OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

2019 Prior Authorization Criteria

(Requirements for approval for certain drugs)

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

Criterios de autorización previa para 2019

(Requisitos para la aprobación de ciertos medicamentos)

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

Các Tiêu Chuẩn Về Sự Chấp Thuận Trước Trong Năm 2019

(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.

شرایط دریافت مجوز قبلی برای سال 2019

(شرایط تأیید داروهای خاص)

لطفاً مطالعه کنید: این نوشتار حاوی اطلاعات مهمی درباره داروهائی است که در این برنامه تحت پوشش داریم.

2019 사전 승인 기준

(특정 의약품의 승인 조건)

읽어 주십시오: 본 문서는 본 플랜에서 보장하는 의약품 정보를 포함하고 있습니다.

خطة OneCare Connect Cal MediConnect (Medicare-Medicaid Plan)

معايير الحصول على تصريح مسبق لعام 2019

(متطلبات الموافقة على أدوية معينة)

يرجى القراءة: هذه الوثيقة تتضمن معلومات بخصوص الأدوية التي نقوم بتغطيتها في هذه الخطة.

OneCare Connect Cal MediConnect 計劃 (Medicare-Medicaid 計劃)

2019 年預先授權標準

（特定藥物的批准要求）

請閱讀：本文件包含關於本計劃所承保藥物的資訊。

ABSSSI 2 WEEK

MEDICATION(S)
DALVANCE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
LABS WITH CULTURE AND SENSITIVITY INFORMATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 2-WEEK INCREMENTS.

OTHER CRITERIA
MEDICAL JUSTIFICATION SPECIFYING THAT VANCOMYCIN HAS BEEN TRIED AND FAILED, IS CONTRAINDICATED, OR WOULD NOT BE MEDICALLY APPROPRIATE FOR THE PATIENT.

ABSSSI 6 DAY

MEDICATION(S)
SIVEXTRO

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
LABS WITH CULTURE AND SENSITIVITY INFORMATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 6-DAY INCREMENTS.

OTHER CRITERIA
N/A

ACYCLOVIR TOPICAL

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

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
HERPES ZOSTER.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 1-MONTH INCREMENTS.

OTHER CRITERIA
N/A

ADHD

MEDICATION(S)
DAYTRANA, DEXTROAMPHETAMINE 10 MG TAB, DEXTROAMPHETAMINE 5 MG TAB, DEXTROAMPHETAMINE SULFATE ER, DEXTROAMPHETAMINE-AMPHET ER, DEXTROAMPHETAMINE-AMPHETAMINE, METHYLPHENIDATE ER, 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

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
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.

AIMOVIG

MEDICATION(S)
AIMOVIG AUTOINJECTOR, AIMOVIG AUTOINJECTOR (2 PACK)

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology

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

OTHER CRITERIA
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).

ALLERGY

MEDICATION(S)
CHLORPHENIRAMINE MALEATE 4 MG TABLET*, DIMENHYDRINATE 50 MG TABLET*, DIPHENHYDRAMINE HCL 25 MG CAPSULE*, PROMETHAZINE HCL/CODEINE 6.25-10/5 SYRUP*, PROMETHAZINE/DEXTROMETHORPHAN 6.25-15/5 SYRUP*, PROMETHAZINE/PHENYLEPH/CODEINE 6.25-5-10 SYRUP*, TRIPROLIDINE/PSEUDOEPHEDRINE 2.5MG-60MG TABLET*

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
UNDER AGE 65 ONLY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

ALPHA-ADRENERGIC AGONISTS

MEDICATION(S)
MIDODRINE HCL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
BLOOD PRESSURE DOCUMENTED WITHIN THE PAST MONTH.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
MAXIMUM DOSE OF 10MG TID.

ALUNBRIG

MEDICATION(S)
ALUNBRIG

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
Approved in 1-year increments.

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

AMIKACIN

MEDICATION(S)
ARIKAYCE

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Labs with culture and sensitivity information.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infectious Disease, Hospitalists

COVERAGE DURATION
Approved in 6-month increments.

OTHER CRITERIA
Documented failure with a minimum of 6 consecutive months of a multidrug background regimen therapy.

ANADROL

MEDICATION(S)
ANADROL-50

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
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
APPROVED IN 6-MONTH INCREMENTS.

OTHER CRITERIA
ANEMIA: 1 TO 5 MG/KG DAILY.

ANDROGENS

MEDICATION(S)
ANDRODERM, ANDROGEL 1.62% GEL PUMP, ANDROGEL 1.62%(1.25G) GEL PCKT, ANDROGEL 1.62%(2.5G) GEL PCKT, METHYLTESTOSTERONE, TESTOSTERONE 1.62% (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

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

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 for muscle building purposes.

REQUIRED MEDICAL INFORMATION
For members 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 received why generic testosterone products cannot be used.

ANTIBACTERIALS, OTHER BROAD-SPECTRUM

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

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
LABS WITH CULTURE AND SENSITIVITY INFORMATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 6-WEEK INCREMENTS.

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

MEDICATION(S)
AJOVY, EMGALITY PEN, EMGALITY SYRINGE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For migraine diagnosis: 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 episodic cluster headache: Patient must have an inadequate response, contraindication, or intolerance to sumatriptan injectable by evidence of a history of pharmacy claims or a physician's statement.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurologist or pain specialist

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

OTHER CRITERIA
N/A

ANTIFUNGAL

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 3-month increments.

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

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

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 3-MONTH INCREMENTS.

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

MEDICATION(S)

ABIRATERONE ACETATE, ABRAXANE, AFINITOR 10 MG TABLET, AFINITOR 2.5 MG TABLET, AFINITOR 5 MG TABLET, AFINITOR DISPERZ, ALECENSA, ALIMTA, BALVERSA, BOSULIF, BRAFTOVI 75 MG CAPSULE, CABOMETYX, CALQUENCE, COMETRIQ, COPIKTRA, COTELLIC, DARZALEX, DAURISMO, DOCETAXEL 160 MG/8 ML VIAL, DOCETAXEL 20 MG/2 ML VIAL, DOCETAXEL 20 MG/ML VIAL, DOCETAXEL 200 MG/10 ML VIAL, DOCETAXEL 80 MG/4 ML VIAL, DOCETAXEL 80 MG/8 ML VIAL, DOXORUBICIN HCL LIPOSOME, ERLEADA, ERLOTINIB HCL, FARYDAK, FIRMAGON, FLUOROURACIL 0.5% CREAM, FLUOROURACIL 2% TOPICAL SOLN, FLUOROURACIL 5% TOPICAL SOLN, FULVESTRANT, GEMCITABINE HCL 1 GRAM VIAL, GILOTRIF, GLEOSTINE 10 MG CAPSULE, GLEOSTINE 100 MG CAPSULE, GLEOSTINE 40 MG CAPSULE, HERCEPTIN, HERCEPTIN HYLECTA, IBRANCE, ICLUSIG, IDHIFA, IMATINIB MESYLATE, IMBRUVICA, INLYTA, INREBIC, IRESSA, JAKAFI, KANJINTI, KEYTRUDA 100 MG/4 ML VIAL, KISQALI, KISQALI FEMARA CO-PACK, LENVIMA, LEUCOVORIN CAL 100 MG/10 ML VL, LEUCOVORIN CAL 500 MG/50 ML VL, LONSURF, LORBRENA, LYNPARZA 100 MG TABLET, LYNPARZA 150 MG TABLET, MEKINIST, MEKTOVI, NERLYNX, NEXAVAR, NINLARO, NUBEQA, ODOMZO, OGIVRI, OXALIPLATIN, PIQRAY, REVLIMID, ROZLYTREK, RUBRACA, SPRYCEL, STIVARGA, SUTENT, SYNRIBO, TAFINLAR, TAGRISSO, TALZENNA, TARCEVA, TASIGNA, TECENTRIQ, THALOMID, TIBSOVO, TYKERB, VALCHLOR, VELCADE, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VOTRIENT, XALKORI, XOSPATA, XPOVIO, XTANDI, YONSA, ZEJULA, ZELBORAF, ZYDELIG, ZYKADIA, ZYTIGA

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

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
N/A

APTIOM

MEDICATION(S)
APTIOM

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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 RECEIVED WHY FORMULARY ALTERNATIVES CARBAMAZEPINE OR OXCARBAZEPINE CANNOT BE USED.

ATYPICALS

MEDICATION(S)
FANAPT, LATUDA, REXULTI, SAPHRIS

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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
Approved in 1-year increments.

OTHER CRITERIA
N/A

AURYXIA

MEDICATION(S)
AURYXIA

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

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
Approved in 3-month increments.

OTHER CRITERIA
Justification why calcium acetate cannot be used.

AVASTIN

MEDICATION(S)
AVASTIN, MVASI

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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

MEDICATION(S)
AVYCAZ, VABOMERE, ZERBAXA

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

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
Approved in 2-week increments.

OTHER CRITERIA
N/A

AZITHROMYCIN 600 MG ORAL TABLET

MEDICATION(S)
AZITHROMYCIN 600 MG TABLET

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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 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

MEDICATION(S)
BAXDELA

COVERED USES
All FDA-approved indications not otherwise excluded from part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Labs with culture and sensitivity information.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Infectious Disease

COVERAGE DURATION
Approved in 14-day increments.

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

MEDICATION(S)
BENZNIDAZOLE

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

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
Approved in 3-month increments.

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

BEVYXXA

MEDICATION(S)
BEVYXXA

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of the following items: (1) member is post hospital discharge for an acute medical illness and Bevyxxa was started in the hospital, (2) patient has restricted mobility, and (3) patient has ONE of the following risk factors for VTE (a) age is 75 years or greater (b) age is 60-74 years is D-dimer level was 2 times or greater than the upper limit of normal or (c) age is 40-59 years of age AND D-dimer level is 2 times or greater than the upper limit of normal and there is a history of either VTE or cancer.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved for up to a total treatment duration of 42 days.

OTHER CRITERIA
N/A

BRONCHODILATORS, SYMPATHOMIMETIC

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

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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 WHY A BETA AGONIST INHALER CANNOT BE USED.

CABLIVI

MEDICATION(S)
CABLIVI

COVERED USES
All FDA-approved indications not otherwise excluded from part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: (1) Diagnosis of aTTP as confirmed by labs indicating microangiopathic hemolytic anemia (MAHA) with hemoglobin of less than 10 gm/dL and severe thrombocytopenia with platelet count of less than 30,000/microL drawn within the past 14 days, (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
Approved in 3-month increments.

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

CALCIFEDIOL

MEDICATION(S)
RAYALDEE

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

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 for why formulary alternative calcitriol or paricalcitol cannot be used.

CANNABIDIOL

MEDICATION(S)
EPIDIOLEX

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

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
Approved in 3-month increments.

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

CARBAGLU

MEDICATION(S)
CARBAGLU

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
N/A

CAROSPIR

MEDICATION(S)
CAROSPIR

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

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 specifying why spironolactone oral tablet cannot be used.

CENEGERMIN

MEDICATION(S)
OXERVATE

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New: Medical chart notes documenting the diagnosis of covered use. COC: medical chart notes documenting a positive response to therapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Ophthalmologist

COVERAGE DURATION
Approved in 8-week increments.

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

CHOLBAM

MEDICATION(S)
CHOLBAM

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
ALT, AST, GGT, Alk Phos, Bilirubin and INR within last 30 days.

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 increments.

OTHER CRITERIA
For continuation, must meet 2 of the following: ALT or AST less than 50 U/L or baseline levels reduced by 80%, total bilirubin less than or equal to 1 mg/dL or no evidence of cholestasis on liver biopsy) OR must meet 1 of the previous laboratory criteria AND body weight increased by 10% or body weight is stable at greater than 50th percentile.

CIMZIA

MEDICATION(S)
CIMZIA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Rheumatology, Dermatology, Gastroenterology

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
For RA: Medical justification specifying that one traditional DMARD (Azathioprine, Leflunomide, Hydroxychloroquine, Methotrexate, Sulfasalazine) has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

COLD SORE

MEDICATION(S)
DOCOSANOL 10% CREAM*

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR THE TREATMENT OF COLD SORES ON THE FACE OR LIPS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

CORLANOR

MEDICATION(S)
CORLANOR

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CARDIOLOGY

COVERAGE DURATION
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
N/A

CORTICOTROPIN

MEDICATION(S)
ACTHAR

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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

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

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
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

MEDICATION(S)
MYTESI

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
INFECTIOUS DIARRHEA

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 6-MONTH INCREMENTS.

OTHER CRITERIA
MEDICAL JUSTIFICATION SPECIFYING WHY A FORMULARY ALTERNATIVES LOPERAMIDE OR DIPHENOXYLATE-ATROPINE CANNOT BE USED.

CSF

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

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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
Approved in 3-month increments.

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.

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 0.0375 MG/DAY PATCH, ESTRADIOL 0.05 MG PATCH, ESTRADIOL 0.06 MG/DAY PATCH, ESTRADIOL 0.075 MG PATCH, ESTRADIOL 0.075 MG/DAY PATCH, ESTRADIOL 0.1 MG PATCH, ESTRADIOL 0.5 MG TABLET, ESTRADIOL 1 MG TABLET, ESTRADIOL 2 MG TABLET, ESTRADIOL TDS 0.025 MG/DAY, ESTRADIOL TDS 0.0375 MG/DAY, ESTRADIOL TDS 0.05 MG/DAY, ESTRADIOL TDS 0.06 MG/DAY, ESTRADIOL TDS 0.075 MG/DAY, ESTRADIOL TDS 0.1 MG/DAY, ESTRADIOL-NORETHINDRONE ACETAT, FLURAZEPAM HCL, FYAVOLV, GLYBURIDE, GLYBURIDE-METFORMIN HCL, 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, 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, MIMVEY LO, 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 SUPPOSITORY, PROMETHAZINE 50 MG TABLET, PROMETHAZINE 6.25 MG/5 ML SOLN, PROMETHAZINE 6.25 MG/5 ML SYRP, PROTRIPTYLINE HCL, SCOPOLAMINE, THIORIDAZINE HCL, TRANSDERM-SCOP, TRIHEXYPHENIDYL HCL, TRIMETHOBENZAMIDE HCL

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

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 ABX

MEDICATION(S)
NITROFURANTOIN, NITROFURANTOIN MONO-MACRO

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

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 all formulary alternatives without age restrictions (ciprofloxacin, TMP/SMX) are contraindicated, or would not be medically appropriate for the patient.

DAE SLEEP DRUGS

MEDICATION(S)
ESZOPICLONE, TEMAZEPAM 15 MG CAPSULE, TEMAZEPAM 30 MG CAPSULE, TRIAZOLAM, ZALEPLON, ZOLPIDEM TARTRATE 10 MG TABLET, ZOLPIDEM TARTRATE 5 MG TABLET

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

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 (Rozerem, Trazodone, Lorazepam, Oxazepam) have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

DEMECLOCYCLINE

MEDICATION(S)
DEMECLOCYCLINE HCL

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 3-MONTH INCREMENTS.

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 FLUID-RESTRICTION AND A FORMULARY ALTERNATIVE SUCH AS FUROSEMIDE CANNOT BE USED.

DERMATITIS

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

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 3-MONTH INCREMENTS.

OTHER CRITERIA
MEDICAL JUSTIFICATION AS TO WHY TOPICAL CORTICOSTEROIDS CANNOT BE USED.

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

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

EXCLUSION CRITERIA
Cosmetic use.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatology, Allergy, Pediatrician

COVERAGE DURATION
Approved in 3-month increments.

OTHER CRITERIA
N/A

DIABETES

MEDICATION(S)
BLOOD SUGAR DIAGNOSTIC STRIP*, DEXTROSE 4 G TAB CHEW*, LANCETS*, URINE GLUCOSE-ACET TEST STRIP*

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PATIENT MUST BE RECEIVING DIABETES MEDICATIONS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

DIAGNOSTIC USE

MEDICATION(S)
ATROPINE 1% EYE DROPS

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
DIAGNOSTIC USE

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
N/A

DIALYSIS-PTH

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

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 3-MONTH INCREMENTS.

OTHER CRITERIA
JUSTIFICATION WHY CALCIUM ACETATE CANNOT BE USED.

DICLOFENAC

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

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

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
Pain Management Specialist (i.e. Anesthesiologist, Neurologist, Physical Medicine and Rehabilitation) or Rheumatologist

COVERAGE DURATION
Approved in 6-month increments.

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.

DOPTELET

MEDICATION(S)
DOPTELET

COVERED USES
All medically accepted indications not otherwise excluded from part D.

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
Approved in 3-month increments.

OTHER CRITERIA
For Thrombocytopenia associated with Chronic Liver Disease: Chart notes are provided confirming member has a planned medical or dental procedure within 10-13 days after starting Doptelet. For chronic ITP: medical justification that Promacta has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

DRY EYE

MEDICATION(S)
RESTASIS, RESTASIS MULTIDOSE, XIIDRA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of test results confirming the diagnosis, such as: tear break-up time [TBUT], ocular surface disease index [OSDI], Schirmer's test, osmolarity test, corneal/conjunctival staining, tear stability test, or meibomian gland grading.

AGE RESTRICTION
N/A

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

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
N/A

DUPIXENT

MEDICATION(S)
DUPIXENT

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
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: Member's condition is stable or showing clinical improvement.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Allergy, Immunology, Dermatology

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

OTHER CRITERIA
Member must have tried and failed, or have a contraindication or intolerance to a generic formulary topical corticosteroid and generic topical tacrolimus. For renewal, the medication quantity is limited to 2 syringes per 28 days.

EGRIFTA

MEDICATION(S)
EGRIFTA

COVERED USES
All FDA-approved indications not otherwise excluded from part D.

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.

EMFLAZA

MEDICATION(S)
EMFLAZA

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

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: Approved in 1-year increments.

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).

ENTRESTO

MEDICATION(S)
ENTRESTO

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

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
Approved in 1-year increments.

OTHER CRITERIA
N/A

ENZYME REPLACEMENTS

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

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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

MEDICATION(S)
EPCLUSA, SOFOSBUVIR-VELPATASVIR

COVERED USES
All FDA approved indications not otherwise excluded from Part D. Criteria will be applied consistent with current AASLD-IDSA guidance and additional consideration for coverage consistent with FDA labeling.

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

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

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 3-MONTH INCREMENTS.

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).

ESKETAMINE

MEDICATION(S)
SPRAVATO

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

EXCLUSION CRITERIA
Aneurysmal vascular disease, arteriovenous malformation, history of intracerebral hemorrhage or history of suicidal ideation/intent.

REQUIRED MEDICAL INFORMATION
(1) Documentation of failure of at least two antidepressants at an optimized dose for at least 8 weeks of treatment for each agent with adherence confirmed by prescription claims data.
(2) Documentation that Spravato will be used in conjunction with an oral antidepressant
(3) Documentation that the healthcare provider is certified in the SPRAVATO REMS program

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Psychiatrist

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
Statement from the prescriber acknowledging medication benefits outweigh potential risks.

EXJADE

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

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

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
Approved in 3-month increments.

OTHER CRITERIA
Dose cannot exceed 99mg/kg/day for Ferriprox or 40mg/kg/day for Exjade and deferasirox (generic for Exjade) products. For transfusional iron overload: serum ferritin must consistently be greater than 1000 mcg/L.

EYE DROPS

MEDICATION(S)
CARBOXYMETHYLCELLULOSE SODIUM 0.5 % DROPERETTE*, CARBOXYMETHYLCELLULOSE SODIUM 0.5 % OPHTHALMIC DROPS*, CARBOXYMETHYLCELLULOSE SODIUM 1 % OPHTHALMIC DROPPER GEL*, MINERAL OIL/PETROLATUM,WHITE 42.5-57.3% OPHTHALMIC OINT. (G)*, POLYVINYL ALCOHOL 1.4 % DROPS*, POLYVINYL ALCOHOL 1.4 % OPHTHALMIC DROPS*, PROPYLENE GLYCOL/PEG 400/PF 0.3 %-0.4% DROPERETTE*, SODIUM CHLORIDE 5 % DROPS*

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PRESCRIBED BY OPHTHALMOLOGIST OR OPTOMETRIST.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

FASENRA

MEDICATION(S)
FASENRA

COVERED USES
All FDA-approved indications not otherwise excluded from part D.

EXCLUSION CRITERIA
Current respiratory disease other than asthma. On dual therapy with another monoclonal antibody for the treatment of asthma.

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 increments.

OTHER CRITERIA
N/A

FENOFIBRATE

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

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

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 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.

FIORICET

MEDICATION(S)
BUTALBITAL-ACETAMINOPHEN-CAFFE

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 3-month increments.

OTHER CRITERIA
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. For enrollees age 65 and over, the prescriber must acknowledge that medication benefits outweigh potential risks.

FOLIC ACID

MEDICATION(S)
FOLIC ACID 0.4 MG TABLET *, FOLIC ACID 0.8 MG TABLET*, FOLIC ACID 1 MG TABLET*

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
RESTRICTED TO FEMALES, AGES 14 THROUGH 45 YEARS. OR PATIENTS RECEIVING A FOLATE-DEPLETING MEDICATION. OR PATIENTS WITH FOLIC ACID DEFICIENCY ANEMIA (MEGALOBLASTIC ANEMIA) AND LABORATORY RESULTS WITHIN THE LAST 90 DAYS DEMONSTRATING SERUM FOLATE LEVEL LESS THAN 3 NG/ML OR RBC FOLATE LEVEL LESS THAN 140 NG/ML. OR PATIENTS WITH A DIAGNOSIS OF CANCER, HIV/AIDS, END-STAGE RENAL DISEASE RECEIVING DIALYSIS, HOMOCYSTEINEMIA, OR TRANSPLANT.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

FORTEO

MEDICATION(S)
FORTEO

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

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
Approved in 1-year increments.

OTHER CRITERIA
Medical justification is required for cumulative use of parathyroid hormone analogs (e.g., FORTEO and TYMLOS) exceeding 24 months during a patient's lifetime. Medical justification if the patient is not receiving calcium or has not tried and failed bisphosphonates.

FOSAPREPITANT

MEDICATION(S)
FOSAPREPITANT DIMEGLUMINE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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

MEDICATION(S)
GALAFOLD

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

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: Approved in 1-year increments.

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

GNRH

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

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
INFERTILITY TREATMENT.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
N/A

GROWTH HORMONE

MEDICATION(S)
GENOTROPIN, HUMATROPE, INCRELEX, NORDITROPIN FLEXPRO, NORDITROPIN NORDIFLEX, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN, SAIZEN-SAIZENPREP, ZOMACTON

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
FOR INITIATION OF TREATMENT OF GROWTH HORMONE (GH) DEFICIENCY IN ADULTS, GH DEFICIENCY MUST BE DEMONSTRATED WITH AT LEAST ONE OF THE FOLLOWING: (1) ARGININE-L-DOPA STIMULATION TEST WITH SERUM GH LESS THAN 1.5NG/ML, (2) INSULIN TOLERANCE TEST (ITT) WITH SERUM GH LESS THAN 5.1NG/ML, OR (3) IGF-I LEVEL LESS THAN THE AGE-SPECIFIC LOWER LIMIT. COVERAGE IS EXCLUDED FOR ADULTS WITHOUT DEMONSTRATED GH DEFICIENCY.

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
APPROVED IN 3-MONTH INCREMENTS.

OTHER CRITERIA
MAXIMUM RECOMMENDED DAILY DOSE.

GROWTH HORMONE ANTAGONISTS

MEDICATION(S)
SOMAVERT

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
MAXIMUM RECOMMENDED DAILY DOSE.

HAE

MEDICATION(S)
HAEGARDA

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

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
Approved in 6- month increments.

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

MEDICATION(S)
HARVONI, LEDIPASVIR-SOFOSBUVIR

COVERED USES
All FDA approved indications not otherwise excluded from Part D. Criteria will be applied consistent with current AASLD-IDSA guidance and additional consideration for coverage consistent with FDA labeling.

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. Trial with preferred formulary alternative Epclusa or Zepatier 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: carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, rosuvastatin, sofosbuvir (as a single agent), Stribild (elvitagravir/cobicistat/emtricitabine /tenofovir), or tipranavir/ritonavir.

HEP-B

MEDICATION(S)
EPIVIR HBV 25 MG/5 ML SOLN, LAMIVUDINE 100 MG TABLET, LAMIVUDINE HBV

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HBeAG antigen test within 3 months.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

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

OTHER CRITERIA
N/A

HEPATITIS B

MEDICATION(S)
ADEFOVIR DIPIVOXIL, BARACLUDE 0.05 MG/ML SOLUTION, ENTECAVIR

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
HBV DNA UNDETECTABLE, CARRIER STATE.

REQUIRED MEDICAL INFORMATION
LFTS, HBEAG, HBV DNA, ANTI-HBE (HBEAB), HBSAG DRAWN WITHIN THE PAST 6 MONTHS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
IN ONE YEAR INCREMENTS DEPENDING UPON RESPONSE TO THERAPY.

OTHER CRITERIA
COMBINATION THERAPY MAY BE APPROVED WITH DOCUMENTED RESISTANCE.

HEPATITIS C

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

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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

HIGH POTENCY ER OPIOID

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Oncology, Palliative Care, Pain Specialist or Consultation

COVERAGE DURATION
Approved in 1-year increments.

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

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Oncology, Palliative Care, Pain Specialist or Consultation

COVERAGE DURATION
Approved in 3-month increments.

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

MEDICATION(S)
JUXTAPID

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 3-MONTH INCREMENTS.

OTHER CRITERIA
MUST CURRENTLY TAKE A STATIN (UNLESS CONTRAINDICATED) OR PROVIDE A MEDICAL JUSTIFICATION AS TO WHY ITS USAGE WOULD NOT BE MEDICALLY APPROPRIATE FOR THE PATIENT.

HYPERLIPIDEMIA

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

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 1-YEAR INCREMENTS.

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

MEDICATION(S)
AMITIZA, MOVANTIK, TRULANCE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 3-MONTH INCREMENTS.

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.

INGREZZA

MEDICATION(S)
INGREZZA, INGREZZA INITIATION PACK

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

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
Approved in 6-month increments.

OTHER CRITERIA
N/A

INTRAROSA

MEDICATION(S)
INTRAROSA

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

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.

IVIG

MEDICATION(S)
FLEBOGAMMA DIF 10% VIAL, GAMMAGARD LIQUID, GAMMAGARD S-D, GAMMAKED 1 GRAM/10 ML VIAL, GAMMAPLEX, GAMUNEX-C 1 GRAM/10 ML VIAL, OCTAGAM, PANZYGA, PRIVIGEN, XEMBIFY

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Indication to determine B or D coverage.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 3-month increments.

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

JADENU

MEDICATION(S)
JADENU

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 6-MONTH INCREMENTS.

OTHER CRITERIA
MEDICAL JUSTIFICATION AS TO WHY A FORMULARY ALTERNATIVE 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

MEDICATION(S)
JYNARQUE

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
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.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Nephrologist

COVERAGE DURATION
Approved in 3-month increments.

OTHER CRITERIA
N/A

KALYDECO

MEDICATION(S)
KALYDECO

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
N/A

KORLYM

MEDICATION(S)
KORLYM

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
PREGNANCY

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
N/A

KRINTAFEL

MEDICATION(S)
KRINTAFEL

COVERED USES
All FDA-approved indications not otherwise excluded from part D.

EXCLUSION CRITERIA
Patients with G6PD deficiency or unknown G6PD status or lactating women when infant has G6PD deficiency or unknown G6PD status

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
16 years of age and older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved as a single dose.

OTHER CRITERIA
Appropriate for the region of travel

KRISTALOSE

MEDICATION(S)
KRISTALOSE, LACTULOSE 10 GM PACKET

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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
Approved in 3-month increments.

OTHER CRITERIA
N/A

LEPTIN

MEDICATION(S)
MYALEPT

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 6-MONTH INCREMENTS.

OTHER CRITERIA
N/A

LMWH

MEDICATION(S)
FONDAPARINUX SODIUM

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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

MEDICATION(S)
LUCEMYRA

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

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.

MAVENCLAD

MEDICATION(S)
MAVENCLAD

COVERED USES
All medically accepted indications not otherwise excluded from part d.

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
Approved in 3-month increments.

OTHER CRITERIA
N/A

MAVYRET

MEDICATION(S)
MAVYRET

COVERED USES
All FDA approved indications not otherwise excluded from Part D. Criteria will be applied consistent with current AASLD-IDSA guidance and additional consideration for coverage consistent with FDA labeling.

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

MEDICATION(S)
MAYZENT 0.25 MG TABLET, MAYZENT 2 MG TABLET

COVERED USES
All medically accepted indications not otherwise excluded from part d.

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

REQUIRED MEDICAL INFORMATION
COC: Documentation that member has demonstrated a response to therapy. 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. Results of CYP2C9 genotype testing.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Neurology, Rheumatology, Gastroenterology

COVERAGE DURATION
Approved in 1-year increments.

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

MEDICALLY ACCEPTED

MEDICATION(S)
ABSORICA, 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, ENBREL, ENBREL MINI, ENBREL SURECLICK, GILENYA 0.5 MG CAPSULE, HUMIRA, HUMIRA PEDIATRIC CROHN'S, HUMIRA PEN, HUMIRA PEN CROHN'S-UC-HS, HUMIRA PEN PSOR-UVEITS-ADOL HS, HUMIRA(CF), HUMIRA(CF) PEDIATRIC CROHN'S, HUMIRA(CF) PEN 40 MG/0.4 ML, HUMIRA(CF) PEN CROHN'S-UC-HS, HUMIRA(CF) PEN PSOR-UV-ADOL HS, ISOTRETINOIN, KEDRAB, KINERET, LIDOCAINE 5% PATCH, MYORISAN, ORENCIA 125 MG/ML SYRINGE, ORENCIA 250 MG VIAL, ORENCIA CLICKJECT, POMALYST, PROLIA, QUININE SULFATE, RELISTOR, SIMPONI, TETRABENAZINE, TRIMIPRAMINE MALEATE, VARIZIG 125 UNIT/1.2 ML VIAL, XGEVA, ZENATANE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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
N/A

MEGESTROL

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

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

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
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
Maximum recommended daily dose.

MEPERIDINE

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

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 3-MONTH INCREMENTS.

OTHER CRITERIA
MEDICAL JUSTIFICATION AS TO WHY TWO FORMULARY ALTERNATIVES CANNOT BE USED IN PATIENTS WITH DECREASED RENAL FUNCTION OR OVER AGE 65.

METHADONE

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

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

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 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

MEDICATION(S)
AMPYRA, AUBAGIO, AVONEX PREFILLED SYR 30 MCG, AVONEX PREFILLED SYR 30 MCG KT, AVONEX PEN, BETASERON, DALFAMPRIDINE ER, GLATIRAMER ACETATE, GLATOPA 20 MG/ML SYRINGE, REBIF, REBIF REBIDOSE, TECFIDERA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGY, RHEUMATOLOGY, GASTROENTEROLOGY

COVERAGE DURATION
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
N/A

MULTAQ

MEDICATION(S)
MULTAQ

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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 SPECIFYING WHY ONE FORMULARY ALTERNATIVE CANNOT BE USED (AMIODARONE).

MYCITE

MEDICATION(S)
ABILIFY MYCITE

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(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. (4) Evidence that patient and provider have access to technology that is sufficient for tracking the usage of Abilify Mycite.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
N/A

NARCOLEPSY

MEDICATION(S)
MODAFINIL, XYREM

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
RESULTS OF A SLEEP STUDY SUPPORTING THE DIAGNOSIS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 1-YEAR INCREMENTS.

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

MEDICATION(S)
NATPARA

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

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
Approved in 1-year increments.

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.

NEUMEGA

MEDICATION(S)
PROMACTA

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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
Approved in 6-month increments.

OTHER CRITERIA
N/A

NIACIN

MEDICATION(S)
NIACIN ER

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

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.

NOCTIVA

MEDICATION(S)
NOCTIVA

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

EXCLUSION CRITERIA
Patient is currently taking any of the following agents: loop diuretics, inhaled or systemic glucocorticoids or has a diagnosis of congestive heart failure (Class II to IV), uncontrolled hypertension, SIADH, primary nocturnal enuresis or renal impairment.

REQUIRED MEDICAL INFORMATION
All of the following must be met: (1) Diagnosis of nocturnal polyuria, (2) 24-hour urine collection noting the presence of greater than one-third of 24-hour urine production occurring at night, (3) Normal serum sodium level based on laboratory reference range within the past 60 days, (4) Medical chart notes or statement from treating physician indicating that the patient awakens at least 2 times per night to void.

AGE RESTRICTION
Patient is greater than or equal to 50 years old

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 12-week increments.

OTHER CRITERIA
N/A

NORTHERA

MEDICATION(S)
NORTHERA

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGY, CARDIOLOGY

COVERAGE DURATION
APPROVED IN 2-WEEK INCREMENTS.

OTHER CRITERIA
N/A

NUCALA

MEDICATION(S)
NUCALA

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

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

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
N/A

OCALIVA

MEDICATION(S)
OCALIVA

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

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
Approved in 1-year increments.

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).

OPHTHALMIC QUINOLONE

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 1-month increments.

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 VANCO

MEDICATION(S)
VANCOMYCIN HCL 125 MG CAPSULE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
LABS WITH CULTURE AND SENSITIVITY INFORMATION.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 2-WEEK INCREMENTS.

OTHER CRITERIA
MEDICAL JUSTIFICATION THAT METRONIDAZOLE HAS BEEN TRIED AND FAILED, IS CONTRAINDICATED, OR WOULD NOT BE MEDICALLY APPROPRIATE FOR THE PATIENT.

OXYCONTIN

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Oncology, Palliative Care, Pain Specialist or Consultation

COVERAGE DURATION
Approved in 3-month increments.

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

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

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
CARDIOLOGY, PULMONOLOGY, OR RHEUMATOLOGY

COVERAGE DURATION
APPROVED IN 3-MONTH INCREMENTS.

OTHER CRITERIA
N/A

PALYNZIQ

MEDICATION(S)
PALYNZIQ

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

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
Approved in 1-year increments.

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

MEDICATION(S)
ZONTIVITY

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
MUST BE USED IN COMBINATION WITH ASPIRIN AND/OR CLOPIDOGREL

PART D

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, 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, DALIRESP, DARAPRIM, DESVENLAFAXINE ER, DESVENLAFAXINE SUCCINATE ER, 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, EURAX, FIRAZYR, FLUCYTOSINE, GARDASIL 9, GLASSIA, HETLIOZ, ICATIBANT, KEVEYIS, LINZESS, LYRICA, LYRICA CR, NAYZILAM, NEUPRO, 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, OLUMIANT 2 MG TABLET, ONFI, ORKAMBI, OTEZLA 28 DAY STARTER PACK, OTEZLA 30 MG TABLET, PHENOXYBENZAMINE HCL, PREGABALIN, PROGLYCEM, PROLASTIN C 1,000 MG VIAL, PULMOZYME, 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, SANDOSTATIN LAR DEPOT, SAVELLA, 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, VIIBRYD 10 MG TABLET, VIIBRYD 10-20 MG STARTER PACK, VIIBRYD 20 MG TABLET, VIIBRYD 40 MG TABLET, XELJANZ, XELJANZ XR, ZEMAIRA

COVERED USES

ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
N/A

PART D (4 DAY)

MEDICATION(S)
DENAVIR

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 4-DAY INCREMENTS.

OTHER CRITERIA
N/A

PART D 3 MONTH

MEDICATION(S)
AMINOSYN II 10% IV SOLUTION, AMINOSYN II 15% IV SOLUTION, AMINOSYN-PF, BOTOX, CLINIMIX 4.25%-10% SOLUTION, CLINIMIX 4.25%-25% SOLUTION, CLINIMIX 4.25%-5% SOLUTION, CLINIMIX 5%-15% SOLUTION, CLINIMIX 5%-20% SOLUTION, CLINIMIX 5%-25% 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, EVZIO, FREAMINE HBC, HEPATAMINE, INTRALIPID, NUTRILIPID, PAMIDRONATE 30 MG/10 ML VIAL, PAMIDRONATE 60 MG/10 ML VIAL, PAMIDRONATE 90 MG/10 ML VIAL, PARICALCITOL 1 MCG CAPSULE, PARICALCITOL 2 MCG CAPSULE, PARICALCITOL 4 MCG CAPSULE, PLENAMINE, PREMASOL, PROCALAMINE, PROSOL, REGRANEX, SIRTURO, TOBI PODHALER, TOBRAMYCIN 300 MG/5 ML AMPULE, TRAVASOL, TRIENTINE HCL, TROPHAMINE, ZOLEDRONIC ACID 4 MG/5 ML VIAL, ZOLEDRONIC ACID 5 MG/100 ML, ZOMETA 4 MG/100 ML INJECTION

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 3-month increments.

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, FLUOROURACIL 5 GM/100 ML BTL, FLUOROURACIL 5 GM/100 ML VIAL, FLUOROURACIL 5,000 MG/100 ML, 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, SENSIPAR, 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

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

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

EXCLUSION CRITERIA
N/A

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
Approved in 3-month increments.

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, documentation of treatment response is required.

PD

MEDICATION(S)
APOKYN, TOLCAPONE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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 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.

PEGINTERFERON ALFA 2A (PEGASYS)

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

COVERED USES
All FDA approved indications not otherwise excluded from Part D. Criteria will be applied consistent with current AASLD-IDSA guidance and additional consideration for coverage consistent with FDA labeling.

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 Epclusa or Zepatier 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).

PLEGRIDY

MEDICATION(S)
PLEGRIDY, PLEGRIDY PEN

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
NEUROLOGY, RHEUMATOLOGY, GASTROENTEROLOGY

COVERAGE DURATION
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
N/A

PRENATAL

MEDICATION(S)
OMEGA-3 FATTY ACIDS 100 MG TAB CHEW*, PRENATAL TABLET*, PYRIDOXINE HCL (VITAMIN B6) 100 MG TABLET*, PYRIDOXINE HCL (VITAMIN B6) 25 MG TABLET*, PYRIDOXINE HCL (VITAMIN B6) 50 MG TABLET*

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
RESTRICTED TO FEMALES, AGES 14 THROUGH 45 YEARS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

PREVYMIS

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology or Infectious Disease specialist

COVERAGE DURATION
Approved in 6-month increments.

OTHER CRITERIA
N/A

PROGESTINS

MEDICATION(S)
CRINONE

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
INFERTILITY TREATMENT.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
MAXIMUM RECOMMENDED DAILY DOSE.

PSORIASIS

MEDICATION(S)
ACITRETIN, STELARA, TREMFYA

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatology, Rheumatology, Gastroenterology

COVERAGE DURATION
Approved in 3-month increments.

OTHER CRITERIA
N/A

PSORIASIS IL-23

MEDICATION(S)
ILUMYA

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatology, Rheumatology

COVERAGE DURATION
Approved in 3-month increments.

OTHER CRITERIA
Medical justification that Methotrexate, Cyclosporine (oral), or Acitretin have been tried and failed, are contraindicated, or would not be medically appropriate for the patient.

QBREXZA

MEDICATION(S)
QBREXZA

COVERED USES
All FDA approved indications not otherwise excluded from part d.

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
Approved in 1-year increments.

OTHER CRITERIA
N/A

RANEXA

MEDICATION(S)
RANEXA, RANOLAZINE ER

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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 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).

REMICADE

MEDICATION(S)
ACTEMRA, ACTEMRA ACTPEN, INFLECTRA, KEVZARA 150 MG/1.14 ML SYRINGE, KEVZARA 200 MG/1.14 ML SYRINGE, REMICADE, RENFLEXIS

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

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.

RITUXAN

MEDICATION(S)
RITUXAN

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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

MEDICATION(S)
RYDAPT

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
Approved in 1-year increments.

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

SEDATIVES/HYPNOTICS

MEDICATION(S)
RAMELTEON, ROZEREM

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 3-MONTH INCREMENTS.

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

MEDICATION(S)
SIGNIFOR

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

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
Approved in 1-year increments.

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

SILIQ

MEDICATION(S)
SILIQ

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatology, Rheumatology

COVERAGE DURATION
Approved in 3-month increments.

OTHER CRITERIA
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.

SKYRIZI

MEDICATION(S)
SKYRIZI (2 SYRINGES) KIT

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

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

MEDICATION(S)
FETZIMA, OLANZAPINE-FLUOXETINE HCL, TRINTELLIX

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

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 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

MEDICATION(S)
SOLIQUA 100-33

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

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
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

MEDICATION(S)
SOLOSEC

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

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.

SOVALDI

MEDICATION(S)
SOVALDI

COVERED USES
All FDA approved indications not otherwise excluded from Part D. Criteria will be applied consistent with current AASLD-IDSA guidance and additional consideration for coverage consistent with FDA labeling.

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 Epclusa or Zepatier 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.

SUPPLEMENT

MEDICATION(S)
ASCORBIC ACID 1000 MG TABLET*, CYANOCOBALAMIN (VITAMIN B-12) 1000 MCG TABLET*, CYANOCOBALAMIN (VITAMIN B-12) 1000MCG/ML VIAL*, HYDROXOCOBALAMIN 1000MCG/ML VIAL*, INFED 100 MG/2 ML VIAL*, RIBOFLAVIN (VITAMIN B2) 50 MG TABLET*, THIAMINE HCL 50 MG TABLET*, VENOFER 100 MG/5 ML VIAL*, VENOFER 200 MG/10 ML VIAL*, VENOFER 50 MG/2.5 ML VIAL*, VITAMIN E (DL,TOCOPHERYL ACET) 200 UNIT CAPSULE*

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
REQUIRES LABORATORY RESULTS DOCUMENTING DEFICIENCY.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

SYLATRON

MEDICATION(S)
SYLATRON

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
For treatment of Hepatitis C, medical justification is required specifying that the requested formulation and dose is medically appropriate.

SYMDEKO

MEDICATION(S)
SYMDEKO

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

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
Approved in 3-month increments.

OTHER CRITERIA
N/A

SYMLIN

MEDICATION(S)
SYMLINPEN 120, SYMLINPEN 60

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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 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

MEDICATION(S)
TAKHZYRO

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
(1) Documentation of HAE confirmed by labwork (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
Approved in 3-month increments.

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

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

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Dermatology, Rheumatology

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
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

MEDICATION(S)
TAVALISSE

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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) labwork 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: Approved in 3-month increments. COC: Approved in 6-month increments.

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

MEDICATION(S)
GATTEX, ZORBTIVE

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterology

COVERAGE DURATION
Approved in 3-month increments.

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

TEGSEDI

MEDICATION(S)
TEGSEDI

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

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
Approved in 3-month increments.

OTHER CRITERIA
N/A

TETRACYCLINE

MEDICATION(S)
TETRACYCLINE HCL

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 14-day increments.

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.

TINIDAZOLE

MEDICATION(S)
TINIDAZOLE

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 1-week increments.

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

TRANSMUCOSAL IMMEDIATE RELEASE FENTANYL

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

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

EXCLUSION CRITERIA
The drug is not indicated in the management of acute or post-operative pain. This medication must not be used in opioid non-tolerant patients. The patient must not have any of the following contraindications: patients with pain not associated with cancer OR that are opioid naive.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology, Pain Management

COVERAGE DURATION
Approved in 3-month increments.

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).

TYMLOS

MEDICATION(S)
TYMLOS

COVERED USES
All FDA-approved indications not otherwise excluded from part D.

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
Approved in 1-year increments.

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. Medical justification is required if the patient has not tried and failed bisphosphonates.

UREA SPLITTING URINARY INFECTION

MEDICATION(S)
LITHOSTAT

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
APPROVED IN 3-MONTH INCREMENTS.

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.

VEMLIDY

MEDICATION(S)
VEMLIDY

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
New Therapy: HBsAg, HBeAb, HBeAg, ALT, and HBV DNA. Continuation: HBeAg, HBsAg, HBV DNA, anti-HBc or anti-HBe, and baseline HBeAg and HBV DNA.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
(1) Member has an HBsAg is positive for greater than 6 months, and (2) Medical justification specifying that Viread has been tried and failed, is contraindicated, or would not be medically appropriate for the patient.

VIBERZI

MEDICATION(S)
VIBERZI

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

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

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Gastroenterology

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
N/A

VIEKIRA

MEDICATION(S)
VIEKIRA PAK

COVERED USES
All FDA approved indications not otherwise excluded from Part D. Criteria will be applied consistent with current AASLD-IDSA guidance and additional consideration for coverage consistent with FDA labeling.

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 Epclusa or Zepatier 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.

VITAMIN

MEDICATION(S)
NIACIN 100 MG TABLET*, NIACIN 250 MG TABLET ER*, NIACIN 50 MG TABLET*

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
REQUEST IS FOR CONTINUATION OF THERAPY. FOR NEW STARTS, MEDICAL JUSTIFICATION THAT TWO FORMULARY STATINS (ATORVASTATIN, LOVASTATIN, PRAVASTATIN, ROSUVASTATIN, OR SIMVASTATIN) HAVE BEEN TRIED AND FAILED, ARE CONTRAINDICATED, OR WOULD NOT BE MEDICALLY APPROPRIATE FOR THE PATIENT. THE FOLLOWING LABORATORY TESTS MUST BE WITHIN SAFE LIMITS: AST, ALT, URIC ACID, AND FASTING GLUCOSE OR A1C.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

VIVITROL

MEDICATION(S)
VIVITROL

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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
N/A

VOSEVI

MEDICATION(S)
VOSEVI

COVERED USES
All FDA approved indications not otherwise excluded from Part D. Criteria will be applied consistent with current AASLD-IDSA guidance and additional consideration for coverage consistent with FDA labeling.

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

MEDICATION(S)
VRAYLAR

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

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 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

MEDICATION(S)
VYNDAQEL

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Cardiologist

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
N/A

WASTING

MEDICATION(S)
OXANDROLONE, SEROSTIM

COVERED USES
ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
HEIGHT, WEIGHT, BODY MASS INDEX (BMI), BODY CELL MASS (BCM) BY BIOELECTRICAL IMPEDANCE ANALYSIS (BIA). MALE RECIPIENTS: SERUM TESTOSTERONE LEVEL WITHIN NORMAL LIMITS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 3-MONTH INCREMENTS.

OTHER CRITERIA
PATIENTS MUST HAVE CONCOMITANT ANTIRETROVIRAL THERAPY AND MEET ONE OF THE FOLLOWING CRITERIA FOR HIV-ASSOCIATED WASTING: 1) 5 PERCENT BCM LOSS WITHIN THE PRECEDING SIX MONTHS OR 2) IN MEN: BCM LESS THAN 35 PERCENT OF TOTAL BODY WEIGHT AND BMI LESS THAN 27 KG/M2 OR 3) IN WOMEN: BCM LESS THAN 23 PERCENT OF TOTAL BODY WEIGHT AND BMI LESS THAN 27 KG/M2 OR 4) BMI LESS THAN 20 KG/M2 OR 5) BMI GREATER THAN 20 KG/M2 AND LESS THAN 25 KG/M2 AND 6) 10% OR MORE UNINTENTIONAL WEIGHT LOSS WITHIN THE PRECEDING 12 MONTHS OR 7.5% UNINTENTIONAL WEIGHT LOSS WITHIN THE PRECEDING SIX MONTHS.

WEIGHT LOSS

MEDICATION(S)
ALLI 60 MG CAPSULE*, BELVIQ 10 MG TABLET*, NALTREXONE/BUPROPION 8-90 MG TABLET*, PHENTERMINE HCL 15 MG CAPSULE*, PHENTERMINE HCL 30 MG CAPSULE*

COVERED USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
BMI IS 30 KG/M2, OR 27 KG/M2 IN THE PRESENCE OF OTHER RISK FACTORS (E.G., DIABETES, HYPERTENSION) AND NO CONTRAINDICATIONS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
N/A

OTHER CRITERIA
N/A

XERMELO

MEDICATION(S)
XERMELO

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Hematology/Oncology, Endocrinology, or Gastroenterology.

COVERAGE DURATION
Approved in 3-month increments.

OTHER CRITERIA
Documentation of refractory symptoms with somatostatin-analog therapy

XIFAXAN

MEDICATION(S)
XIFAXAN

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

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
Approved for 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

MEDICATION(S)
XOLAIR

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

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
Approved in 3-month increments.

OTHER CRITERIA
Maximum dose of 375mg every 2 weeks.

ZEPATIER

MEDICATION(S)
ZEPATIER

COVERED USES
All FDA approved indications not otherwise excluded from Part D. Criteria will be applied consistent with current AASLD-IDSA guidance and additional consideration for coverage consistent with FDA labeling.

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. 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.

ZURAMPIC

MEDICATION(S)
ZURAMPIC

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Current serum uric acid levels is greater than or equal to 6mg/dL if no uric acid crystal deposits (no tophi) OR greater than or equal to 5mg/dL if there are uric acid crystal deposits (with tophi).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Approved in 1-year increments.

OTHER CRITERIA
(1) The patient must have had at least 2 gout flares in the prior 12 months as documented by chart notes. (2) Medical justification that Probenecid or Probenecid/Colchicine have been tried and failed, are contraindicated, or would not be medically appropriate for the patient. (3) The patient has been taking either allopurinol or Uloric at optimal doses for at least 3 months. (4) Clinical justification for usage if the patient has severe renal impairment, end stage renal disease, is a kidney transplant recipient, or on dialysis.