavir, efavirenz, atorvastatin, lovastatin, simvastatin, rosuvastatin at doses greater than 10mg, or cyclosporine at doses greater than 100mg per day. Patient must not have prior failure of a DAA (direct-acting antiviral) regimen with NS5A-inhibitor and HCV protease inhibitor.

MAYZENT

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
MAYZENT

EXCLUSION CRITERIA
Patients with a CYP2C9*3/ *3 genotype.

REQUIRED MEDICAL INFORMATION
Results of CYP2C9 genotype testing. NEW: Baseline liver function test (AST, ALT, bilirubin), complete blood count and documentation provided showing member has received cardiac evaluation (ECG) and ophthalmologic evaluation prior to starting Mayzent. COC: Documentation that member has demonstrated a response to therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology, Rheumatology, Gastroenterology

COVERAGE DURATION
3 months

OTHER CRITERIA
Requested dose is within FDA approved recommendation based on member’s CYP2C9 genotype.

MEDICALLY ACCEPTED

COVERED USES

All Medically-Accepted Indications

MEDICATION(S)

ABSORICA, ABSORICA LD, ACTIMMUNE, ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML VIAL, AMMONIUM LACTATE, AMNESTEEM, AMPHOTERICIN B, ATOVAQUONE, BCG VACCINE (TICE STRAIN), BENLYSTA 200 MG/ML AUTOINJECT, BENLYSTA 200 MG/ML SYRINGE, CLARAVIS, HYPERRAB, ISOTRETINOIN, LIDOCAINE 5% PATCH, MYORISAN, POMALYST, QUININE SULFATE, TETRABENAZINE, VARIZIG 125 UNIT/1.2 ML VIAL, XGEVA, ZENATANE

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

MEGESTROL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MEGESTROL 20 MG TABLET, MEGESTROL 40 MG TABLET, MEGESTROL ACET 40 MG/ML SUSP, MEGESTROL ACET 400 MG/10 ML

EXCLUSION CRITERIA
Tablets used for weight gain.

REQUIRED MEDICAL INFORMATION
Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved until end of plan year.

OTHER CRITERIA
Maximum recommended daily dose.

MEPERIDINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MEPERIDINE 100 MG/ML VIAL, MEPERIDINE 25 MG/ML VIAL, MEPERIDINE 50 MG/5 ML SOLUTION, MEPERIDINE 50 MG/ML VIAL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Labs with SCr, BUN drawn within the past 30 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Medical justification as to why two formulary alternatives cannot be used in patients with decreased renal function or over age 65.

METHADONE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
METHADONE 10 MG/5 ML SOLUTION, METHADONE 5 MG/5 ML SOLUTION, METHADONE HCL 10 MG TABLET, METHADONE HCL 5 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying why at least two long-acting formulary alternatives (Fentanyl patch, Kadian, Morphine ER, Oxycodone ER, or Oxymorphone ER) cannot be used. If the patient is currently receiving treatment with a long-acting opioid medication, a prescriber statement is required indicating all other long-acting opioid medications will be discontinued. For doses above 30mg of methadone daily, consultation with a pain management specialist is required.

MS STEP 1

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
AUBAGIO, AVONEX, AVONEX PEN, DALFAMPRIDINE ER, DIMETHYL FUMARATE, GILENYA 0.5 MG CAPSULE, GLATIRAMER ACETATE, PLEGRIDY, PLEGRIDY PEN, REBIF, REBIF REBIDOSE, TECFIDERA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology, Rheumatology, Gastroenterology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

MS STEP 2

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
BETASERON

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology, Rheumatology, Gastroenterology

COVERAGE DURATION
1 year

OTHER CRITERIA
A previous trial of or contraindication to any two of the following preferred agents: Aubagio, Avonex, Gilenya, Plegridy, Rebif, Tecfidera, glatiramer acetate, and dalfampridine.

MULTAQ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
MULTAQ

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying why one formulary alternative cannot be used (amiodarone).

MYCITE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ABILIFY MYCITE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
(1) Medical justification specifying that two formulary alternatives (olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient, (2) Evidence by paid pharmacy claims that member is currently prescribed aripiprazole and has no adverse effects to the drug, (3) Documented history of medication non-compliance, and (4) Evidence that patient and provider have access to technology that is sufficient for tracking the usage of Abilify Mycite.

NARCOLEPSY

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ARMODAFINIL, MODAFINIL, XYREM

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Results of a sleep study supporting the diagnosis. Narcolepsy: positive polysomnography (sleep study) for Narcolepsy and dose does not exceed FDA label maximum. Obstructive Sleep Apnea/Hypopnea Syndrome (OSAHS): patient has positive polysomnography for OSAHS, and hypersomnolence score of at least 10 on the Epworth Sleepiness Scale and dose does not exceed FDA label maximum. Shift Work Sleep Disorder (SWSD): patient is night shift worker with hours of 11pm-7am, early morning shift worker with starting hours between 4am -7am, or rotating shift worker with night shifts, and dose does not exceed FDA label maximum. Refractory Depression: prescribed or recommended by a psychiatrist OR patient has failed therapy with one prior antidepressant regimen and is experiencing symptoms of fatigue or excessive daytime sedation while on the current antidepressant regimen, and modafinil will be added to current regimen, and dose does not exceed FDA label maximum. Bipolar depression: dose does not exceed FDA label maximum.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
If the patient is receiving concomitant sedatives (ramelteon, zaleplon, zolpidem) or benzodiazepines (alprazolam, chlordiazepoxide, clobazam, clonazepam, diazepam, estazolam, flurazepam, lorazepam, oxazepam, quazepam, temazepam, triazolam), justification as to why both agents are medically necessary.

NATPARA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NATPARA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Labs including serum calcium, albumin, and 25-hydroxyvitamin D.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
If 25-hydroxyvitamin D stores are insufficient and the patient is not on replacement therapy, medical justification is required. For maintenance therapy, if the corrected serum calcium is above 9 mg/dL, the dose must be decreased, or medical justification is required.

NAYZILAM

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NAYZILAM

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation via physician notes, statement or medication claims that the member is currently on a stable antiepileptic regimen.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

NEUMEGA

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
PROMACTA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
CBC with differential drawn within the past 30 days.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

NEXLETOL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NEXLETOL, NEXLIZET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Lipid panel, ALT, AST drawn within the past 30 days. For diagnosis of clinical atherosclerotic cardiovascular disease, diagnosis confirmed by one of the following: acute coronary syndrome, coronary or other arterial revascularization, history of MI, peripheral arterial disease, angina, stroke, or TIA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiology, Gastroenterology, Endocrinology or Lipidology

COVERAGE DURATION
1 year

OTHER CRITERIA
Clinical information provided that the patient is utilizing the maximally tolerated dose of any statin or a prescriber attestation of statin-intolerance, and history of previously failure with ezetimibe.

NIACIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NIACIN ER

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
AST, ALT, Uric Acid, Fasting Glucose or A1c drawn within the previous 3 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved until end of plan year.

OTHER CRITERIA
Medical justification specifying that two formulary statins (atorvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) or two formulary fibrates (fenofibrate or gemfibrozil) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

NIMODIPINE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
NYMALIZE 30 MG/5 ML ORAL SYRNG, NYMALIZE 60 MG/10 ML ORAL SYRN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
21 days

OTHER CRITERIA
Clinical information provided that oral nimodipine capsules are not appropriate or otherwise contraindicated.

NORTHERA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NORTHERA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology, Cardiology

COVERAGE DURATION
2 weeks

OTHER CRITERIA
N/A

NPLATE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
NPLATE 125 MCG VIAL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: Platelet count less than 30,000mm3, and member has either (1) symptoms of an active bleed or (2) risk factors for bleeding (e.g. hypertension, peptic ulcer disease, anticoagulation, recent surgery, or head trauma). Continuation: Labwork indicating platelet count greater than 30,000mm3 (w/in last 90 days) or medical document showing platelet count increased compared to baseline demonstrating efficacy (although member may need an increase in dose).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
New: Approved in 3-month increments. Continuation: Approved in 6-month increments.

OTHER CRITERIA
New: Medical justification specifying that a formulary alternative (corticosteroid, danazol, rituximab (Rituxan)) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient, or that the patient has had a splenectomy.

NUCALA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
NUCALA

EXCLUSION CRITERIA
Current respiratory disease other than asthma.

REQUIRED MEDICAL INFORMATION
For severe asthma: blood eosinophils of greater than or equal to 150 cells/mcL at initiation of therapy (within 6 weeks of dosing) or blood eosinophils of greater than or equal to 300 cells/mcL within 12 months prior to initiation of therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Allergy, Immunology, Pulmonology, Rheumatology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

OCALIVA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OCALIVA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For new therapy: Diagnosis is confirmed by two of the following: (1) Alkaline phosphatase (ALP) level of at least 1.5x upper limit of normal (ULN), (2) The presence of antimitochondrial antibodies (AMA) at a titer of 1:40 or higher, or (3) Histologic evidence of non-suppurative destructive cholangitis and destruction of interlobular bile ducts.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterology, Hepatology

COVERAGE DURATION
1 year

OTHER CRITERIA
(1) Medical justification that Ursodiol has been tried and failed (at a dosage of 13-15mg/kg/day for at least one year), is contraindicated, or would not be medically appropriate for the patient. (2) Ocaliva will be used in combination with ursodiol (unless contraindicated, or not medically appropriate for the patient).

OLUMIANT

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OLUMIANT

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Rheumatoid arthritis: previous trial of or contraindication to both of the following preferred agents: Humira, Enbrel.

OPHTHALMIC QUINOLONE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
BESIVANCE, CILOXAN 0.3% OINTMENT, MOXIFLOXACIN 0.5% EYE DROPS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 month

OTHER CRITERIA
Medical justification specifying that two formulary alternatives without prior authorization restriction (ciprofloxacin, gatifloxacin, levofloxacin, or ofloxacin ophthalmic solution) have been tried and failed, are contraindicated, or are not medically appropriate for the patient, OR an ophthalmologist or optometrist has prescribed the medication or provided a consult to recommend the medication.

ORAL ALLERGENS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GRASTEK, ODACTRA, ORALAIR 300 IR ADULT SAMPLE KT, ORALAIR 300 IR STARTER PACK, ORALAIR 300 IR SUBLINGUAL TAB

EXCLUSION CRITERIA
Uncontrolled Asthma, Eosinophilic esophagitis

REQUIRED MEDICAL INFORMATION
New: Clinical information documenting a diagnosis confirmed by one of the following: positive skin prick test OR In vitro testing showing positive pollen-specific IgE antibodies. COC: Documentation of response to therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Allergist/Immunology

COVERAGE DURATION
1 year

OTHER CRITERIA
1) Medical justification specifying that two of the following classes have been tried and failed, are contraindicated, or would not be medically appropriate for the patient: oral antihistamines (cetirizine, loratadine, desloratadine, or fexofenadine), intranasal antihistamines (azelastine), intranasal corticosteroids (fluticasone, flunisolide or triamcinolone), or leukotriene inhibitor (montelukast). (2) Clinical information indicating the member has an epinephrine auto-injector/syringe prescription.

ORAL VANCO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VANCOMYCIN HCL 125 MG CAPSULE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Labs with culture and sensitivity information.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 weeks

OTHER CRITERIA
N/A

ORENCIA

COVERED USES
All FDA-Approved Indications

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Rheumatoid arthritis and polyarticular juvenile idiopathic arthritis: prescribed by or in consultation with a rheumatologist. Psoriatic arthritis: prescribed by or in consultation with a dermatologist or rheumatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Rheumatoid arthritis or polyarticular juvenile idiopathic arthritis: previous trial of or contraindication to both of the following preferred agents: Humira, Enbrel. Psoriatic arthritis: previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel.

OTEZLA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OTEZLA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psoriatic arthritis: prescribed by or in consultation with a dermatologist or rheumatologist. Psoriasis: prescribed by or in consultation with a dermatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Psoriatic arthritis or plaque psoriasis: previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel. The preferred agents do not apply for the treatment of oral ulcers associated with Behcet's Disease.

OXBRYTA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OXBRYTA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) Hemoglobin level drawn in the last 30 days with result between 5.5 and 10.5 mg/dL and (2) clinical information indicating at history of least 1 vaso-occlusive crisis within the previous 12 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology or Sickle Cell specialist

COVERAGE DURATION
1 year

OTHER CRITERIA
Information that member is either currently stable on hydroxyurea or hydroxyurea has been tried and failed, is contraindicated, or would not be medically appropriate.

OXYCONTIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OXYCONTIN ER 10 MG TABLET, OXYCONTIN ER 15 MG TABLET, OXYCONTIN ER 20 MG TABLET, OXYCONTIN ER 30 MG TABLET, OXYCONTIN ER 40 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Oncology, Palliative Care, Pain Specialist

COVERAGE DURATION
3 months

OTHER CRITERIA
Medical justification specifying that the patient has a contraindication or intolerance to generic extended release oxycodone. Requests will also be covered when generic extended release oxycodone is not available.

PAH

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ADEMPAS, ALYQ, AMBRISENTAN, BOSENTAN, OPSUMIT, ORENITRAM ER, SILDENAFIL, SILDENAFIL 10 MG/ML ORAL SUSP, SILDENAFIL 20 MG TABLET, TADALAFIL 20 MG TABLET, TRACLEER, VENTAVIS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FDA approved functional class (WHO class or NYHA class)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiology, Pulmonology, or Rheumatology

COVERAGE DURATION
1 year

OTHER CRITERIA
For new requests: The diagnosis of PAH (pulmonary arterial hypertension) is confirmed by right heart catheterization, the pulmonary hypertension has progressed despite surgical treatment and/or maximal medical treatment of the underlying condition, and the medication used for treatment is consistent with its FDA approved functional class. For continuation of therapy: Documentation that the medication has been effective (i.e. member is stable on current dose and/or no evidence of disease progression). For combination therapy with 2 agents: Patient is refractory to monotherapy or has a history of failure, contraindication, or intolerance to monotherapy and the 2 agents must have different mechanisms of action. For combination therapy with 3 agents: Patient is refractory or poorly responsive to 2-drug combination therapy and the 3 agents must have different mechanisms of action.

PALYNZIQ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PALYNZIQ

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: Labs showing blood phenylalanine level is greater than 600 micromol/L within the past 30 days.
Continuation: updated labs showing the phenylalanine level decreased by 20% or more from baseline or phenylalanine level is less than 600 micromol/L if the patient has received the maximum dose for 16 weeks or more.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrine or Metabolic disorder specialist

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification that Kuvan has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

PAR-1 ANTAGONIST

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZONTIVITY

EXCLUSION CRITERIA
A history of stroke, transient ischemic attack (TIA), or intracranial hemorrhage (ICH), or active pathological bleeding.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiology

COVERAGE DURATION
1 year

OTHER CRITERIA
Must be used in combination with aspirin and/or clopidogrel

PART D

COVERED USES

All FDA-Approved Indications

MEDICATION(S)

ALOSETRON HCL, ARALAST NP 1,000 MG VIAL, BRIVIACT 10 MG TABLET, BRIVIACT 10 MG/ML ORAL SOLN, BRIVIACT 100 MG TABLET, BRIVIACT 25 MG TABLET, BRIVIACT 50 MG TABLET, BRIVIACT 75 MG TABLET, CALCIPOTRIENE 0.005% CREAM, CALCIPOTRIENE 0.005% OINTMENT, CALCIPOTRIENE 0.005% SOLUTION, CAYSTON, CELECOXIB 400 MG CAPSULE, CINRYZE, CLOBAZAM, CLONAZEPAM 0.125 MG DIS TAB, CLONAZEPAM 0.125 MG ODT, CLONAZEPAM 0.25 MG ODT, CLONAZEPAM 0.5 MG DIS TABLET, CLONAZEPAM 0.5 MG ODT, CLONAZEPAM 1 MG DIS TABLET, CLONAZEPAM 1 MG ODT, CLONAZEPAM 2 MG ODT, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYSTADANE, DARAPRIM, DESVENLAFAXINE ER, DESVENLAFAXINE SUCCINATE ER, DIAZOXIDE, DIHYDROERGOTAMINE 4 MG/ML SPRY, DRONABINOL, ELMIRON, EMSAM, ENGERIX-B 20 MCG/ML SYRN, ENGERIX-B PEDI 10 MCG/0.5 SYRN, ERGOLOID MESYLATES, ESBRIET, FINTEPLA, FLUCYTOSINE, GARDASIL 9, GLASSIA, HETLIOZ, ICATIBANT, KEVEYIS, LINZESS, NUEDEXTA, OCTREOTIDE 1,000 MCG/5 ML VIAL, OCTREOTIDE 1,000 MCG/ML VIAL, OCTREOTIDE 5,000 MCG/5 ML VIAL, OCTREOTIDE ACET 0.05 MG/ML VL, OCTREOTIDE ACET 100 MCG/ML AMP, OCTREOTIDE ACET 100 MCG/ML VL, OCTREOTIDE ACET 200 MCG/ML VL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE ACET 50 MCG/ML VIAL, OCTREOTIDE ACET 500 MCG/ML AMP, OCTREOTIDE ACET 500 MCG/ML VL, OFEV, ORKAMBI, PHENOXYBENZAMINE HCL, PROGLYCEM, PROLASTIN C 1,000 MG VIAL, PULMOZYME, PYRIMETHAMINE, RECOMBIVAX HB 10 MCG/ML SYR, RECOMBIVAX HB 10 MCG/ML VIAL, RECOMBIVAX HB 40 MCG/ML VIAL, RECOMBIVAX HB 5 MCG/0.5 ML SYR, SYMPAZAN, SYNDROS, UPTRAVI 1,000 MCG TABLET, UPTRAVI 1,200 MCG TABLET, UPTRAVI 1,400 MCG TABLET, UPTRAVI 1,600 MCG TABLET, UPTRAVI 200 MCG TABLET, UPTRAVI 400 MCG TABLET, UPTRAVI 600 MCG TABLET, UPTRAVI 800 MCG TABLET, VALGANCICLOVIR 450 MG TABLET, ZEMAIRA

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

1 year

OTHER CRITERIA

N/A

PART D 3 MONTH

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
AMINOSYN II 10% IV SOLUTION, AMINOSYN II 15% IV SOLUTION, AMINOSYN-PF 7% IV SOLUTION, BOTOX, CLINIMIX 4.25%-10% SOLUTION, CLINIMIX 4.25%-5% SOLUTION, CLINIMIX 5%-15% SOLUTION, CLINIMIX 5%-20% SOLUTION, CLINIMIX E 2.75%-5% SOLUTION, CLINIMIX E 4.25%-10% SOLUTION, CLINIMIX E 4.25%-5% SOLUTION, CLINIMIX E 5%-15% SOLUTION, CLINIMIX E 5%-20% SOLUTION, CLINISOL, CLOVIQUE, CYSTARAN, DOXERCALCIFEROL 4 MCG/2 ML AMP, DOXERCALCIFEROL 4 MCG/2 ML VL, FREAMINE HBC, HEPATAMINE, INTRALIPID, NUTRILIPID, PARICALCITOL 1 MCG CAPSULE, PARICALCITOL 2 MCG CAPSULE, PARICALCITOL 4 MCG CAPSULE, PLENAMINE, PREMASOL 10% IV SOLUTION, PROCALAMINE, PROSOL, REGRANEX, SIRTURO, TOBI PODHALER, TOBRAMYCIN 300 MG/5 ML AMPULE, TRAVASOL, TRIENTINE HCL, TROPHAMINE 10% IV SOLUTION, ZOLEDRONIC ACID

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
N/A

PART D VS PART B

MEDICATION(S)

AZASAN, AZATHIOPRINE, CELLCEPT 200 MG/ML ORAL SUSP, CELLCEPT 250 MG CAPSULE, CELLCEPT 500 MG TABLET, CINACALCET HCL, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE MODIFIED, EVEROLIMUS 0.25 MG TABLET, EVEROLIMUS 0.5 MG TABLET, EVEROLIMUS 0.75 MG TABLET, FLUOROURACIL 1,000 MG/20 ML VL, FLUOROURACIL 5 GM/100 ML BTL, FLUOROURACIL 5 GM/100 ML VIAL, FLUOROURACIL 5,000 MG/100 ML, FLUOROURACIL 500 MG/10 ML VIAL, GENGRAF 100 MG CAPSULE, GENGRAF 100 MG/ML SOLUTION, GENGRAF 25 MG CAPSULE, MYCOPHENOLATE 200 MG/ML SUSP, MYCOPHENOLATE 250 MG CAPSULE, MYCOPHENOLATE 500 MG TABLET, MYCOPHENOLIC ACID, MYFORTIC, NEORAL, PROGRAF 0.2 MG GRANULE PACKET, PROGRAF 0.5 MG CAPSULE, PROGRAF 1 MG CAPSULE, PROGRAF 1 MG GRANULE PACKET, PROGRAF 5 MG CAPSULE, RAPAMUNE, SANDIMMUNE 100 MG CAPSULE, SANDIMMUNE 100 MG/ML SOLN, SANDIMMUNE 25 MG CAPSULE, SIROLIMUS, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 1 MG CAPSULE, TACROLIMUS 5 MG CAPSULE, ZORTRESS

DETAILS

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

PCSK9

COVERED USES
All FDA-Approved Indications

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

EXCLUSION CRITERIA
Concurrent use with another PCSK9 agent (Praluent, Repatha) or a lipotropic agent (Juxtapid, Kynamro).

REQUIRED MEDICAL INFORMATION
Lipid panel, ALT, AST drawn within the past 30 days. For continuation of therapy, baseline lipid panel. For Heterozygous Familial Hypercholesterolemia (HeFH) or Homozygous Familial Hypercholesterolemia (HoFH), confirmation of the diagnosis by LDLR DNA Sequence Analysis, LDLR Deletion/Duplication Analysis (only if the Sequence Analysis is negative), APOB and PCSK9 testing (if both of the above tests are negative but a strong clinical picture exists), or diagnosis by clinical criteria (such as Simon Broome or the Dutch Lipid Network criteria for HeFH, or history of untreated LDL-C greater than 500 mg/dL together with Xanthoma before 10 years of age), or evidence of HeFH in both parents.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiology, Gastroenterology, Endocrinology or Lipidologist

COVERAGE DURATION
3 months

OTHER CRITERIA
For all treatable medical conditions, must currently take high-intensity statin. If there has been a previous trial/failure of either atorvastatin or rosuvastatin, then must currently take maximally tolerated dose of any statin or provide a prescriber attestation of statin-intolerance. For treatment of clinical atherosclerotic cardiovascular disease, LDL-C must be 100mg/dL or higher while on maximal treatment, and at least one of the following is required: acute coronary syndrome, coronary or other arterial revascularization, history of MI, peripheral arterial disease presumed to be of atherosclerotic

origin, stable or unstable angina, stroke, or TIA. For continuation of therapy, criteria have been satisfied AND there is confirmation of LDL reduction.

PD

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
APOKYN, TOLCAPONE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying that one formulary alternative (bromocriptine, pramipexole, or ropinirole, entacapone, or selegiline) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient. When indicated as adjunct therapy, concomitant use with formulary alternatives may be approved.

PEGASYS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PEGASYS, PEGASYS PROCLICK 180 MCG/0.5

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HCV RNA level within past 6 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (hepatologist), or a specially trained group such as ECHO (extension for community healthcare outcomes) model

COVERAGE DURATION
Hep B: 48 weeks. Hep C: Criteria will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD-IDSA guidance. For requests for use of peginterferon as part of a combination regimen with other Hepatitis C virus (HCV) antiviral drugs: trial with preferred formulary alternative ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, or Mavyret where the regimen is listed as an acceptable regimen for the specific genotype per AASLD/IDSA guidance. No approval for requests where provider attests that patient has life expectancy less than 12 months due to non-liver related comorbid conditions (per AASLD/IDSA treatment guideline recommendation).

PREVYMIS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PREVYMIS 240 MG TABLET, PREVYMIS 480 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis is allogenic hematopoietic stem cell transplant (HSCT), use is for prophylaxis of CMV infection and disease, patient is CMV-seropositive [R+], therapy will be initiated between day 0 and day 28 post-transplantation. For continuation of treatment beyond 100 days post-transplant, medical justification is required.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology, Infectious Disease specialist, or Transplant specialist

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

PROGESTINS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
CRINONE

EXCLUSION CRITERIA
Infertility treatment.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Maximum recommended daily dose.

PROLIA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
PROLIA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Osteoporosis is defined as a BMD T-Score of less than or equal to -2.5. For osteoporosis treatment, risk factors for osteoporotic fracture is defined as: Hypogonadism or premature ovarian failure, Low body mass, Smoking, Rheumatoid arthritis, Alcohol intake of 3 or more drinks/day, Vitamin D deficiency, Low calcium intake, Hyperkyphosis, Parental hip fracture, Multiple falls, Medication: Anticoagulants, anticonvulsants, aromatase inhibitors, cancer chemotherapeutic drugs, gonadotropin-releasing hormone agonists, (glucocorticoid daily dosage equivalent to 5 mg or greater of prednisone for at least 3 months). For the treatment of bone loss, risk factors for osteoporotic fracture is defined as: Low body mass, Smoking, Rheumatoid arthritis, Alcohol intake of 3 or more drinks/day, Vitamin D deficiency, Low calcium intake, Hyperkyphosis, Parental hip fracture, Multiple falls, Medication: Anticoagulants, anticonvulsants, (glucocorticoid daily dosage equivalent to 5 mg or greater of prednisone for at least 3 months).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
For osteoporosis treatment, individual has had at least ONE osteoporotic (minimal trauma) fracture OR has two or more risk factors for osteoporotic fracture OR Individual has failed or is intolerant to other available osteoporosis therapies (such as, bisphosphonates). For treatment of bone loss, member has had at least ONE osteoporotic (minimal trauma) fracture OR has one or more risk factors for

osteoporotic fracture.

PTH ANALOG

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FORTEO, TYMLOS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
BMD (bone mineral density) measurements or fracture documentation.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification is required for cumulative use of parathyroid hormone analogs (e.g., FORTEO and TYMLOS) exceeding 24 months during a patients lifetime. Patient has one of the following: (A) Has been refractory to a trial of an oral bisphosphonate therapy OR (B) Intolerance or contraindications to oral bisphosphonate as defined by having at least one of the following: 1. Hypersensitivity to TWO oral bisphosphonates (one of which must be alendronate) 2. Inability to sit or stand upright for at least 30 minutes, 3. Pre-existing gastrointestinal disorders (Barrett's esophagus, hypersecretory disorders, delayed esophageal emptying, etc.). 4. Uncorrected hypocalcemia. 5. Severe renal insufficiency as defined by creatinine clearance less than 35 mL/min for alendronate agents or creatinine clearance less than 30 mL/min for risedronate and ibandronate.

QBREXZA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
QBREXZA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: Hyperhidrosis Disease Severity Scale (HDSS) of 3 or 4. COC: Hyperhidrosis Disease Severity Scale (HDSS) of improved by 2 or more points.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatologist

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

RANEXA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
RANOLAZINE ER

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying why one formulary alternative cannot be used (acebutolol, atenolol, betaxolol, bisoprolol, carvedilol, labetalol, metoprolol, nadolol, pindolol, propranolol, timolol, diltiazem, verapamil, amlodipine, felodipine, isosorbide dinitrate, isosorbide mononitrate, transdermal nitroglycerin, or translingual nitroglycerin).

RELISTOR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
RELISTOR

EXCLUSION CRITERIA
Individual has a known or suspected mechanical gastrointestinal obstruction.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Individual must have a previous trial of or insufficient response to polyethylene glycol (generic MiraLax) AND a trial and inadequate response or intolerance to a preferred agent (Movantik/Amitiza) OR the preferred agent (Movantik/Amitiza) is not acceptable due to concomitant clinical situations, warnings or contraindications, such as but not limited to the following: (1) individual is taking a diphenylheptane opioid (e.g., methadone), where effectiveness has not been established in the treatment of OIC (Amitiza) OR (2) individual has disruption to the blood-brain barrier and may be at increased risk for opioid withdrawal and/or reduced analgesia (Movantik) OR (3) individual is taking strong CYP3A4 inhibitors and may be at increased risk for opioid withdrawal and/or reduced analgesia (Movantik).

REMICADE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
INFLECTRA, REMICADE, RENFLEXIS

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 1-year increments

OTHER CRITERIA
Medical justification must be provided to support the prescribed dosage if it exceeds the FDA-approved maximum daily dose

RIBAVIRIN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
RIBAVIRIN 200 MG CAPSULE, RIBAVIRIN 200 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HCV RNA level (viral load), Hepatitis C Virus (HCV) genotype drawn within the past 6 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterology, Infectious Disease, Hepatology, Transplant specialist, Gynecology or Oncology.

COVERAGE DURATION
Hep C: Per current AASLD/IDSA guidance. Hep B or AIDS-related Kaposi sarcoma: 16 wks. Other: 1 yr.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance

RITUXAN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
RITUXAN, RUXIENCE, TRUXIMA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology, Rheumatology

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
N/A

RYDAPT

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
RYDAPT

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
1 year

OTHER CRITERIA
For Advanced Systemic Mastocytosis with KIT D816V mutation status negative/unknown, medical justification is required why Gleevec cannot be used.

SAVELLA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SAVELLA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
For Fibromyalgia, individual had a trial of and insufficient response or intolerance to TWO of the following: (1) Cymbalta (duloxetine HCl) (2) Gabapentin (3) Tricyclic antidepressants (such as, amitriptyline, clomipramine, desipramine, nortriptyline), (4) Cyclobenzaprine OR (5) Fluoxetine.

SEDATIVES/HYPNOTICS

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
RAMELTEON

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
PA required for enrollees age 60 and under. No PA required for enrollees over age 60.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
For patients under age 60, medical justification that the formulary alternatives (zolpidem, zaleplon, temazepam, or triazolam) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient. If the patient is receiving a concomitant stimulant, justification as to why both agents are medically necessary.

SIGNIFOR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SIGNIFOR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Fasting plasma glucose, hemoglobin A1C, liver function tests, ECG, and gallbladder ultrasound.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinology

COVERAGE DURATION
1 year

OTHER CRITERIA
For patients with Cushing's disease not due to pituitary tumor, medical justification is required.

SILIQ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SILIQ

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Plaque psoriasis: previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel. Patient has been counseled on and expresses understanding of the risk of suicidal ideation and behavior. Renewal: patient has not developed or reported worsening depressive symptoms or suicidal ideation and behaviors while on treatment with Siliq. The quantity will be limited to 3 syringes for the first 28 days of therapy. For maintenance therapy, the quantity will be limited to 2 syringes per 28 days. Medical justification is required to exceed the quantity limits.

SIMPONI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SIMPONI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Rheumatoid arthritis, ankylosing spondylitis: prescribed by or in consultation with a rheumatologist. Psoriatic arthritis: prescribed by or in consultation with a rheumatologist or dermatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Rheumatoid arthritis: previous trial of or contraindication to both of the following preferred agents: Humira, Enbrel. Psoriatic arthritis: previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel. Ankylosing spondylitis: previous trial of or contraindication to any two of the following preferred agents: Humira, Cosentyx, Enbrel. Ulcerative colitis: previous trial of or contraindication to Humira.

SKYRIZI

COVERED USES
All FDA-Approved Indications

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
The quantity will be limited to 4 syringes for the first 28 days of therapy. For maintenance therapy, the quantity will be limited to 2 syringes per 84 days. Medical justification is required to exceed the quantity limits.

SNRI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FETZIMA, TRINTELLIX, VIIBRYD 10 MG TABLET, VIIBRYD 10-20 MG STARTER PACK, VIIBRYD 20 MG TABLET, VIIBRYD 40 MG TABLET

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes are required documenting the symptoms and duration of the episode. For treatment of depression, the depression rating scale and score are required.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatrist or Mental Health/Behavioral Health Specialist

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying that two of the formulary alternatives (citalopram, desvenlafaxine, escitalopram, fluoxetine, paroxetine, sertraline or venlafaxine) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

SOLIQUA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SOLIQUA 100-33

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Patients must currently be inadequately controlled on basal insulin (i.e. Basaglar, Lantus, Levemir, Toujeo, or Tresiba) less than 60 units daily. A prescriber statement is required to confirm that basal insulin will be discontinued when treatment with Soliqua begins. Patients must also have tried and failed a glucagon-like peptide (i.e. Adlyxin, Byetta, Bydureon, Tanzeum, Trulicity, or Victoza) within the previous 180 days.

SOLOSEC

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SOLOSEC

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved as single dose.

OTHER CRITERIA
Medical justification specifying that tinidazole AND either clindamycin or metronidazole have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

SORIATANE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ACITRETIN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
N/A

SOVALDI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SOVALDI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (hepatologist), or a specially trained group such as ECHO (extension for community healthcare outcomes) model

COVERAGE DURATION
Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance. Trial with preferred formulary alternative ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, or Mavyret where that regimen is listed as an acceptable regimen for the specific genotype per AASLD/IDSA guidance. For patients on Sovaldi plus Daklinza regimens there will be no approvals for concurrent use of any of these (contraindicated or not recommended by the manufacturer) medications: amiodarone, carbamazepine, phenytoin, or rifampin. Requests for Sovaldi in combination with Daklinza will require that the patient also meets all criteria for Daklinza.

STELARA

COVERED USES
All FDA-Approved Indications

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psoriatic arthritis: prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis: prescribed by or in consultation with a dermatologist. Crohn's disease: prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Psoriatic arthritis: previous trial of or contraindication to at least one DMARD (disease-modifying antirheumatic drug) such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine. Plaque psoriasis: previous trial of or contraindication at least one conventional therapy such as PUVA (phototherapy ultraviolet light A), UVB (ultraviolet light B), topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. Crohn's disease: previous trial of or contraindication to at least one conventional therapy such as corticosteroids (i.e. budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine.

SYMDEKO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SYMDEKO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: Baseline FEV1 and recent laboratory report within the past 90 days showing ALT, AST, and bilirubin levels are within normal range. Confirmed genetic testing for homozygous F508del mutation of the CFTR gene or a CFTR (cystic fibrosis transmembrane conductance regulator) gene mutation that is responsive to the Symdeko per package labeling. COC: Confirmation that member has improvement of symptoms (i.e. improved FEV1, weight gain, or decreased exacerbation). Recent laboratory report (within last 90 days) for ALT, AST, and bilirubin are within normal range.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pulmonologist or Specialist in Cystic Fibrosis

COVERAGE DURATION
3 months

OTHER CRITERIA
N/A

SYMLIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
SYMLINPEN 120, SYMLINPEN 60

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification for patients receiving concomitant metoclopramide, Precose or Glyset, patients with an A1c over 9%, patients not receiving concomitant insulin, patients with a diagnosis of gastroparesis.

TAKHZYRO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TAKHZYRO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) Documentation of HAE confirmed by lab work (HAE I: low C4 level AND low C1-INH antigenic level, HAE II: low C4 level AND normal or elevated C1-INH antigenic level AND low C1-INH function level, HAE III: low C4 level AND normal C1-INH antigenic level AND normal C1-INH function level AND documentation of a family history of HA or FXII mutation). Chart notes documenting (2A) that the member requires 4 or more acute treatment for HAE per month, OR (2B) that the member has frequent symptoms that cannot be adequately controlled by on-demand treatment, AND either (3A) History of one or more attacks per month resulting in documented ER treatment or hospitalization, (3B) History of laryngeal attacks, OR (3C) 2 or more attacks per month involving the face, throat, or abdomen.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Allergist, Immunology, Hematology, or Dermatology

COVERAGE DURATION
3 months

OTHER CRITERIA
Member is not receiving medications that can worsen the severity or frequency of angioedema episodes (estrogen-containing products, angiotensin-converting enzyme [ACE] inhibitors, others). Medical justification specifying that the member has a contraindication or intolerance to Haegarda. COC: (1) chart notes within the last 6 months is provided showing disease state improvement (such as decrease in the number, severity, and/or duration of the acute HAE attacks), and (2) member is receiving only one agent for HAE attacks.

TALTZ

COVERED USES
All FDA-Approved Indications

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Plaque psoriasis: prescribed by or in consultation with a dermatologist. Psoriatic arthritis: prescribed by or in consultation with a rheumatologist or dermatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Plaque psoriasis or psoriatic arthritis: previous trial of or contraindication to any two of the following preferred agents: Humira, Cosentyx, Stelara, Enbrel. The quantity will be limited to 7 pens or syringes for the first 84 days of therapy. For maintenance therapy, the quantity will be limited to 1 pen or syringe per 28 days. Medical justification is required to exceed the quantity limits.

TAVALISSE

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
TAVALISSE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: Platelet count less than 30,000mm3. COC: ALT, AST, and bilirubin (drawn within the last 90 days) less than 3x the upper limit of normal. Documentation of either (1) lab work indicating platelet count greater than 30,000mm3 (drawn within last 90 days), or (2) medical document showing that the platelet count increased compared to baseline demonstrating efficacy (although member may need an increase in dose).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology, Oncology

COVERAGE DURATION
New: 3 months COC: 6 months

OTHER CRITERIA
New: Medical justification specifying that a formulary alternative (corticosteroid [e.g. prednisone, dexamethasone], Promacta, or rituximab (Rituxan)) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient, or that the patient has had a splenectomy.

TEDUGLUTIDE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
GATTEX, SAIZEN 8.8 MG VIAL, ZORBTIVE

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Endocrinology, Gastroenterology

COVERAGE DURATION
3 months

OTHER CRITERIA
Approval for continued therapy with Gattex or Zorbtive requires a decrease of parenteral nutritional volume. Quantity limited to #1 vial per day.

TEGASEROD

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZELNORM

EXCLUSION CRITERIA
Evidence of labeled contraindications

REQUIRED MEDICAL INFORMATION
eGFR lab within the past 30 days

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Medical justification for: (1) The concomitant use of antidiarrheals or non?opioid constipating medications. (2) Why osmotic
laxatives and Amitiza (lubiprostone) could not be used.

TEGSEDI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TEGSEDI

EXCLUSION CRITERIA
Platelet count less than 100 x 10^9/L or UPCR of 1000 mg/g or higher or previous hypersensitivity reaction with use of Tegsedi

REQUIRED MEDICAL INFORMATION
Labs for platelet count, serum creatinine, eGFR, AST, ALT, urine protein to creatinine ratio (UPCR), total bilirubin and urinalysis within the past 2 weeks.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
3 months

OTHER CRITERIA
N/A

TETRACYCLINE

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TETRACYCLINE HCL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Medical justification specifying that one applicable formulary antibacterial has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

TIOPRONIN

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
THIOLA, THIOLA EC

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: One of the following: (1) stone analysis positive for cystine, (2) urinalysis positive for pathognomonic hexagonal cystine
crystals, (3) family history of cystinuria with a positive cyanide?nitroprusside screen, (4) 24?hour urine collection with urinary
cystine greater than 500, or (5) failed response to all of the following: increased fluid intake, modest reduction in sodium and protein
intake, and urinary alkalinization. COC: One of the following: (1) urinary cystine concentration less than 250, or (2) reduction in cystine stone production.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Nephrology, Urology

COVERAGE DURATION
3 months

OTHER CRITERIA
N/A

TOPICAL ANTIHERPETIC

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
ACYCLOVIR 5% CREAM, ACYCLOVIR 5% OINTMENT, DENAVIR

EXCLUSION CRITERIA
Herpes zoster.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 month

OTHER CRITERIA
Inadequate response, intolerable side effect, or contraindication to one oral antiviral agent (acyclovir, famciclovir, valacyclovir) and dose does not exceed FDA label maximum.

TRANSMUCOSAL IMMEDIATE RELEASE FENTANYL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
FENTANYL CIT OTFC 1,200 MCG, FENTANYL CIT OTFC 1,600 MCG, FENTANYL CITRATE OTFC 200 MCG, FENTANYL CITRATE OTFC 400 MCG, FENTANYL CITRATE OTFC 600 MCG, FENTANYL CITRATE OTFC 800 MCG

EXCLUSION CRITERIA
Any of the following: 1. Management of acute or post-operative pain. 2. Opioid non-tolerant patients. 3. Pain not associated with cancer. 4. Opioid naive.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology, Pain Management

COVERAGE DURATION
3 months

OTHER CRITERIA
Concurrent chemotherapy or chart notes documenting a diagnosis of cancer is required. Patients must be opioid tolerant, as demonstrated by one week or longer of around-the-clock therapy with a total daily dose of 60 mg of oral morphine (or equivalent dose of another opioid).

TREMFYA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TREMFYA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication. New requests for plaque psoriasis: Psoriasis involving greater than or equal to 5% of body surface area or psoriatic lesions affecting the hands, feet, face, or genital area.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Plaque psoriasis: previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel.

TRIKAFTA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
TRIKAFTA

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: (1) Baseline FEV1, weight/ BMI, and (2) Documentation confirming at least one F508del mutation in the CFTR. COC: Information provided that member has had an improved clinical response as indicated by improvement in FEV1, reduced number of pulmonary exacerbations, or improvement in body mass index (BMI).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pulmonologist or Cystic Fibrosis specialist

COVERAGE DURATION
New: 6 months. COC: 12 months

OTHER CRITERIA
Must have a history of failure, contraindication, or reason(s) for intolerance to Orkambi or Symdeko.

UREA SPLITTING URINARY INFECTION

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
LITHOSTAT

EXCLUSION CRITERIA
Pregnancy or SCr less than 20mL/min

REQUIRED MEDICAL INFORMATION
SCr is required. For women, pregnancy status is required. For continuation of therapy, CBC with reticulocyte count, platelet count, and white cell count within the past 30 days is required.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
Medical justification which documents the plan for curative treatment with surgical removal of stones and antibiotic therapy. Or medical justification which documents why curative treatment is not appropriate.

VALTOCO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VALTOCO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Clinical information provided that the member is on existing antiepileptic therapy and is experiencing acute, intermittent, or frequent seizure activity.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

VIBERZI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VIBERZI

EXCLUSION CRITERIA
Concurrent use of Lotronex, opioids, or anticholinergic medications.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterology

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

VIEKIRA

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VIEKIRA PAK

EXCLUSION CRITERIA
Decompensated cirrhosis, moderate or severe liver impairment (Child-Pugh B or C)

REQUIRED MEDICAL INFORMATION
HCV RNA level within past 6 months. Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (hepatologist), or a specially trained group such as ECHO (extension for community healthcare outcomes) model

COVERAGE DURATION
Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance. Trial with preferred formulary alternative ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, or Mavyret where that regimen is listed as an acceptable regimen for the specific genotype per AASLD/IDSA guidance. No approval for requests where provider attests that patient has life expectancy less than 12 months due to non-liver related comorbid conditions (per AASLD/IDSA treatment guideline recommendation). Patient is not concurrently taking any of the following: alfuzosin, carbamazepine, phenytoin, phenobarbital, gemfibrozil, rifampin, ergotamine dihydroergotamine, ergonovine, methylergonovine, ethinyl estradiol containing medications (such as combined oral contraceptives, NuvaRing, Ortho Evra or Xulane transdermal patch system), St. Johns wort, lovastatin, simvastatin, pimozide, efavirenz, Revatio, triazolam, oral midazolam, darunavir/ritonavir, lopinavir/ritonavir, rilviripine, salmeterol.

VIVITROL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VIVITROL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Individual is not currently on opioid analgesics for pain management AND is not currently in acute opioid withdrawal AND does not have any of the following: a positive urine screen for opioids OR a failed naloxone challenge test OR acute hepatitis OR liver failure OR previous hypersensitivity to naltrexone or any component of the diluent. For alcohol dependence, individual is not actively drinking at the time of initial injectable naltrexone (Vivitrol) administration AND is able to abstain from alcohol for at least 7 days in an outpatient setting prior to treatment initiation AND actively participates in a comprehensive rehabilitation program that includes psychosocial support. For Opioid dependence, individual has successfully completed an opioid detoxification program AND has been opioid-free (including buprenorphine and methadone) for at least 7 days prior to initiating treatment with naltrexone (Vivitrol) injection AND actively participates in a comprehensive rehabilitation program that includes psychosocial support.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

VOSEVI

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VOSEVI

EXCLUSION CRITERIA
Severe renal impairment, ESRD or on hemodialysis. Moderate or severe hepatic impairment (Child-Pugh B or C).

REQUIRED MEDICAL INFORMATION
HCV RNA level within past 6 months

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (hepatologist), or a specially trained group such as ECHO (extension for community healthcare outcomes) model

COVERAGE DURATION
Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Trial with preferred formulary alternative Mavyret where Mavyret regimen is listed as an acceptable regimen for the specific genotype per AASLD/IDSA guidance. Patient is not concurrently taking any of the following medications not recommended by the manufacturer: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, cyclosporine, pitavastatin, pravastatin (doses above 40mg), rosuvastatin, methotrexate, mitoxantrone, imatinib, irinotecan, lapatinib, sulfasalazine, topotecan, or HIV regimen that contains efavirenz, atazanavir, lopinavir or tipranavir/ritonavir.

VRAYLAR

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
VRAYLAR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification that two formulary alternatives (Aripiprazole, Olanzapine, Paliperidone, Quetiapine, Risperidone, Ziprasidone, or Rexulti) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

VYNDAQEL

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
VYNDAMAX, VYNDAQEL

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiologist

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

WASTING

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
OXANDROLONE, SEROSTIM 4 MG VIAL, SEROSTIM 6 MG VIAL

EXCLUSION CRITERIA
Using to enhance athletic performance or physique.

REQUIRED MEDICAL INFORMATION
Height, weight, body mass index (BMI), Body cell mass (BCM) by bioelectrical impedance analysis (BIA). Male recipients: a prescriber statement is required attesting treatment is not prescribed to enhance athletic performance or physique.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
3 months

OTHER CRITERIA
For HIV-associated wasting, patients must have concomitant antiretroviral therapy and meet the following criteria. For HIV-associated wasting or cachexia associated with chronic disease: dose does not exceed FDA approved maximum and patient meets at least one of the following: weighs less than 90% ideal body weight, OR 10% or more unintentional weight loss within the preceding 12 months, OR 7.5% unintentional weight loss within the preceding six months, OR has a baseline BIA or total body DEXA showing body cell mass (BCM) below 40% in males and 35% in females, OR 5% BCM loss within the preceding six months, OR BMI less than 20 kg/m2. Reauthorization: improvement or stabilization in the body weight or body cell mass (BCM) compared to baseline.

XCOPRI

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
XCOPRI

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
Medical justification specifying that two formulary alternatives (Carbamazepine, Clorazepate, Felbamate, Gabapentin, Lamotrigine, Levetiracetam, Oxcarbazepine, Pregabalin, Tiagabine, Topiramate, Valproic Acid, Zonisamide) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

XELJANZ

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
XELJANZ, XELJANZ XR

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Renewal: Physician attestation that the patient continues to benefit from the medication.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Rheumatoid arthritis: prescribed by or in consultation with a rheumatologist. Psoriatic arthritis: prescribed by or in consultation with a rheumatologist or dermatologist. Ulcerative colitis: prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION
Initial: 6 months. Renewal: 1 year.

OTHER CRITERIA
Initial: Rheumatoid arthritis: previous trial of or contraindication to both of the following preferred agents: Humira, Enbrel. Psoriatic arthritis: previous trial of or contraindication to any two of the following preferred agents: Humira, Stelara, Cosentyx, Enbrel. Ulcerative colitis: previous trial of or contraindication to Humira.

XERMELO

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
XERMELO

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology, Endocrinology, or Gastroenterology.

COVERAGE DURATION
Initial: 3 months. Continuation: 1 year

OTHER CRITERIA
For initial therapy: Individual is using in combination with somatostatin analog (SSA) therapy (such as but not limited to, lanreotide (Somatuline Depot), octreotide (Sandostatin)) AND individual has had an inadequate response on a stable dose of SSA monotherapy for at least 3 months. For continuation therapy: Individual has previously met the initiation criteria AND clinically significant improvements are confirmed after 12 weeks of treatment with Xermelo (telotristat ethyl) when added to SSA therapy.

XIFAXAN

COVERED USES
All Medically-Accepted Indications

MEDICATION(S)
XIFAXAN

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Restricted to Gastroenterology for treatment of Crohn's Disease

COVERAGE DURATION
3 days for traveler's diarrhea, 1 year for hepatic encephalopathy, or 3 months for IBS.

OTHER CRITERIA
For hepatic encephalopathy must first try lactulose or metronidazole or provide medical justification.

XOLAIR

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
XOLAIR

EXCLUSION CRITERIA
Non-allergic asthma.

REQUIRED MEDICAL INFORMATION
For IgE medicated allergic asthma: Perennial aeroallergen IgE levels, documented trial and failure of at least one inhaled corticosteroid (Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone, or Mometasone). For chronic idiopathic urticaria: Medical justification that an H1 antihistamine has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pulmonology, Allergy, Dermatology, or Immunology

COVERAGE DURATION
3 months

OTHER CRITERIA
Maximum dose of 375mg every 2 weeks.

ZEPATIER

COVERED USES
All FDA-Approved Indications

MEDICATION(S)
ZEPATIER

EXCLUSION CRITERIA
Moderate or severe liver impairment (Child-Pugh B or C)

REQUIRED MEDICAL INFORMATION
HCV RNA level within past 6 months. For genotype 1A: testing for NS5A resistance-associated polymorphisms. Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (hepatologist), or a specially trained group such as ECHO (extension for community healthcare outcomes) model

COVERAGE DURATION
Duration will be applied consistent with current AASLD/IDSA guidance.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance. Trial with preferred formulary alternative ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, or Mavyret where that regimen is listed as an acceptable regimen for the specific genotype per AASLD/IDSA guidance. No approval for requests where provider attests that patient has life expectancy less than 12 months due to non-liver related comorbid conditions (per AASLD/IDSA treatment guideline recommendation). Patient is not concurrently taking any of the following: phenytoin, carbamazepine, rifampin, efavirenz, atazanavir, darunavir, lopinavir, saquinavir, tipranavir, cyclosporine, nafcillin, ketoconazole, modafinil, bosentan, etravirine, elvitegravir/cobicistat/emtricitabine/tenofovir, atorvastatin at doses above 20mg per day or rosuvastatin at doses greater than 10mg per day.