OneCare (HMO SNP)

2018 Prior Authorization Criteria

(Requirements for approval for certain drugs)

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

OneCare (HMO SNP)

Criterios de autorización previa para 2018

(Requisitos para la aprobación de ciertos medicamentos)

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

Chương Trình OneCare (HMO SNP)

Các Tiêu Chuẩn Về Sự Chấp Thuận Trước Trong Năm 2018

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

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

ABSSSI 2 WEEK

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% 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-AMPHETAMINE, METHYLPHENIDATE ER 18 MG TAB, METHYLPHENIDATE ER 20 MG TAB, METHYLPHENIDATE ER 27 MG TAB, METHYLPHENIDATE ER 36 MG TAB, METHYLPHENIDATE ER 54 MG TAB, METHYLPHENIDATE ER 72 MG TAB, METHYLPHENIDATE ER (LA), METHYLPHENIDATE 10 MG TABLET, METHYLPHENIDATE 10 MG/5 ML SOL, METHYLPHENIDATE 20 MG TABLET, METHYLPHENIDATE 5 MG TABLET, METHYLPHENIDATE 5 MG/5 ML SOLN, METHYLPHENIDATE HCL CD, METHYLPHENIDATE HCL ER (CD), METHYLPHENIDATE LA, METHYLPHENIDATE SR

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 70 MG/ML 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
NEW: THE MEMBER HAS (1) HISTORY OF FAILURE OR INTOLERANCE TO AT LEAST TWO DIFFERENT TRIPTANS (NARATRIPTAN, RIZATRIPTAN, SUMATRIPTAN, ZOLMITRIPTAN) WITH A DOCUMENTATION OF 3 OR MORE MODERATE TO SEVERE MIGRAINE ATTACKS OR HAS SIDE EFFECTS WHILE ON THESE AGENTS, OR (2) DOCUMENTATION IN CHART NOTES OF CONTRAINDICATION TO USE OF A TRIPTAN MEDICATION (SUCH AS PATIENTS WITH HISTORY, SYMPTOMS, OR SIGNS OF ISCHEMIC CARDIAC, CEREBROVASCULAR, PERIPHERAL VASCULAR SYNDROMES [E.G. ANGINA PECTORIS, MYOCARDIAL INFARCTION, SILENT MYOCARDIAL ISCHEMIA, STROKE, TRANSIENT ISCHEMIC ATTACKS, ISCHEMIC BOWEL DISEASE], CORONARY ARTERY DISEASE, RISK FACTORS FOR CORONARY ARTERY DISEASE, UNCONTROLLED HYPERTENSION, SEVERE HEPATIC IMPAIRMENT, CONCOMITANT ERGOTAMINE-CONTAINING OR ERGOT-TYPE MEDICATION WITHIN 24 HOURS OF EACH OTHER, OR CONCOMITANT 5-HT1 AGONIST). COC: DOCUMENTATION INDICATING THAT THE MEMBER HAS EXPERIENCED (1) A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH WITH THERAPY OR (2) A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION.

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)

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 PKT, TESTOSTERONE CYPIONATE, 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. 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 500 MG VIAL, ERTAPENEM, INVANZ 1 GM VIAL, LINCOMYCIN HCL, LINEZOLID, LINEZOLID-D5W, MEROPENEM, SYNERCID, 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.

ANTIBIOTIC SINGLE DOSE

MEDICATION(S)
ORBACTIV

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 AS SINGLE DOSE.

OTHER CRITERIA
N/A

ANTIBIOTICS

MEDICATION(S)
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

ANTIFUNGAL

MEDICATION(S)
ABELCET, AMBISOME, CASPOFUNGIN ACETATE, ERAXIS (WATER DILUENT), MYCAMINE, NOXAFIL 40 MG/ML SUSPENSION, NOXAFIL 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)
ALOXI, APREPITANT, CESAMET, GRANISETRON HCL 1 MG TABLET, PALONOSETRON 0.25 MG/2 ML VIAL, 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)

ABRAXANE, AFINITOR 10 MG TABLET, AFINITOR 2.5 MG TABLET, AFINITOR 5 MG TABLET, AFINITOR DISPERZ, ALECENSA, ALIMTA, ALIQOPA, ARRANON, AZACITIDINE, BAVENCIO, BELEODAQ, BENDEKA, BICNU, BLEOMYCIN SULFATE 30 UNIT VIAL, BORTEZOMIB, BOSULIF, BRAFTOVI, BUSULFAN, CABOMETYX, CALQUENCE, CARMUSTINE, CLADRIBINE, CLOFARABINE, COMETRIQ, COTELLIC, CYRAMZA, CYTARABINE 1000 MG/50 ML VIAL, CYTARABINE 2 G/20 ML VIAL, CYTARABINE 20 MG/ML VIAL, DACTINOMYCIN, DARZALEX, DECITABINE, DOCETAXEL 160 MG/16 ML VIAL, DOCETAXEL 20 MG/2 ML VIAL, DOCETAXEL 80 MG/4 ML VIAL, DOCETAXEL 80 MG/8 ML VIAL, DOXORUBICIN HCL LIPOSOME, EMPLICITI, EPIRUBICIN 200 MG/100 ML VIAL, ERBITUX 100 MG/50 ML VIAL, ERLEADA, ERWINAZE, FARYDAK, FASLODEX, FIRMAGON 2 X 120 MG KIT, FIRMAGON 80 MG KIT, FLUDARABINE 50 MG VIAL, FLUOROURACIL 0.5% CREAM, FLUOROURACIL 2% TOPICAL SOLN, FLUOROURACIL 5% TOPICAL SOLN, FOLOTYN 40 MG/2 ML VIAL, GEMCITABINE HCL 1 GRAM VIAL, GEMCITABINE HCL 200 MG VIAL, GILOTRIF, GLEOSTINE 10 MG CAPSULE, GLEOSTINE 100 MG CAPSULE, GLEOSTINE 40 MG CAPSULE, HALAVEN, HERCEPTIN, HYDROXYPROGESTERONE 1.25 G/5ML, IBRANCE, ICLUSIG, IDARUBICIN HCL, IDHIFA, IFOSFAMIDE 1 GM VIAL, IMATINIB MESYLATE, IMBRUVICA, IMFINZI, INLYTA, IRESSA, IRINOTECAN HCL 100 MG/5 ML VL, JAKAFI, JEVTANA, KADCYLA 160 MG VIAL, KEYTRUDA 100 MG/4 ML VIAL, KISQALI, KISQALI FEMARA CO-PACK, KYPROLIS, LARTRUVO, LENVIMA, LEVOLEUCOVORIN 175 MG/17.5 ML, LEVOLEUCOVORIN 250 MG/25 ML VL, LEVOLEUCOVORIN 50 MG VIAL, LONSURF, LORBRENA, LYNPARZA, MEKINIST, MEKTOVI, MELPHALAN HCL, MITOMYCIN, MOZOBIL, MUSTARGEN, MUTAMYCIN, MYLOTARG, NERLYNX, NEXAVAR, NINLARO, NIPENT, ODOMZO, OPDIVO, OXALIPLATIN, PACLITAXEL, PERJETA, REVLIMID, RUBRACA, SPRYCEL, STIVARGA, SUTENT, SYLVANT, SYNRIBO, TAFINLAR, TAGRISSO, TALZENNA, TARCEVA, TASIGNA, TECENTRIQ 1,200 MG/20 ML VIAL, THALOMID, THIOTEPA, TIBSOVO, TOPOTECAN HCL 4 MG VIAL, TREANDA 100 MG VIAL, TREANDA 25 MG VIAL, TRETINOIN 10 MG CAPSULE, TYKERB, VALCHLOR, VELCADE, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VINBLASTINE SULFATE, VINCRISTINE 1 MG/ML VIAL, VIZIMPRO, VOTRIENT, VYXEOS, XALKORI, XTANDI, YERVOY 50 MG/10 ML VIAL, YONDELIS, YONSA, ZALTRAP 100 MG/4 ML VIAL, ZANOSAR, ZEJULA, ZELBORAF, ZYDELIG, ZYKADIA 150 MG CAPSULE, 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
HEMATOLOGY/ONCOLOGY

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.

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, 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.

AVASTIN

MEDICATION(S)
AVASTIN

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

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 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
N/A

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.

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 COVERAGE.

EXCLUSION CRITERIA
AGE LESS THAN 2 OR GREATER THAN 55 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. (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.

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, TOTAL BILIRUBIN MUST BE LESS THAN OR EQUAL TO 1MG/DL.

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.

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.

CORLANOR

MEDICATION(S)
CORLANOR 5 MG TABLET, CORLANOR 7.5 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
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 FUMERATE, 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 (2 PENS)

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)
LEUKINE, NEULASTA 6 MG/0.6 ML SYRINGE, NEUPOGEN, ZARXIO

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

EXCLUSION CRITERIA
NEUTROPHIL COUNT HIGHER THAN 10,000/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.

DAE

MEDICATION(S)

ACTIVELLA, AMABELZ, AMITRIPTYLINE HCL, ANGELIQ, BENZTROPINE MESYLATE, 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 CRPJT, DIPHENHYDRAMINE 50 MG/ML SYRNG, DIPHENHYDRAMINE 50 MG/ML VIAL, DIPHENOXYLATE-ATROPINE, DIPYRIDAMOLE 25 MG TABLET, DIPYRIDAMOLE 50 MG TABLET, DIPYRIDAMOLE 75 MG TABLET, 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, ESTROPIPATE 0.625(0.75 MG) TAB, FLURAZEPAM HCL, FYAVOLV, GLYBURIDE, GLYBURIDE-METFORMIN HCL, GUANFACINE HCL, HYDROXYZINE HCL, HYDROXYZINE PAMOATE, IMIPRAMINE HCL, INDOMETHACIN 25 MG CAPSULE, INDOMETHACIN 50 MG CAPSULE, JINTELI, MECLIZINE 12.5 MG TABLET, MECLIZINE 25 MG TABLET, MENEST, MENOSTAR, MEPROBAMATE, METHOCARBAMOL 500 MG TABLET, METHOCARBAMOL 750 MG TABLET, METHYLDOPA, METHYLDOPA-HCTZ 250-25 MG TAB, METHYLDOPATE HCL, MIMVEY, MIMVEY LO, NIFEDIPINE, NORETHIN-ETH ESTRAD 1 MG-5 MCG, NORETHIND-ETH ESTRAD 0.5-2.5, NORTRIPTYLINE 10 MG/5 ML SOLN, NORTRIPTYLINE HCL 10 MG CAP, NORTRIPTYLINE HCL 25 MG CAP, NORTRIPTYLINE HCL 50 MG CAP, NORTRIPTYLINE HCL 75 MG CAP, ORPHENADRINE CITRATE, 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, PREMARIN 25 MG VIAL, PREMPHASE, PREMPRO, PROMETHAZINE HCL, PROTRIPTYLINE HCL, THIORIDAZINE HCL, 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.

DAKLINZA

MEDICATION(S)
DAKLINZA

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). NO APPROVALS FOR CONCURRENT USE WITH ANY OF THESE (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN. APPROVAL FOR INTERFERON INELIGIBLE PATIENTS -INTERFERON INELIGIBILITY INCLUDES CONCURRENT DIAGNOSIS OF AUTOIMMUNE HEPATITIS OR OTHER AUTOIMMUNE DISORDER, A KNOWN HYPERSENSITIVITY REACTION (SUCH AS URTICARIA, ANGIOEDEMA, BRONCHOCONSTRICTION AND ANAPHYLAXIS TO ALPHA INTERFERONS, PEG, OR ANY COMPONENT OF PEGINTERFERON), DOCUMENTED DEPRESSION, DECOMPENSATED HEPATIC DISEASE, A BASELINE NEUTROPHIL COUNT BELOW 1,500 PER MICROLITER, A BASELINE PLATELET COUNT BELOW 90,000, OR A BASELINE HEMOGLOBIN BELOW 10G/DL THAT HAS NOT RESPONDED TO TREATMENT.

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.

MEDICATION(S)
KEPIVANCE

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
MAXIMUM RECOMMENDED DAILY DOSE.

DERMATITIS

MEDICATION(S)
ELIDEL, 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

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)
FLECTOR, PENNSAID 2% PUMP, PENNSAID 2% SOLUTION PACKET

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION THAT ONE FORMULARY ORAL NSAID AND DICLOFENAC 1% GEL HAVE 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.

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, OR RHEUMATOLOGY

COVERAGE DURATION
APPROVED IN 6-MONTH INCREMENTS.

OTHER CRITERIA
N/A

DUPIXENT

MEDICATION(S)
DUPIXENT 300 MG/2 ML SYRINGE

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
ALLERGIST, IMMUNOLOGIST, DERMATOLOGIST

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.

EFFIENT

MEDICATION(S)
PRASUGREL 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 1-YEAR INCREMENTS.

OTHER CRITERIA
MEDICAL JUSTIFICATION SPECIFYING WHY ONE FORMULARY ALTERNATIVE CANNOT BE USED (CLOPIDOGREL OR TICAGRELOR).

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 37.4 INCHES (95 CM), WAIST TO HIP RATIO GREATER 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
MEDICAL JUSTIFICATION SPECIFYING THAT AN ACE INHIBITOR OR ARB THERAPY HAS BEEN TOLERATED FOR AT LEAST 4 WEEKS, IS CONTRAINDICATED, OR WOULD NOT BE MEDICALLY APPROPRIATE FOR THE PATIENT.

ENZYME REPLACEMENTS

MEDICATION(S)
ADAGEN, ALDURAZYME, CEREZYME, CYSTAGON, ELAPRASE, ELELYSO, FABRAZYME, KUVAN 100 MG TABLET, KUVAN 500 MG POWDER PACKET, LUMIZYME, MIGLUSTAT, NAGLAZYME, RAVICTI, SODIUM PHENYLBUTYRATE POWDER, VPRIV, ZAVESCA

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

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).

EXJADE

MEDICATION(S)
EXJADE, FERRIPROX 100 MG/ML SOLUTION, FERRIPROX 500 MG TABLET

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
SERUM FERRITIN MUST CONSISTENTLY BE GREATER THAN 1000 MCG/L. DOSE CANNOT EXCEED 99MG/KG/DAY FOR FERRIPROX OR 40MG/KG/DAY FOR EXJADE PRODUCTS.

EXONDYS

MEDICATION(S)
EXONDYS 51

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
DOCUMENTATION CONFIRMING A MUTATION OF THE DMD GENE THAT IS AMENDABLE TO EXON 51 SKIPPING.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
MEDICATION IS PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN WHO SPECIALIZES IN TREATMENT OF DUCHENNE MUSCULAR DYSTROPHY.

COVERAGE DURATION
3-MONTH INCREMENTS.

OTHER CRITERIA
NEW THERAPY: (1) MEMBER HAS BEEN ON STABLE GLUCOCORTICOIDS FOR AT LEAST 24 WEEKS, AND (2) MEMBER HAS THE ABILITY TO WALK 180 METERS ON THE 6 MINUTE WALK TEST. FOR CONTINUATION: (1) PA HISTORY AND DOCUMENTATION OF INCREASE IN DYSTROPHIN LEVEL FROM BASELINE OR INCREASE IN 6-MINUTE WALK DISTANCE FROM BASELINE.

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 GREATER THAN OR EQUAL TO 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 GREATER THAN OR EQUAL TO 12% AND 200 ML AFTER ALBUTEROL ADMINISTRATION. MEMBER HAS HAD ONE OR MORE ASTHMA EXACERBATIONS IN THE PAST 12 MONTHS. THE MEMBER HAS POOR ASTHMA CONTROL DESPITE ADHERENCE TO AT LEAST 3 CONSECUTIVE MONTHS OF CONCURRENT TREATMENT WITH BOTH (ICS) AND (LABA).

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)
BUTALB-ACETAMIN-CAFF 50-325-40

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.

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 REQUIRED FOR TREATMENT DURATION BEYOND 24 MONTHS. MEDICAL JUSTIFICATION IF THE PATIENT IS NOT RECEIVING CALCIUM OR HAS NOT TRIED AND FAILED BISPHOSPHONATES.

GASTROINTESTINAL AGENT

MEDICATION(S)
ENTYVIO

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 1-YEAR INCREMENTS

OTHER CRITERIA
N/A

GNRH

MEDICATION(S)
ELIGARD, LEUPROLIDE 2WK 1 MG/0.2 ML KIT, LEUPROLIDE 2WK 14 MG/2.8 ML KT, LUPRON DEPOT, LUPRON DEPOT (LUPANETA), LUPRON DEPOT-PED 11.25 MG KIT, LUPRON DEPOT-PED 15 MG KIT, LUPRON DEPOT-PED 30 MG 3MO 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, 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

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, SIMEPREVIR, 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, RIBASPHERE 400 MG TABLET, RIBASPHERE 600 MG TABLET, 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

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, KYNAMRO

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. FOR LOMITAPIDE, MUST FIRST TRY AND FAIL MIPOMERSEN.

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

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)
BIVIGAM, CARIMUNE NF 6 GM VIAL, FLEBOGAMMA DIF 10% VIAL, GAMASTAN S-D, GAMMAGARD LIQUID, GAMMAGARD S-D 10 G (IGA<1) SOL, GAMMAGARD S-D 5 G (IGA<1) SOLN, GAMMAKED 1 GRAM/10 ML VIAL, GAMMAPLEX, GAMUNEX-C 1 GRAM/10 ML VIAL, OCTAGAM, PRIVIGEN

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 45 MG-15 MG TABLET, JYNARQUE 60 MG-30 MG TABLET, JYNARQUE 90 MG-30 MG TABLET

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 150 MG TABLET, KALYDECO 50 MG GRANULES PACKET, KALYDECO 75 MG GRANULES PACKET

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

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, FRAGMIN

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

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
CRITERIA 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.

MEDICALLY ACCEPTED

MEDICATION(S)
ABSORICA, ACTIMMUNE, ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML VIAL, AMNESTEEM, AMPHOTERICIN B, ATGAM, ATOVAQUONE, BCG VACCINE (TICE STRAIN), BENLYSTA, CLARAVIS 10 MG CAPSULE, ENBREL, ENBREL SURECLICK, GANCICLOVIR SODIUM, GILENYA 0.5 MG CAPSULE, HEXALEN, 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, HYPERRAB S-D, ILARIS, IMOGAM RABIES-HT, ISOTRETINOIN, KADCYLA 100 MG VIAL, KINERET, LIDOCAINE 5% PATCH, MYORISAN, ORENCIA 125 MG/ML SYRINGE, ORENCIA 250 MG VIAL, ORENCIA CLICKJECT, POMALYST, PROLEUKIN, PROLIA, QUININE SULFATE, RELISTOR 12 MG/0.6 ML SYRINGE, RELISTOR 12 MG/0.6 ML VIAL, RELISTOR 150 MG TABLET, RELISTOR 8 MG/0.4 ML SYRINGE, SIMPONI, SIMPONI ARIA, SIMULECT 20 MG VIAL, TEMSIROLIMUS, TETRABENAZINE, THYMOGLOBULIN, TORISEL, TRIMIPRAMINE MALEATE, VARIZIG 125 UNIT/1.2 ML VIAL, VECTIBIX 100 MG/5 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

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 10 MG/ML VIAL, METHADONE HCL 200 MG/20 ML VL, 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 30 MCG VIAL KIT, AVONEX PREFILLED SYR 30 MCG KT, AVONEX PEN 30 MCG/0.5 ML KIT, BETASERON 0.3 MG KIT, DALFAMPRIDINE ER, GLATIRAMER ACETATE, GLATOPA 20 MG/ML SYRINGE, REBIF, REBIF REBIDOSE, TECFIDERA, TYSABRI

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).

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. FOR NEW THERAPY, IF CORRECTED SERUM CALCIUM IS ABOVE 7.5 MG/DL, MEDICAL JUSTIFICATION IS REQUIRED.

NEUMEGA

MEDICATION(S)
PROMACTA 12.5 MG TABLET, PROMACTA 25 MG TABLET, PROMACTA 50 MG TABLET, PROMACTA 75 MG TABLET

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
PATIENT'S WEIGHT, 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

NPLATE

MEDICATION(S)
NPLATE

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, AND MEMBER HAS EITHER (1) SYMPTOMS OF AN ACTIVE BLEED; OR (2) RISK FACTORS FOR BLEEDING (E.G. HYPERTENSION, PEPTIC ULCER DISEASE, ANTICOAGULATION, RECENT SURGERY, OR HEAD TRAUMA)
CONTINUATION: LABWORK INDICATING PLATELET COUNT GREATER THAN 30,000MM3 (W/IN LAST 90 DAYS) OR MEDICAL DOCUMENT SHOWING PLATELET COUNT INCREASED COMPARED TO BASELINE DEMONSTRATING EFFICACY (ALTHOUGH MEMBER MAY NEED AN INCREASE IN DOSE).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
NEW: APPROVED IN 3-MONTH INCREMENTS. CONTINUATION: APPROVED IN 6-MONTH INCREMENTS.

OTHER CRITERIA
NEW: MEDICAL JUSTIFICATION SPECIFYING THAT A FORMULARY ALTERNATIVE (CORTICOSTEROID, DANAZOL, RITUXIMAB (RITUXAN)) HAS BEEN TRIED AND FAILED, IS CONTRAINDICATED, OR WOULD NOT BE MEDICALLY APPROPRIATE FOR THE PATIENT, OR THAT THE PATIENT HAS HAD A SPLENECTOMY.

NUCALA

MEDICATION(S)
NUCALA 100 MG VIAL

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

EXCLUSION CRITERIA
CURRENT RESPIRATORY DISEASE OTHER THAN ASTHMA.

REQUIRED MEDICAL INFORMATION
EOSINOPHILIC ASTHMA PHENOTYPE, AS DETERMINED BY 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
ALLERGIST, IMMUNOLOGIST, PULMONOLOGIST.

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 ANTIMITOCHRONDRIAL 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. FOR CONTINUATION THERAPY: DOCUMENTATION THAT ALKALINE PHOSPHATASE (ALP) LEVELS HAVE DECREASED BY AT LEAST 15% FROM BASELINE WHILE ON TREATMENT WITH OCALIVA.

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, LETAIRIS, OPSUMIT, ORENITRAM ER, REMODULIN, REVATIO 10 MG/ML ORAL SUSP, SILDENAFIL, SILDENAFIL 10 MG/12.5 ML VIAL, 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

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, BEXAROTENE, BRIVIACT, BYDUREON, BYDUREON BCISE, BYDUREON PEN, CALCIPOTRIENE, CAYSTON, CELECOXIB 400 MG CAPSULE, CIDOFOVIR, 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, DESMOPRESSIN 40 MCG/10 ML VIAL, DESMOPRESSIN AC 4 MCG/ML AMPUL, DESMOPRESSIN AC 4 MCG/ML VIAL, DESVENLAFAXINE ER 100 MG TAB, DESVENLAFAXINE ER 50 MG TAB, DESVENLAFAXINE SUCCINATE ER, DEXRAZOXANE 250 MG VIAL, DIHYDROERGOTAMINE 4 MG/ML SPRY, DRONABINOL, ELMIRON, EMSAM, ENGERIX-B ADULT, ENGERIX-B PEDIATRIC-ADOLESCENT, ERGOLOID MESYLATES, ESBRIET, EURAX, FIRAZYR, FLUCYTOSINE, GARDASIL, GARDASIL 9, GLASSIA, HETLIOZ, KEVEYIS, LINZESS, LYRICA, LYRICA CR, 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 SYR, OCTREOTIDE ACET 100 MCG/ML VL, OCTREOTIDE ACET 200 MCG/ML VL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE ACET 50 MCG/ML SYR, OCTREOTIDE ACET 50 MCG/ML VIAL, OCTREOTIDE ACET 500 MCG/ML AMP, OCTREOTIDE ACET 500 MCG/ML VL, OFEV, ONFI, ORKAMBI, OTEZLA 28 DAY STARTER PACK, OTEZLA 30 MG TABLET, PANRETIN, PHENOXYBENZAMINE HCL, 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, SYNDROS, TARGRETIN 1% GEL, 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 II 8.5% IV SOLUTION, AMINOSYN II WITH ELECTROLYTES, AMINOSYN WITH ELECTROLYTES, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-RF, BOTOX, CLINIMIX, CLINIMIX E, CLINISOL, CYSTARAN, DOXERCALCIFEROL 4 MCG/2 ML AMP, DOXERCALCIFEROL 4 MCG/2 ML VL, DYSPORT, ELITEK, EVZIO 2 MG AUTO-INJECTOR, FOMEPIZOLE, FREAMINE HBC, HEPATAMINE, INTRALIPID, MIACALCIN 200 UNIT/ML VIAL, MIACALCIN 400 UNIT/2 ML VIAL, NALBUPHINE HCL, NUTRILIPID, PAMIDRONATE 30 MG/10 ML VIAL, PAMIDRONATE 60 MG/10 ML VIAL, PAMIDRONATE 90 MG/10 ML VIAL, PARICALCITOL, PLENAMINE, PREMASOL, PROCALAMINE, PROSOL, REGRANEX, SIRTURO, TOBI PODHALER, TOBRAMYCIN 300 MG/5 ML AMPULE, TRAVASOL, TRIENTINE HCL, TROPHAMINE, XEOMIN 100 UNIT VIAL, XEOMIN 50 UNIT VIAL, 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, AZATHIOPRINE SODIUM, CELLCEPT, CYCLOSPORINE, CYCLOSPORINE MODIFIED, FLUOROURACIL 1,000 MG/20 ML VL, FLUOROURACIL 2,500 MG/50 ML VL, FLUOROURACIL 2.5 GM/50 ML BTL, FLUOROURACIL 2.5 GM/50 ML VIAL, FLUOROURACIL 5 GM/100 ML BTL, FLUOROURACIL 5 GM/100 ML VIAL, FLUOROURACIL 5,000 MG/100 ML, FLUOROURACIL 500 MG/10 ML VIAL, GENGRAF 100 MG CAPSULE, GENGRAF 100 MG/ML SOLUTION, GENGRAF 25 MG CAPSULE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID, MYFORTIC, NEORAL, NULOJIX, PROGRAF 0.5 MG CAPSULE, PROGRAF 1 MG CAPSULE, PROGRAF 5 MG CAPSULE, PROGRAF 5 MG/ML AMPULE, RAPAMUNE, SANDIMMUNE, SENSIPAR, SIROLIMUS 0.5 MG TABLET, SIROLIMUS 1 MG TABLET, SIROLIMUS 2 MG TABLET, 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

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). HEPATITIS C: CONCURRENT USE OF RIBAVIRIN.

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

PREVYMIS

MEDICATION(S)
PREVYMIS

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 100 MG/ML SYRINGE

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

RADICAVA

MEDICATION(S)
RADICAVA

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

COVERAGE DURATION
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
MEDICAL JUSTIFICATION FOR WHY RILUZOLE CANNOT BE USED. MEDICATION QUANTITY IS LIMITED TO 2,800 ML PER 28 DAYS FOR INITIAL TREATMENT AND 2,000 ML PER 28 DAYS FOR SUBSEQUENT TREATMENTS.

RANEXA

MEDICATION(S)
RANEXA

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, INFLECTRA, KEVZARA, 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
REMICADE/INFLECTRA: MAXIMUM DOSE OF 10 MG/KG/DOSE FOR ALL INDICATIONS.

RHOPHYLAC

MEDICATION(S)
RHOPHYLAC

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
CONTINUATION: MEDICAL DOCUMENTATION SHOWING PLATELET COUNT LESS THAN 20,000 CELLS/M3 OR LESS THAN 30,000 CELLS/M3 WITH CLINICALLY SIGNIFICANT BLEEDING.

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)
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, SIGNIFOR LAR

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 CUSHINGS 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.

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 OR OLYSIO WILL REQUIRE THAT THE PATIENT ALSO MEETS ALL CRITERIA FOR THE RESPECTIVE AGENT USED (DAKLINZA OR OLYSIO).

STRENSIQ

MEDICATION(S)
STRENSIQ

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
POSITIVE TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING, AND SERUM ALKALINE PHOSPHATASE (ALP) LEVEL.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
ENDOCRINOLOGY, ORTHOPEDICS, PEDIATRICS, GENETICS, METABOLIC SPECIALIST.

COVERAGE DURATION
APPROVED IN 1-YEAR INCREMENTS.

OTHER CRITERIA
SERUM ALKALINE PHOSPHATASE (ALP) LEVEL IS BELOW THAT OF NORMAL RANGE FOR PATIENT AGE AT SCREENING.

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 100/150 MG-150 MG TABS

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.

SYNAGIS

MEDICATION(S)
SYNAGIS

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
GESTATIONAL AGE, RSV RISK FACTORS.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
APPROVED IN 6-MONTH INCREMENTS.

OTHER CRITERIA
N/A

TALTZ

MEDICATION(S)
TALTZ AUTOINJECTOR, TALTZ 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
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.

TECHNIVIE

MEDICATION(S)
TECHNIVIE

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
CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.

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). MUST BE USED CONCURRENTLY WITH RIBAVIRIN UNLESS PATIENT IS TREATMENT NAIVE AND HAS CONTRAINDICATION TO RIBAVIRIN. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER): ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, RIFAMPIN, ERGOTAMINE DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ (ATRIPLA, SUSTIVA), REVATIO (SILDENAFIL DOSE OF 20MG AND/OR DOSED TID FOR PAH), TRIAZOLAM, ORAL MIDAZOLAM, LOPINAVIR/RITONAVIR, RILVIRAPINE, SALMETEROL.

TEDUGLUTIDE

MEDICATION(S)
GATTEX 5 MG 30-VIAL KIT, 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 DOCUMENTATION OF AN INCREASE IN PATIENT WEIGHT, AND DECREASE PARENTERAL NUTRITIONAL VOLUME. QUANTITY LIMITED TO #1 VIAL PER DAY.

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 IS NOT RECEIVING CALCIUM OR 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 (2A) RECEIVING CHEMOTHERAPY, OR (2B) RECEIVING IMMUNOSUPPRESSIVE (I.E. ON ANTIRETROVIRALS PER CLAIMS HX, ETC.), OR (2C) ON THE LIVER TRANSPLANT WAITING LIST, OR (2D) POST LIVER TRANSPLANT, AND (3) 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, VIEKIRA XR

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.

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
CRITERIA 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.

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.

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 OR ENDOCRINOLOGY

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. NO CONCURRENT USE WITH SOVALDI.

ZINPLAVA

MEDICATION(S)
ZINPLAVA

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
STOOL TEST FOR CLOSTRIDIUM DIFFICILE COLLECTED NO MORE THAN 7 DAYS PRIOR, AND DOCUMENTATION OF DIARRHEA (DEFINED AS PASSAGE OF 3 OR MORE LOOSE BOWEL MOVEMENTS IN 24 HOURS OR LESS). MEMBER IS RECEIVING ANTIBACTERIAL DRUG TREATMENT FOR CLOSTRIDIUM DIFFICILE INFECTION (CDI) AND IS AT HIGH RISK FOR CDI RECURRENCE (I.E., MEMBERS AGED 65 YEARS AND OLDER, HISTORY OF CDI IN THE PAST 6 MONTHS, IMMUNOCOMPROMISED STATE, SEVERE CDI AT PRESENTATION, OR C. DIFFICILE RIBOTYPE 027).

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST

COVERAGE DURATION
APPROVED IN 1-DOSE INCREMENTS.

OTHER CRITERIA

A DIAGNOSIS OF CLOSTRIDIUM DIFFICILE INFECTION (CDI) IS CONFIRMED BY DOCUMENTATION OF POSITIVE STOOL TEST FOR CLOSTRIDIUM DIFFICILE COLLECTED NO MORE THAN 7 DAYS PRIOR. AND THE PATIENT WILL RECEIVE OR IS CURRENTLY RECEIVING CONCOMITANT ANTIBACTERIAL DRUG TREATMENT FOR CDI (E.G. METRONIDAZOLE, VANCOMYCIN, FIDAXOMICIN). AND THE PATIENT HAS HAD AT LEAST TWO EPISODES OF CDI RECURRENCE (3 EPISODES OF CDI) IN THE PREVIOUS 6 MONTHS AND HAS BEEN TREATED WITH APPROPRIATE TREATMENT FOR CDI (METRONIDAZOLE, VANCOMYCIN, FIDAXOMICIN), INCLUDING A PULSED VANCOMYCIN REGIMEN FOR THE SECOND RECURRENCE. AND IF THE PATIENT HAS HEART FAILURE, A PRESCRIBER STATEMENT IS REQUIRED INDICATING THAT THE BENEFIT OF TREATMENT WITH ZINPLAVA OUTWEIGHS TO POTENTIAL RISK. AND IF THE PATIENT HAS BEEN PREVIOUSLY TREATED WITH ZINPLAVA AT ANY TIME, A PRESCRIBER STATEMENT IS REQUIRED DOCUMENTING THE SAFETY AND EFFICACY OF REPEAT ADMINISTRATION. AND THE PRESCRIBED DOSE IS 10 MG/KG FOR ONE DOSE ONLY.

ZURAMPIC

MEDICATION(S)
DUZALLO 200-300 MG TABLET, 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.