# **ABALOPARATIDE**

### **Products Affected**

TYMLOS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., ALENDRONATE, RISEDRONATE, IBANDRONATE).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **ABATACEPT IV**

### **Products Affected**

• ORENCIA (WITH MALTOSE)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: RA: 6 MOS. JIA: 4 MOS. PSA: 12 MOS. RENEWAL: 12 MOS ALL INDICATIONS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. JUVENILE IDIOPATHIC ARTHRITIS (JIA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA, OTEZLA, OR COSENTYX.

# **ABATACEPT SQ**

#### **Products Affected**

#### ORENCIA

#### · ORENCIA CLICKJECT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. JUVENILE IDIOPATHIC ARTHRITIS (JIA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA, OTEZLA, OR COSENTYX.

# **ABEMACICLIB**

### **Products Affected**

VERZENIO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO IBRANCE (PALBOCICLIB) WHEN REQUEST IS FOR COMBINATION THERAPY WITH FULVESTRANT FOR HORMONE RECEPTOR (HR)-POSITIVE, HER2-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER.

# **ABIRATERONE**

### **Products Affected**

· ZYTIGA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **ACALABRUTINIB**

### **Products Affected**

· CALQUENCE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **ADALIMUMAB**

#### **Products Affected**

- HUMIRA PEDIATRIC CROHN'S START
- HUMIRA PEN
- HUMIRA PEN CROHN'S-UC-HS START
- HUMIRA PEN PSORIASIS-UVEITIS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.4 ML, 40 MG/0.8 ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: CURRENT WEIGHT. PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL:RA:6 MO PSA/AS:4 MO PJIA:5 MO PSO/CD/UC/HS:3 MO UVEITIS:6 MO RENEWAL:12 MO ALL INDICATIONS

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS
	TRIAL OF ONE DMARD (DISEASE-MODIFYING
	ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE,
	LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR
	SULFASALAZINE. POLYARTICULAR JUVENILE
	IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF ONE
	DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG)
	SUCH AS METHOTREXATE, LEFLUNOMIDE,
	HYDROXYCHLOROQUINE, OR SULFASALAZINE.
	PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF ONE
	DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG)
	SUCH AS METHOTREXATE, LEFLUNOMIDE,
	HYDROXYCHLOROQUINE, OR SULFASALAZINE.
	ANKYLOSING SPONDYLITIS: TRIAL OF FORMULARY
	AGENTS NOT REQUIRED. PLAQUE PSORIASIS (PSO):
	PREVIOUS TRIAL OF ONE OF THE FOLLOWING
	CONVENTIONAL THERAPIES SUCH AS PUVA
	(PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB
	(ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS,
	CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR
	CYCLOSPORINE. CROHN'S DISEASE (CD): PREVIOUS TRIAL
	OF ONE CONVENTIONAL AGENT SUCH AS A
	CORTICOSTEROID (I.E., BUDESONIDE,
	METHYLPREDNISOLONE), AZATHIOPRINE,
	MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
	ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF ONE
	CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID
	(I.E., BUDESONIDE, METHYLPREDNISOLONE),
	AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE,
	OR MESALAMINE.

# AFATINIB DIMALEATE

#### **Products Affected**

• GILOTRIF

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **ALECTINIB**

### **Products Affected**

· ALECENSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# ALEMTUZUMAB - LEMTRADA

#### **Products Affected**

#### LEMTRADA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 1 MONTH. RENEWAL: 12 MONTHS.
Other Criteria	TRIAL WITH TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, OR GLATIRAMER. RENEWAL REQUESTS FOR ALEMTUZUMAB REQUIRE THAT AT LEAST 12 MONTHS HAVE ELAPSED SINCE RECEIVING THE FIRST COURSE OF LEMTRADA. PATIENTS ARE LIMITED TO TWO COURSES OF THERAPY WITH LEMTRADA WITHIN A LIFETIME.

# **ALIROCUMAB**

### **Products Affected**

#### • PRALUENT PEN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OF AGE AND OLDER.
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	MUST HAVE A LDL CHOLESTEROL LEVEL GREATER
	THAN 100MG/DL WHILE ON MAXIMAL DRUG
	TREATMENT FOR THE PAST 2 MONTHS AND ONE OF THE
	FOLLOWING DIAGNOSES: (1) HETEROZYGOUS FAMILIAL
	HYPERCHOLESTEROLEMIA (HEFH) DETERMINED BY
	SIMON BROOME DIAGNOSTIC CRITERIA FOR HEFH OR A
	SCORE OF 6 OR GREATER ON THE DUTCH LIPID
	NETWORK CRITERIA FOR HEFH OR (2) HISTORY OF
	ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD)
	AS DOCUMENTED BY PHYSICIAN ATTESTATION. PATIENT
	MUST NOT HAVE CONCURRENT USE OF REPATHA OR
	OTHER PCSK9 AGENT. INITIAL THERAPY: FOR STATIN
	TOLERANT PATIENTS: MUST HAVE TAKEN
	ATORVASTATIN OR ROSUVASTATIN FOR THE PAST 2
	MONTHS. FOR STATIN INTOLERANT PATIENTS:
	DOCUMENTATION OF STATIN INTOLERANCE BY ONE OF
	THE FOLLOWING: (1) PHYSICIAN ATTESTATION, (2)
	PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN,
	OR STATIN THERAPY AT ANY DOSE AND HAS
	EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS
	(E.G., MYOPATHY). PATIENTS WITH
	CONTRAINDICATIONS TO STATINS INCLUDING ACTIVE
	DECOMPENSATED LIVER DISEASE, NURSING FEMALE,
	PREGNANCY OR PLANS TO BECOME PREGNANT OR
	HYPERSENSITIVITY REACTIONS WILL BE APPROVED FOR
	PRALUENT THERAPY WITHOUT REQUIREMENT OF
	DOCUMENTATION OF STATIN INTOLERANCE. RENEWAL
	CRITERIA: RECEIVING PRIOR PRALUENT THERAPY FOR
	THE PAST 6 MONTHS AND NO CLAIMS FOR REPATHA,
	JUXTAPID, OR KYNAMRO SINCE PRALUENT APPROVAL.

### **AMANTADINE**

#### **Products Affected**

 GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG, 68.5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **ANAKINRA**

#### **Products Affected**

#### KINERET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RHEUMATOID ARTHRITIS (RA) RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS NOMID/CAPS: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA, OR ACTEMRA.

# **APALUTAMIDE**

### **Products Affected**

• ERLEADA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **APREMILAST**

### **Products Affected**

#### OTEZLA

#### • OTEZLA STARTER

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE
	EXCLUDED FROM PART D.
Exclusion Criteria	
Criteria	
Required Medical	INITIAL: MODERATE TO SEVERE PLAQUE PSORIASIS
Information	INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY
	SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE
	HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN
	ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber	PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN
Restrictions	CONSULTATION WITH A DERMATOLOGIST OR
	RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR
	GIVEN IN CONSULTATION WITH A DERMATOLOGIST
Coverage	INITIAL: PSORIATIC ARTHRITIS: 4 MONTHS. PSORIASIS:
Duration	5 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL
	OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING
	ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE,
	LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR
	SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS
	TRIAL OF HUMIRA AND ONE CONVENTIONAL THERAPY
	SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT
	A), UVB (ULTRAVIOLET LIGHT B), TOPICAL
	CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN,
	METHOTREXATE, OR CYCLOSPORINE.

# **ASFOTASE**

### **Products Affected**

• STRENSIQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION, SERUM ALKALINE PHOSPHATASE (ALP) LEVEL, SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS, URINE PHOSPHOETHANOLAMINE (PEA) LEVEL, RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP)
Age Restrictions	PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP): 6 MONTHS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET. JUVENILE-ONSET HYPOPHOSPHATASIA (HPP): 18 YEARS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET.
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, A GENETICIST, OR A METABOLIC SPECIALIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

Other Criteria  INITIAL: FOR PATIENTS WITH PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.) RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.) PRESENCE OF TWO OR MORE OF THE FOLLOWING: RACHITIC CHEST DEFORMITY, CRANIOSYNOSTOSIS (PREMATURE CLOSURE OF SKULL BONES), DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, NEPHROCALCINOSIS, OR HISTORY OF ELEVATED SERUM CALCIUM. HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. FOR PATIENTS WITH HUMENILE ONSET HYPORHOGREMATASIA (HRD). ALL OF	PA Criteria	Criteria Details
THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.)URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.)RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, OSTEOMALACIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.)PRESENCE OF TWO OR MORE OF THE FOLLOWING:RACHITIC DEFORMITIES (RACHITIC CHEST,	Other Criteria	ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.) RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.) PRESENCE OF TWO OR MORE OF THE FOLLOWING: RACHITIC CHEST DEFORMITY, CRANIOSYNOSTOSIS (PREMATURE CLOSURE OF SKULL BONES), DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, NEPHROCALCINOSIS, OR HISTORY OF ELEVATED SERUM CALCIUM. HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. FOR PATIENTS WITH JUVENILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (TPSATIENT AGE 2.) SERUM PYRIDOXAL-5'-PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PRIDOXAL-5'-PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-PHOSPHATASE, (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 4.) RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP), (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, OSTEOMALACIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.) PRESENCE OF TWO OR MORE OF THE

PA Criteria	Criteria Details
	BOWED LEGS, KNOCK-KNEES),PREMATURE LOSS OF
	PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, DELAY IN
	SKELETAL GROWTH RESULTING IN DELAY OF MOTOR
	DEVELOPMENT, OR HISTORY OR PRESENCE OF NON-
	TRAUMATIC FRACTURES OR DELAYED FRACTURE
	HEALING. STRENSIQ WILL NOT BE APPROVED FOR THE
	FOLLOWING PATIENTS: PATIENTS CURRENTLY
	RECEIVING TREATMENT WITH A BISPHOSPHONATE [E.G.,
	BONIVA (IBANDRONATE), FOSAMAX (ALENDRONATE),
	ACTONEL (RISEDRONATE)], PATIENTS WITH SERUM
	CALCIUM OR PHOSPHATE LEVELS BELOW THE NORMAL
	RANGE, PATIENTS WITH A TREATABLE FORM OF
	RICKETS. RENEWAL: PATIENT HAS EXPERIENCED AN
	IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF
	HYPOPHOSPHATASIA (HPP) (E.G., IMPROVEMENT OF THE
	IRREGULARITY OF THE PROVISIONAL ZONE OF
	CALCIFICATION, PHYSEAL WIDENING, METAPHYSEAL
	FLARING, RADIOLUCENCIES, PATCHY OSTEOSCLEROSIS,
	RATIO OF MID-DIAPHYSEAL CORTEX TO BONE
	THICKNESS, GRACILE BONES, BONE FORMATION AND
	FRACTURES.

# **ASPARAGINASE**

#### **Products Affected**

ONCASPAR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	

# **ATEZOLIZUMAB**

### **Products Affected**

• TECENTRIQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **AVELUMAB**

#### **Products Affected**

BAVENCIO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **AXITINIB**

### **Products Affected**

• INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF AT LEAST ONE SYSTEMIC THERAPY FOR THE TREATMENT OF RCC SUCH AS NEXAVAR (SORAFENIB), TORISEL (TEMSIROLIMUS), SUTENT (SUNITINIB), VOTRIENT (PAZOPANIB), OR AVASTIN (BEVACIZUMAB) IN COMBINATION WITH INTERFERON.

# **BECAPLERMIN**

#### **Products Affected**

#### REGRANEX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	NON-DIABETIC ULCERS, NEOPLASM AT APPLICATION SITE, PRESSURE OR VENOUS STASIS ULCERS AND ULCERS THAT DO NOT EXTEND THROUGH THE DERMIS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST, PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	3 MONTHS
Other Criteria	

# BEDAQUILINE FUMARATE

### **Products Affected**

#### · SIRTURO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OF AGE AND OLDER.
Prescriber Restrictions	
Coverage Duration	24 WEEKS
Other Criteria	SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS.

### **BELIMUMAB**

#### **Products Affected**

- BENLYSTA INTRAVENOUS
- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	AUTOANTIBODY POSITIVE LUPUS TEST.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. NO APPROVAL FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS, SEVERE CENTRAL NERVOUS SYSTEM LUPUS OR CONCURRENT USE OF BIOLOGIC AGENTS OR INTRAVENOUS CYCLOPHOSPHAMIDE. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.

# **BELINOSTAT**

### **Products Affected**

• BELEODAQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **BENDAMUSTINE**

#### **Products Affected**

BENDEKA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **BENRALIZUMAB**

### **Products Affected**

FASENRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **BEVACIZUMAB**

#### **Products Affected**

AVASTIN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **BEXAROTENE**

#### **Products Affected**

• bexarotene

#### • TARGRETIN TOPICAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **BLINATUMOMAB**

#### **Products Affected**

• BLINCYTO INTRAVENOUS KIT

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: RELAPSED OR REFRACTORY B-CELL: 3 MOS. MRD-POSITIVE B-CELL: 2 MOS. RENEWAL: 12 MOS.
Other Criteria	INITIAL: RELAPSED OR REFRACTORY B-CELL PRECURSOR ALL: APPROVAL IS FOR 2 CYCLES, MAY APPROVE FOR 1 ADDITIONAL CYCLE DUE TO TREATMENT INTERRUPTION FOR DOSE MODIFICATION. RENEWAL: FOR DIAGNOSIS OF RELAPSED OR REFRACTORY B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED COMPLETE REMISSION (CR) OR CR WITH PARTIAL HEMATOLOGICAL RECOVERY OF PERIPHERAL BLOOD COUNTS AFTER 2 CYCLES OF TREATMENT. RENEWAL IS NOT APPROVED FOR PATIENTS WHO RECEIVED AN ALLOGENEIC HEMATOPOIETIC STEM-CELL TRANSPLANT. FOR DIAGNOSIS OF MINIMAL RESIDUAL DISEASE (MRD)-POSITIVE B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED UNDETECTABLE MINIMAL RESIDUAL DISEASE (MRD) WITHIN ONE CYCLE OF BLINCYTO TREATMENT AND IS RELAPSE-FREE (I.E., HEMATOLOGICAL OR EXTRAMEDULLARY RELAPSE, OR SECONDARY LEUKEMIA).

### **BORTEZOMIB**

#### **Products Affected**

BORTEZOMIB

#### • VELCADE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **BOSUTINIB**

#### **Products Affected**

• BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CML: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT BOTH T315I AND V299L MUTATIONS ARE NOT PRESENT.

### **BOTULINUM NEUROTOXIN**

#### **Products Affected**

- BOTOX INJECTION RECON SOLN 100 UNIT, 200 UNIT
- MYOBLOC INTRAMUSCULAR

SOLUTION 10,000 UNIT/2 ML, 2,500 UNIT/0.5 ML, 5,000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	COSMETIC DIAGNOSIS: WRINKLES.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MIGRAINE HEADACHE: TRIAL OF TWO OF THE FOLLOWING: BETA BLOCKERS, TRICYCLIC ANTIDEPRESSANTS, OR VALPROIC ACID. OVERACTIVE BLADDER: TRIAL OF OR CONTRAINDICATION TO THE USE OF ONE ANTICHOLINERGIC MEDICATION SUCH AS ORAL OXYBUTYNIN, ORAL OXYBUTYNIN ER, TOLTERODINE, TOLTERODINE ER, TOVIAZ, TROSPIUM, OR TROSPIUM ER. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

## **BRIGATINIB**

#### **Products Affected**

- ALUNBRIG ORAL TABLET 180 MG, ALUNE 30 MG, 90 MG PACK
- ALUNBRIG ORAL TABLETS, DOSE PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **BRODALUMAB**

### **Products Affected**

• SILIQ

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: COSENTYX OR OTEZLA. PATIENT HAS BEEN COUNSELED ON AND EXPRESSES UNDERSTANDING OF THE RISK OF SUICIDAL IDEATION AND BEHAVIOR. RENEWAL: PATIENT HAS NOT DEVELOPED OR REPORTED WORSENING DEPRESSIVE SYMPTOMS OR SUICIDAL IDEATION AND BEHAVIORS WHILE ON TREATMENT WITH SILIQ.

# C1 ESTERASE INHIBITOR

#### **Products Affected**

CINRYZE

#### HAEGARDA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEMATOLOGIST, IMMUNOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	

# **CABOZANTINIB**

### **Products Affected**

· COMETRIQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **CABOZANTINIB S-MALATE - CABOMETYX**

#### **Products Affected**

 CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **CANAKINUMAB**

### **Products Affected**

• ILARIS (PF)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	CAPS: 4 YEARS AND OLDER. SJIA: 2 YEARS AND OLDER.
Prescriber Restrictions	PRESCRIBED OR SUPERVISED BY RHEUMATOLOGIST, DERMATOLOGIST, OR AN IMMUNOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	

# **CANNABINOIDS**

### **Products Affected**

dronabinol

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO CONVENTIONAL ANTIEMETIC THERAPIES SUCH AS ONDANSETRON, STEROIDS INDICATED FOR EMESIS OR EMEND. NO ADDITIONAL REQUIREMENTS FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS.

# **CANNABINOIDS ORAL SOLUTION**

### **Products Affected**

#### SYNDROS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO FORMULARY DRONABINOL CAPSULES AND ONE CONVENTIONAL ANTIEMETIC THERAPY SUCH AS ONDANSETRON, STEROIDS INDICATED FOR EMESIS OR APREPITANT. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS REQUIRES A TRIAL OF OR CONTRAINDICATION TO FORMULARY DRONABINOL CAPSULES.

# **CARFILZOMIB**

### **Products Affected**

KYPROLIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **CERITINIB**

### **Products Affected**

#### ZYKADIA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	POSITIVE FOR ANAPLASTIC LYMPHOMA KINASE (ALK) FUSION ONCOGENE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

## **CERTOLIZUMAB PEGOL**

#### **Products Affected**

#### CIMZIA

#### CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS. PSA/AS: 4 MONTHS. CD: 12 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL OF HUMIRA. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF HUMIRA AND ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.

# **CLOBAZAM**

### **Products Affected**

- ONFI ORAL SUSPENSION
- ONFI ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	2 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF LAMOTRIGINE OR TOPIRAMATE. REQUESTS FOR ORAL SUSPENSION APPROVABLE IF PATIENT IS UNABLE TO SWALLOW OR IS UNDER THE AGE OF 5 YEARS.

# **COBIMETINIB FUMARATE**

### **Products Affected**

· COTELLIC

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **COPANLISIB DI-HCL**

### **Products Affected**

· ALIQOPA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **CORTICOTROPIN**

### **Products Affected**

· ACTHAR H.P.

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INFANTILE SPASMS AND MULTIPLE SCLEROSIS: 28 DAYS. OTHER FDA APPROVED INDICATIONS:12 MONTHS.
Other Criteria	ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS REQUIRE A TRIAL OF OR CONTRAINDICATION TO IV CORTICOSTEROIDS. NOT APPROVED FOR DIAGNOSTIC PURPOSES.

# **CRIZOTINIB**

### **Products Affected**

XALKORI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **DABRAFENIB MESYLATE**

#### **Products Affected**

TAFINLAR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **DACLATASVIR**

### **Products Affected**

### DAKLINZA

PA Criteria	Criteria Details
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	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	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. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI, OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO APPROVALS FOR CONCURRENT USE WITH ANY OF THESE (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN.

# **DALFAMPRIDINE**

### **Products Affected**

### AMPYRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT IN WALKING ABILITY.

# **DARATUMUMAB**

### **Products Affected**

DARZALEX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **DASATINIB**

### **Products Affected**

 SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUSLY-TREATED CHRONIC MYELOID LEUKEMIA (CML) REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, T315A, F317L/V/I/C.

## **DEFERASIROX**

### **Products Affected**

- EXJADE
- JADENU

### • JADENU SPRINKLE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L. NON- TRANSFUSION DEPENDENT THALASSEMIA (NTDT) INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L AND LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L OR LIC OF 3 MG FE/G DRY WEIGHT OR GREATER

# **DEFERIPRONE**

### **Products Affected**

### • FERRIPROX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL CRITERIA: REQUIRES TRIAL OF EXJADE, JADENU, OR GENERIC DEFEROXAMINE AND ONE OF THE FOLLOWING CRITERIA 1) PHYSICIAN ATTESTATION THAT PATIENT IS EXPERIENCING INTOLERABLE TOXICITIES, CLINICALLY SIGNIFICANT ADVERSE EFFECTS, OR CONTRAINDICATION TO THESE THERAPIES OR 2) INADEQUATE CHELATION DEFINED BY ONE OF THE FOLLOWING: A) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 2500 MCG/L OR B) EVIDENCE OF CARDIAC IRON ACCUMULATION. RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L

# **DEFEROXAMINE**

### **Products Affected**

• deferoxamine

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	AT LEAST 3 YEARS OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000MCG/L RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L

### **DEFLAZACORT**

#### **Products Affected**

- EMFLAZA ORAL SUSPENSION
- MG, 36 MG, 6 MG
- EMFLAZA ORAL TABLET 18 MG, 30

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING DMD DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL CRITERIA: REQUIRE TRIAL OF PREDNISONE OR PREDNISOLONE FOR AT LEAST 6 MONTHS AND PATIENT MEETS ONE OF THE FOLLOWING:1) REQUEST DUE TO ADVERSE EFFECTS OF PREDNISONE OR PREDNISOLONE OR 2) REQUEST DUE TO LACK OF EFFICACY OF PREDNISONE OR PREDNISOLONE AND ALL OF THE FOLLOWING CRITERIA ARE MET: A) PATIENT IS NOT IN STAGE 1 (PRE-SYMPTOMATIC PHASE) B) STEROID MYOPATHY HAS BEEN RULED OUT C) PHYSICIAN ATTESTATION OF DETERIORATION IN AMBULATION, FUNCTIONAL STATUS, OR PULMONARY FUNCTION CONSISTENT WITH ADVANCING DISEASE. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION)

# **DELAFLOXACIN**

### **Products Affected**

• BAXDELA ORAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE MONTH
Other Criteria	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST OR ABSSSI ORGANISM ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO ONE PREFERRED FORMULARY STANDARD OF CARE AGENT OR IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED FORMULARY AGENTS: A PENICILLIN, A FLUOROQUINOLONE, A CEPHALOSPORIN, OR A GRAM POSITIVE TARGETING ANTIBIOTIC

# **DENOSUMAB-XGEVA**

### **Products Affected**

• XGEVA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **DESIRUDIN**

### **Products Affected**

• IPRIVASK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 MONTH
Other Criteria	

# **DEUTETRABENAZINE**

### **Products Affected**

 AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **DICHLORPHENAMIDE**

### **Products Affected**

#### KEVEYIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	HEPATIC INSUFFICIENCY, PULMONARY OBSTRUCTION, OR A HEALTH CONDITION THAT WARRANTS CONCURRENT USE OF HIGH-DOSE ASPIRIN
Required Medical Information	
Age Restrictions	18 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	INITIAL: 2 MONTHS RENEWAL: 12 MONTHS
Other Criteria	RENEWAL REQUIRES THE PATIENT EXPERIENCED AT LEAST TWO FEWER ATTACKS PER WEEK FROM THEIR BASELINE

# **DICLOFENAC EPOLAMINE**

### **Products Affected**

• FLECTOR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

## **DICLOFENAC TOPICAL**

#### **Products Affected**

- diclofenac sodium topical gel 3 % PENNSAID TOPICAL SOLUTION IN

### METERED-DOSE PUMP

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

## **DIMETHYL FUMARATE**

#### **Products Affected**

 TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **DINUTUXIMAB**

### **Products Affected**

UNITUXIN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **DROXIDOPA**

### **Products Affected**

### NORTHERA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE (LYING FACE UP) POSITION AT BASELINE AND RENEWAL.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF ORTHOSTATIC HYPOTENSION AS DOCUMENTED BY A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION. RENEWAL: PATIENT HAD AN INCREASE IN SYSTOLIC BLOOD PRESSURE FROM BASELINE OF AT LEAST 10 MMHG UPON STANDING FROM A SUPINE (LYING FACE UP) POSITION.

# **DUPILUMAB**

### **Products Affected**

### DUPIXENT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PATIENT HAS MINIMUM BODY SURFACE AREA (BSA) INVOLVEMENT OF AT LEAST 10%, ECZEMA AREA AND SEVERITY INDEX (EASI) SCORE OF AT LEAST 16, OR PHYSICIAN GLOBAL ASSESSMENT (PGA) SCORE OF AT LEAST 3. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL:12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: TOPICAL CORTICOSTEROIDS, TOPICAL CALCINEURIN INHIBITORS [E.G., ELIDEL (PIMECROLIMUS), GENERIC TACROLIMUS OINTMENT], OR TOPICAL PDE4 INHIBITOR [E.G., EUCRISA (CRISABOROLE)].

### **DURVALUMAB**

### **Products Affected**

IMFINZI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **EDARAVONE**

### **Products Affected**

#### · RADICAVA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### ELBASVIR/GRAZOPREVIR

### **Products Affected**

#### ZEPATIER

PA Criteria	Criteria Details
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.
Age Restrictions	
Prescriber Restrictions	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.

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO CONCURRENT USE OF SOVALDI AND ANY OF THE FOLLOWING AGENTS: PHENYTOIN, CARBAMAZEPINE, RIFAMPIN, EFAVIRENZ, ATAZANAVIR, DARUNAVIR,
	LOPINAVIR, SAQUINAVIR, TIPRANAVIR, CYCLOSPORINE, NAFCILLIN, KETOCONAZOLE, MODAFINIL, BOSENTAN, ETRAVIRINE, ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVI R, ATORVASTATIN AT DOSES GREATER THAN 20MG PER DAY OR ROSUVASTATIN AT DOSES GREATER THAN 10MG PER DAY.

### **ELIGLUSTAT TARTRATE**

#### **Products Affected**

· CERDELGA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **ELOSULFASE ALFA**

#### **Products Affected**

VIMIZIM

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME OF MEMBERSHIP IN PLAN.
Other Criteria	

### **ELOTUZUMAB**

#### **Products Affected**

• EMPLICITI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **ELTROMBOPAG**

### **Products Affected**

#### PROMACTA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ITP:INITIAL: 2MO.RENEW:AFTER RESPONSE:12MO, INADEQUATE DOSE:2MO.HCV:12MO.SEVERE APLASTIC ANEMIA:12MO
Other Criteria	CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ITP: RENEWAL: PATIENT HAS A CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10^9/L (GREATER THAN OR EQUAL TO 50,000 PER UL) AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS. HEPATITIS C: CONCURRENT INTERFERON THERAPY.

### **ENASIDENIB**

### **Products Affected**

• IDHIFA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **ENDOTHELIN RECEPTOR ANTAGONISTS**

#### **Products Affected**

- LETAIRIS
- · OPSUMIT
- TRACLEER ORAL TABLET
- TRACLEER ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. LETAIRIS: PATIENT DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS (IPF) TRACLEER: PATIENT DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASES IN BILIRUBIN BY 2 OR MORE TIMES ULN. PATIENT IS NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.

### **ENZALUTAMIDE**

### **Products Affected**

XTANDI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO ZYTIGA (ABIRATERONE ACETATE) IS ALSO REQUIRED IN PATIENTS WHO DO NOT HAVE A CONTRAINDICATION OR INTOLERANCE TO PREDNISONE.

### **EPOPROSTENOL IV**

### **Products Affected**

• epoprostenol (glycine)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	COVERED UNDER LOCAL COVERAGE POLICY OF APPLICABLE MEDICARE DMERC.
Required Medical Information	FORMULARY DRUG ADMINISTERED IN A LONG TERM CARE FACILITY TO A PATIENT WHOSE PART A COVERAGE HAS EXPIRED OR FORMULARY DRUG NOT ADMINISTERED VIA AN IMPLANTABLE PUMP OR AN EXTERNAL PUMP OR DRUG ADMINISTERED VIA AN IMPLANTABLE PUMP/AN EXTERNAL PUMP. DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT HAS SHOWN IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

### **ERLOTINIB**

#### **Products Affected**

 TARCEVA ORAL TABLET 100 MG, 150 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

## ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA

#### **Products Affected**

- EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML
- PROCRIT INJECTION SOLUTION

10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL ANEMIA IN HEPATITIS C BEING TREATED IN COMBINATION WITH RIBAVIRIN AND INTERFERON ALFA OR PEGINTERFERON ALFA.
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	
	HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE:12 MONTHS.SURGERY:1 MO.HCV:6 MOS.

PA Criteria	Criteria Details
Other Criteria	ALL INDICATIONS: TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

## ERYTHROPOIESIS STIMULATING AGENTS - MIRCERA

#### **Products Affected**

 MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 200 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC RENAL FAILURE REQUIRES HEMOGLOBIN LEVELS LESS THAN 10G/DL RENEWAL: CHRONIC RENAL FAILURE REQUIRES THAT THE PATIENT MEETS ONE OF THE FOLLOWING: IF THE PATIENT IS CURRENTLY RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 11G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 11G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. IF THE PATIENT IS NOT RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA DUE TO CKD WITH OR WITHOUT DIALYSIS: 12 MONTHS.
Other Criteria	TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

### **ETANERCEPT**

#### **Products Affected**

ENBREL

#### • ENBREL SURECLICK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, PSORIATIC ARTHRITIS: 18 YEARS OR OLDER
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS. PJIA: 3 MONTHS. PSA/AS/PSO: 4 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA, OR ACTEMRA.POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA OR ACTEMRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA, OTEZLA, OR COSENTYX. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA OR COSENTYX. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: COSENTYX OR OTEZLA.

### **ETEPLIRSEN**

### **Products Affected**

• EXONDYS 51

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING THAT MUTATION IN DUCHENNE MUSCULAR DYSTROPHY (DMD) GENE IS AMENABLE TO EXON 51 SKIPPING.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL CRITERIA: PATIENT IS AMBULATORY AND IS CURRENTLY RECEIVING TREATMENT WITH OR HAS A CONTRAINDICATION TO CORTICOSTEROIDS. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION) DURING THE PAST 24 WEEKS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

### **EVEROLIMUS**

#### **Products Affected**

AFINITOR DISPERZ

MG, 5 MG, 7.5 MG

• AFINITOR ORAL TABLET 10 MG, 2.5

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR.

### **EVOLOCUMAB**

#### **Products Affected**

- REPATHA PUSHTRONEX
- REPATHA SURECLICK

#### REPATHA SYRINGE

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	FOR HETEROZYGOUS FAMILIAL
	HYPERCHOLESTEROLEMIA (HEFH): MUST HAVE LDL
	LEVEL GREATER THAN 100MG/DL ON MAXIMAL DRUG
	TREATMENT (MDT) FOR AT LEAST 2 MONTHS WITHIN
	THE PAST 2 MONTHS AND ONE OF THE FOLLOWING: (1)
	HEFH DETERMINED BY SIMON BROOME DIAGNOSTIC
	(SBD) CRITERIA OR A SCORE OF 6 OR GREATER ON THE
	DUTCH LIPID NETWORK (DLN) CRITERIA. HOMOZYGOUS
	FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): LDL
	LEVEL GREATER THAN 100MG/DL ON MDT FOR AT LEAST
	2 MONTHS WITHIN THE PAST 2 MONTHS AND HOFH
	DETERMINED BY ONE OF THE FOLLOWING: 1) SBD
	CRITERIA, 2) A SCORE OF 8 OR GREATER ON THE DLN
	CRITERIA, OR 3) A CLINICAL DIAGNOSIS BASED ON A
	HISTORY OF AN UNTREATED LDL-C CONCENTRATION
	GREATER THAN 500 MG/DL TOGETHER WITH EITHER
	XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF
	HEFH IN BOTH PARENTS. NO CONCURRENT USE OF
	OTHER PCSK9 INHIBITORS. INITIAL THERAPY: FOR
	STATIN TOLERANT PATIENTS: MUST HAVE TRIED
	MAXIMALLY TOLERATED DOSE OF HIGH INTENSITY
	STATIN SUCH AS ATORVASTATIN OR ROSUVASTATIN.
	FOR STATIN INTOLERANT PATIENTS WITH HEFH: ONE OF
	THE FOLLOWING MUST BE MET: PHYSICIAN
	ATTESTATION OF STATIN INTOLERANCE (INCLUDING
	BUT NOT LIMITED TO MYOPATHY), OR PATIENT HAS
	TRIED ROSUVASTATIN OR ATORVASTATIN AT ANY DOSE.
	PATIENTS WITH CONTRAINDICATIONS TO STATINS INCLUDING ACTIVE DECOMPENSATED LIVER DISEASE,
	NURSING FEMALE, PREGNANCY OR PLANS TO BECOME
	PREGNANT OR HYPERSENSITIVITY REACTIONS WILL BE
	APPROVED FOR REPATHA THERAPY WITHOUT
	DOCUMENTED STATIN INTOLERANCE. FOR STATIN
	INTOLERANT PATIENTS WITH HOFH: MUST BE ON MAX
	LIPID-LOWERING THERAPY INCLUDING ONE OF THE
	FOLLOWING: NIACIN, BILE ACID SEQUESTRANT,
	LOMITAPIDE OR MIPOMERSEN. QUALIFIERS MUST
	PROVIDE DOCUMENTATION OF STATIN INTOLERANCE
	TO ONE OF THE FOLLOWING: A HIGH INTENSITY STATIN
	(ROSUVASTATIN OR ATORVASTATIN) OR OTHER STATIN
	THERAPY AT ANY DOSE. STATIN INTOLERANT PATIENTS
	MUST BE ON MAXIMAL LIPID-LOWERING MEDICATION
	(NON-STATIN THERAPY) FOR AT LEAST 2 MONTHS
	WITHIN THE PAST 2 MONTHS WITH DOCUMENTATION OF

PA Criteria	Criteria Details
	STATIN INTOLERANCE TO ATORVASTATIN OR ROSUVASTATIN OR STATIN THERAPY AT ANY DOSE. DOCUMENTATION OF STATIN INTOLERANCE INCLUDES: (1) PHYSICIAN ATTESTATION, OR (2) PATIENT HAS TRIED ROSUVASTATIN OR ATORVASTATIN AND HAS EXPERIENCED SKELETAL MUSCLE RELATED EVENTS (E.G. MYOPATHY). RENEWAL CRITERIA: RECEIVING PRIOR REPATHA THERAPY FOR AT LEAST 6 MONTHS AND NOT ON CONCURRENT THERAPY WITH OTHER PCSK9 INHIBITORS, MIPOMERSEN, OR LOMITAPIDE.

### FENTANYL NASAL SPRAY

### **Products Affected**

#### · LAZANDA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE ER, OXYCODONE ER, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES AND TRIAL OR CONTRAINDICATION TO GENERIC FENTANYL CITRATE LOZENGE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

#### **Products Affected**

• fentanyl citrate

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE ER, OXYCODONE ER, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

### **FINGOLIMOD**

#### **Products Affected**

• GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### FOSTAMATINIB DISODIUM

#### **Products Affected**

TAVALISSE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **GEFITINIB**

#### **Products Affected**

• IRESSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **GEMTUZUMAB OZOGAMICIN**

#### **Products Affected**

MYLOTARG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **GLATIRAMER ACETATE**

#### **Products Affected**

- glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml
- glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### GLECAPREVIR/PIBRENTASVIR

#### **Products Affected**

#### MAVYRET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
Exclusion Criteria	MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD PUGH B OR C)
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN 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	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
PA Criteria Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER 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 REGIMEN WITH NS5A INHIBITOR AND HCV PROTEASE INHIBITOR.

### **GLYCEROL PHENYLBUTYRATE**

#### **Products Affected**

RAVICTI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYLBUTYRATE (BUPHENYL).

### **GOLIMUMAB IV**

#### **Products Affected**

#### SIMPONI ARIA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS: PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA, OR ACTEMRA. PSORIATIC ARTHRITIS: PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA, OTEZLA, OR COSENTYX. ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA OR COSENTYX.

## **GOLIMUMAB SQ**

### **Products Affected**

· SIMPONI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS. PSA/AS: 4 MONTHS. UC: 12 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA OR ACTEMRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA, OTEZLA, OR COSENTYX. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA OR COSENTYX. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING CONVENTIONAL AGENTS SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDINSOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.

### **GUSELKUMAB**

### **Products Affected**

#### TREMFYA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: COSENTYX OR OTEZLA.

### HYDROXYPROGESTERONE CAPROATE-DELALUTIN GENERIC

### **Products Affected**

• hydroxyprogesterone caproate

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

### **IBRUTINIB**

### **Products Affected**

• IMBRUVICA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### IBUPROFEN-FAMOTIDINE

### **Products Affected**

DUEXIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF ONE OF THE FOLLOWING GENERIC, FEDERAL LEGEND HISTAMINE H2-RECEPTOR ANTAGONISTS: FAMOTIDINE, CIMETIDINE, NIZATIDINE, OR RANITIDINE, AND TRIAL OF GENERIC, FEDERAL LEGEND IBUPROFEN.

### **IDELALISIB**

### **Products Affected**

• ZYDELIG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **IMATINIB MESYLATE**

#### **Products Affected**

• imatinib oral tablet 100 mg, 400 mg

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ALL DIAGNOSES: 12 MONTHS. ADJUVANT GASTROINTESTINAL STROMAL TUMOR (GIST) TREATMENT: 36 MONTHS.
Other Criteria	PATIENTS WITH PREVIOUSLY-TREATED CML REQUIRE A BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT THE PATIENT IS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, F317L/V/I/C, Y253H, E255K/V, F359V/C/I.

## IMIQUIMOD - ALDARA

### **Products Affected**

• imiquimod

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACTINIC KERATOSIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. SUPERFICIAL BASAL CELL CARCINOMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR AN ONCOLOGIST.
Coverage Duration	4 MONTHS
Other Criteria	EXTERNAL GENITAL WARTS: TRIAL OF PODOFILOX (CONDYLOX) 0.5% TOPICAL SOLUTION. ACTINIC KERATOSIS BRAND DRUG REQUEST: TRIAL OF GENERIC IMIQUIMOD 5% CREAM. SUPERFICIAL BASAL CELL CARCINOMA: LESS THAN 2CM IN SIZE AND NOT ON THE FACE.

### **INFLIXIMAB**

### **Products Affected**

### · REMICADE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 % BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: CD/UC: 8 MO. RA: 6 MO. PSA/AS/PSO: 4 MO. RENEWAL FOR ALL INDICATIONS: 12 MO.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS
	TRIAL OF HUMIRA FOLLOWED BY ONE OF THE
	FOLLOWING: ORENCIA, XELJANZ, CIMZIA, OR ACTEMRA.
	PSORIATRIC ARTHRITIS (PSA): PREVIOUS TRIAL OF
	HUMIRA FOLLOWED BY ONE OF THE FOLLOWING:
	CIMZIA, OTEZLA, OR COSENTYX. ANKYLOSING
	SPONDYLITIS (AS): PREVIOUS TRIAL OF HUMIRA
	FOLLOWED BY CIMZIA OR COSENTYX. PLAQUE
	PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA
	FOLLOWED BY ONE OF THE FOLLOWING: COSENTYX OR
	OTEZLA. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF
	HUMIRA FOLLOWED BY CIMZIA. ULCERATIVE COLITIS
	(UC): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE
	OF THE FOLLOWING: SIMPONI OR ENTYVIO.

### **INFLIXIMAB-ABDA**

### **Products Affected**

#### RENFLEXIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: GASTROENTEROLOGIST.
Coverage Duration	INITIAL: CD/UC: 8 MOS. RA: 6 MOS. PSA/AS/PSO: 4 MOS. RENEWAL FOR ALL INDICATIONS: 12 MOS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS
	TRIAL OF HUMIRA FOLLOWED BY ONE OF THE
	FOLLOWING: ORENCIA, XELJANZ, CIMZIA, OR ACTEMRA.
	PSORIATRIC ARTHRITIS (PSA): PREVIOUS TRIAL OF
	HUMIRA FOLLOWED BY ONE OF THE FOLLOWING:
	CIMZIA, OTEZLA, OR COSENTYX. ANKYLOSING
	SPONDYLITIS (AS): PREVIOUS TRIAL OF HUMIRA
	FOLLOWED BY CIMZIA OR COSENTYX. PLAQUE
	PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA
	FOLLOWED BY ONE OF THE FOLLOWING: COSENTYX OR
	OTEZLA. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF
	HUMIRA FOLLOWED BY CIMZIA. ULCERATIVE COLITIS
	(UC): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE
	OF THE FOLLOWING: SIMPONI OR ENTYVIO.

### **INFLIXIMAB-DYYB**

### **Products Affected**

### INFLECTRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY GIVEN OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: GASTROENTEROLOGIST.
Coverage Duration	INITIAL: CD/UC: 8 MOS. RA: 6 MOS. PSA/AS/PSO: 4 MOS. RENEWAL FOR ALL INDICATIONS: 12 MOS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: ORENCIA, XELJANZ, CIMZIA, OR ACTEMRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: CIMZIA, OTEZLA, OR COSENTYX. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: CIMZIA OR COSENTYX. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: COSENTYX OR OTEZLA. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY CIMZIA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING: SIMPONI OR ENTYVIO.

### **INOTUZUMAB OZOGAMICIN**

### **Products Affected**

BESPONSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **INTERFERON ALFA-2B**

### **Products Affected**

• INTRON A INJECTION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. FOR USE TO TREAT HEPATITIS C, CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEPATITIS C: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST). NO REQUIREMENT FOR OTHER FDA APPROVED INDICATIONS.
Coverage Duration	6 MONTHS
Other Criteria	LIMITED TO 1 YEAR OF THERAPY EXCEPT 18 MONTHS FOR FOLLICULAR LYMPHOMA. HEPATITIS C GENOTYPE 1, 2, 3, 4, 5, OR 6: REQUIRES A TRIAL OF OR CONTRAINDICATION TO PEGINTERFERON ALFA-2A OR PEGINTERFERON ALFA-2B USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED.

# INTERFERONS FOR MS-AVONEX, PLEGRIDY, REBIF

#### **Products Affected**

- AVONEX (WITH ALBUMIN)
- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- PLEGRIDY
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

## INTERFERONS FOR MS-BETASERON, EXTAVIA

#### **Products Affected**

• BETASERON SUBCUTANEOUS KIT • EXTAVIA SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	TRIAL WITH TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, AND GLATIRAMER
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **IPILIMUMAB**

### **Products Affected**

YERVOY

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: UNRESECTABLE/MET MELANOMA: 4 MO, RCC: 3 MO. CUTANEOUS MELANOMA: INITIAL AND RENEWAL: 6 MO
Other Criteria	RENEWAL FOR ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS).

### **IVABRADINE**

### **Products Affected**

### · CORLANOR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PATIENT MUST HAVE NEW YORK HEART ASSOCIATION (NYHA) CLASS II TO IV HEART FAILURE
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: APPROVAL REQUIRES THE PATIENT DOES NOT HAVE A DEMAND PACEMAKER SET TO A RATE OF 60 BEATS PER MINUTE OR GREATER. PATIENT IS CURRENTLY RECEIVING TREATMENT WITH OR HAS AN INTOLERANCE TO A FORMULARY BETA BLOCKER SUCH AS METOPROLOL SUCCINATE, BISOPROLOL, OR CARVEDILOL. RENEWAL: APPROVAL REQUIRES DIAGNOSIS OF HEART FAILURE AND PATIENT MUST BE IN SINUS RHYTHM.

### **IVACAFTOR**

### **Products Affected**

### KALYDECO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE.
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	6 YEARS OF AGE OR OLDER.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **IVACAFTOR - GRANULE PACKETS**

### **Products Affected**

#### KALYDECO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	F508DEL MUTATION IN CFTR GENE.
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	2 YEARS OF AGE TO 5 YEARS OF AGE
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **IXAZOMIB**

### **Products Affected**

NINLARO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **IXEKIZUMAB**

### **Products Affected**

TALTZ AUTOINJECTOR

#### TALTZ SYRINGE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL (FOR ALL INDICATIONS): PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	PLAQUE PSORIASIS (PSO) AND PSORIATIC ARTHRITIS (PSA): INITIAL 4 MONTHS, RENEWAL 12 MONTHS.
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: COSENTYX OR OTEZLA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA, OTEZLA, OR COSENTYX.

### LEDIPASVIR-SOFOSBUVIR

### **Products Affected**

#### HARVONI

PA Criteria	Criteria Details
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	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber	GASTROENTEROLOGIST, INFECTIOUS DISEASE
Restrictions	SPECIALIST, PHYSICIAN SPECIALIZING IN THE
	TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A
	SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION
	FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage	CRITERIA WILL BE APPLIED CONSISTENT WITH
Duration	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:
	CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL,
	OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE,
	ROSUVASTATIN, SIMEPREVIR, SOFOSBUVIR (AS A SINGLE
	AGENT), STRIBILD
	(ELVITEGRAVIR/COBICISTAT/EMTRICITABINE
	/TENOFOVIR), OR TIPRANAVIR/RITONAVIR.

### **LENALIDOMIDE**

### **Products Affected**

• REVLIMID

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### LENVATINIB MESYLATE

#### **Products Affected**

LENVIMA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **LETERMOVIR**

#### **Products Affected**

PREVYMIS INTRAVENOUS
 ML
 SOLUTION 240 MG/12 ML, 480 MG/24
 PREVYMIS ORAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 MONTHS
Other Criteria	

### **L-GLUTAMINE**

### **Products Affected**

ENDARI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	INITIAL CRITERIA FOR ADULTS (18 YEARS OR OLDER): PHYSICIAN ATTESTATION OF ONE OF THE FOLLOWING: (1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR OR (2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING OR (3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME (ACS). INITIAL REQUESTS FOR PATIENTS BETWEEN THE AGES OF 5-17 WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA. RENEWAL FOR ALL PATIENTS: PHYSICIAN ATTESTATION THAT PATIENT HAS MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE.

### **LIDOCAINE**

### **Products Affected**

lidocaine topical adhesive patch,medicated
 lidocaine topical ointment

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL COVERAGE FOR DIABETIC NEUROPATHY WILL BE CONSIDERED FOR REQUESTS FOR LIDOCAINE TOPICAL PATCHES.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PATCH: 12 MONTHS. OINTMENT: 3 MONTHS.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

### LIFITEGRAST OPHTHALMIC

### **Products Affected**

#### XIIDRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN OPHTHALMOLOGIST, OPTOMETRIST OR RHEUMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO CYCLOSPORINE OPHTHALMIC (RESTASIS).

### **LOMITAPIDE**

### **Products Affected**

 JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LDL CHOLESTEROL LEVEL, LDL RECEPTOR STATUS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST.
Coverage Duration	INITIAL: 7 MONTHS RENEWAL: 6 MONTHS

PA Criteria	Criteria Details
Other Criteria	DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: SIMON BROOME DIAGNOSTIC CRITERIA (DEFINITE), (E.G. GENETIC TESTING CONSISTENT WITH HOPH AND PRETREATMENT BASELINE LDL CHOLESTEROL IS GREATER THAN 190 MG/DL), CASCADE SCREENING, DUTCH LIPID NETWORK CRITERIA WITH A SCORE OF AT LEAST 6, OR HISTORY OF UNTREATED CHOLESTEROL GREATER THAN 500MG/DL) (OR TREATED CHOLESTEROL GREATER THAN 500MG/DL) AND CUTANEOUS XANTHOMA BEFORE 10 YEARS OF AGE. LOMITAPIDE WILL NOT BE APPROVED FOR PATIENTS CONCURRENTLY USING ANY OF THE FOLLOWING STRONG OR MODERATE CYP3A4 MEDICATIONS: CLARITHROMYCIN, CONIVAPTAN, INDINAVIR, ITRACONAZOLE, KETOCONAZOLE, LOPINAVIR/RITONAVIR, MIBEFRADIL, NEFAZODONE, NELFINAVIR, POSACONAZOLE, RITONAVIR, SAQUINAVIR, TELITHROMYCIN, TIPRANAVIR/RITONAVIR, VORICONAZOLE, AMPRENAVIR, APREPITANT, ATAZANAVIR, CIPROFLOXACIN, CRIZOTINIB, DARUNAVIR/RITONAVIR, DILTIAZEM, ERYTHROMYCIN, FLUCONAZOLE, FOSAMPRENAVIR, IMATINIB, OR VERAPAMIL. INITIAL: LDL CHOLESTEROL LEVEL OF AT LEAST 160MG/DL WHILE ON LIPID-LOWERING THERAPY PRIOR TO INITIATING LOMITAPIDE. PREVIOUS TRIAL OF A PCSK9 INHIBITOR (E.G. ALIROCUMAB OR EVOLOCUMAB), UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. PREVIOUS TRIAL OF ROSUVASTATIN OR ATORVASTATIN, UNLESS THE PATIENT HAS AN ABSOLUTE CONTRAINDICATION TO STATIN THEREPY (E.G. ACTIVE, DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTION), STATIN-TOLERANT PATIENTS MUST BE TAKING ATORVASTATIN OR ROSUVASTATIN FOR THE PAST 2 MONTHS PRIOR TO STARTING LOMITAPIDE. LOMITAPIDE MUST BE USED IN COMBINATION WITH ATORVASTATIN OR ROSUVASTATIN, FOR THE PAST 2 MONTHS PRIOR TO STARTING LOMITAPIDE. LOMITAPIDE MUST BE USED IN COMBINATION WITH ATORVASTATIN OR ROSUVASTATIN, IF THE PATIENT HAS PREVIOUSLY TRIED ATORVASTATIN OR ROSUVASTATIN, LOMITAPIDE MUST BE USED IN COMBINATION WITH ANOTHER STATIN OR FORMULARY LDL-LOWERING AGENT (E.G. BILE ACID SEQUESTRANT, GEMFIBROZIL OR OTHER FIBRATE, EZETIMIBE, OR NIACIN). STATIN-INTOLERANT PATIENTS REQUIRE EITHER PHYSICIAN ATTESTATION OF

PA Criteria	Criteria Details
	STATIN INTOLERANCE OR HISTORY OF SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY) DUE TO A PREVIOUS TRIAL OF STATINS (E.G. ROSUVASTATIN OR ATORVASTATIN). FOR STATIN-INTOLERANT PATIENTS, LOMITAPIDE MUST BE USED IN COMBINATION WITH ONE OF THE FOLLOWING FORMULARY LIPID-LOWERING TREATMENTS: EZETIMIBE, FENOFIBRATE, NIACIN, OR A BILE ACID SEQUESTRANT (E.G. CHOLESTYRAMINE, COLESTIPOL, COLESEVELAM). RENEWAL: PATIENT HAS RECEIVED AT LEAST 6 MONTHS OF THERAPY WITH LOMITAPIDE IN COMBINATION WITH ANOTHER AND LIPID-LOWERING AGENT.

### **LUMACAFTOR-IVACAFTOR**

### **Products Affected**

#### ORKAMBI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL 12 MONTHS.
Other Criteria	RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS OR IMPROVEMENT IN BODY MASS INDEX (BMI).

### **MEPOLIZUMAB**

### **Products Affected**

NUCALA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	SEVERE ASTHMA: CONCURRENT USE OF XOLAIR.
Required Medical Information	SEVERE ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE LAST 6 WEEKS OR GREATER THAN OR EQUAL TO 300 CELLS/MCL WITHIN THE LAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	SEVERE ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE, AN ALLERGIST OR AN IMMUNOLOGIST.
Coverage Duration	INITIAL: SEVERE ASTHMA: 24 WEEKS. EGPA: 12 MONTHS. RENEWAL FOR ALL INDICATIONS: 12 MONTHS.
Other Criteria	INITIAL THERAPY: SEVERE ASTHMA: PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION WHICH INCLUDES ANY OF THE FOLLOWING: LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, OR ORAL CORTICOSTEROID. RENEWAL: SEVERE ASTHMA: REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED IMPROVEMENT IN ASTHMA EXACERBATIONS FROM BASELINE (PHYSICIAN ATTESTATION) AND A REDUCTION IN ORAL CORTICOSTEROID DOSE (IF THE PATIENT WAS ON A MAINTENANCE REGIMEN OF ORAL CORTICOSTEROIDS AT THE INITIATION OF TREATMENT).

### **METHYLNALTREXONE**

#### **Products Affected**

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	ADVANCED ILLNESS: OPIOID-INDUCED CONSTIPATION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS FOR PATIENTS RECEIVING PALLIATIVE CARE,12 MONTHS FOR PATIENTS WITH CHRONIC,NON-CANCER PAIN.
Other Criteria	ADVANCED ILLNESS: PATIENT IS RECEIVING PALLIATIVE CARE. CHRONIC NON-CANCER PAIN: PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) OR LUBIPROSTONE (AMITIZA).

# METHYLNALTREXONE ORAL

#### **Products Affected**

· RELISTOR ORAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) OR LUBIPROSTONE (AMITIZA).

# **MIDOSTAURIN**

### **Products Affected**

RYDAPT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS
Other Criteria	

# **MIFEPRISTONE**

#### **Products Affected**

KORLYM

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **MILTEFOSINE**

#### **Products Affected**

• IMPAVIDO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **MIPOMERSEN**

#### **Products Affected**

#### KYNAMRO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LDL CHOLESTEROL LEVEL, LDL RECEPTOR STATUS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	INITIAL: 7 MONTHS RENEWAL 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	DIAGNOSIS OF HOMOZYGOUS FAMILIAL
	HYPERCHOLESTEROLEMIA AS DETERMINED BY ONE OF
	THE FOLLOWING CRITERIA: SIMON BROOME
	DIAGNOSTIC CRITERIA (DEFINITE) [EXAMPLE: GENETIC
	TESTING CONSISTENT WITH HOFH AND PRETREATMENT
	BASELINE LDL CHOLESTEROL IS GREATER THAN 190
	MG/DL], CASCADE SCREENING, DUTCH LIPID NETWORK
	CRITERIA WITH A SCORE AT LEAST 6, OR HISTORY OF
	UNTREATED CHOLESTEROL GREATER THAN 500MG/DL
	(OR TREATED GREATER THAN 300MG/DL) AND
	CUTANEOUS XANTHOMA BEFORE AGE 10. INITIAL
	CRITERIA: CURRENT LDL CHOLESTEROL LEVEL IS AT
	LEAST 160MG/DL. PATIENT DOES NOT HAVE ANY OF THE
	FOLLOWING CONTRAINDICATIONS TO KYNAMRO
	(MIPOMERSEN): MODERATE OR SEVERE HEPATIC
	IMPAIRMENT OR ACTIVE LIVER DISEASE, INCLUDING
	UNEXPLAINED PERSISTENT ELEVATIONS OF SERUM
	TRANSAMINASES. PREVIOUS TRIAL OF A PCSK9
	INHIBITOR (SUCH AS ALIROCUMAB OR EVOLOCUMAB)
	UNLESS THE PATIENT HAS NON-FUNCTIONING LDL
	RECEPTORS. PREVIOUS TRIAL WITH ONE OF THE FOLLOWING STATINS: ROSUVASTATIN OR
	ATORVASTATIN. PATIENTS WITH ABSOLUTE
	CONTRAINDICATION TO STATIN THERAPY (ACTIVE,
	DECOMPENSATED LIVER DISEASE, NURSING FEMALE,
	PREGNANCY OR PLANS TO BECOME PREGNANT,
	HYPERSENSITIVITY REACTION) WILL BE APPROVED FOR
	THERAPY WITHOUT REQUIREMENT OF A TRIAL WITH A
	STATIN. STATIN-TOLERANT PATIENTS: PRIOR TO
	(KYNAMRO), PATIENT MUST HAVE BEEN TAKING ONE OF
	THE FOLLOWING: ATORVASTATIN OR ROSUVASTATIN,
	FOR AT LEAST 2 MONTHS WITHIN THE PAST 2 MONTHS.
	FOR STATIN-INTOLERANT PATIENTS: DOCUMENTATION
	OF STATIN INTOLERANCE WHICH INCLUDES THE
	FOLLOWING: PHYSICIAN ATTESTATION OR PATIENT HAS
	TRIED ROSUVASTATIN OR ATORVASTATIN AND HAS
	EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS
	(E.G., MYOPATHY). UNLESS CONTRAINDICATED,
	COLESTIPOL, COLESEVELAMIJ). KENEWAL CRITERIA:
	FOR AT LEAST 2 MONTHS WITHIN THE PAST 2 MONTHS. FOR STATIN-INTOLERANT PATIENTS: DOCUMENTATION OF STATIN INTOLERANCE WHICH INCLUDES THE FOLLOWING: PHYSICIAN ATTESTATION OR PATIENT HAS TRIED ROSUVASTATIN OR ATORVASTATIN AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS

PA Criteria	Criteria Details
	PATIENT HAS RECEIVED THERAPY FOR AT LEAST 6 MONTHS AND MUST ALSO BE TAKING KYNAMRO IN COMBINATION WITH ANOTHER LIPID-LOWERING AGENT.

# NAPROXEN- ESOMEPRAZOLE

#### **Products Affected**

VIMOVO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF ONE OF THE FOLLOWING GENERIC, FEDERAL LEGEND PROTON PUMP INHIBITORS: OMEPRAZOLE, LANSOPRAZOLE, OR PANTOPRAZOLE AND A TRIAL OF GENERIC, FEDERAL LEGEND NAPROXEN.

# **NATALIZUMAB**

### **Products Affected**

#### TYSABRI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	MULTIPLE SCLEROSIS: 12 MONTHS. CROHN'S DISEASE: INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	MULTIPLE SCLEROSIS INITIAL CRITERIA: PREVIOUS TRIAL OF TWO OF THE FOLLOWING PREFERRED AGENTS FOR MULTIPLE SCLEROSIS: GLATIRAMER, REBIF, AVONEX, PLEGRIDY, TECFIDERA, GILENYA, OR AUBAGIO. CROHN'S DISEASE INITIAL CRITERIA: PREVIOUS TRIAL OF HUMIRA AND CIMZIA. CROHN'S DISEASE RENEWAL CRITERIA: PATIENT HAS RECEIVED AT LEAST 12 MONTHS OF THERAPY WITH TYSABRI WITH PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT REQUIRED MORE THAN 3 MONTHS OF CORTICOSTEROID USE WITHIN THE PAST 12 MONTHS TO CONTROL THEIR CROHN'S DISEASE WHILE ON TYSABRI, OR PATIENT HAS ONLY RECEIVED 6 MONTHS OF THERAPY WITH TYSABRI WITH PHYSICIAN ATTESTATION THAT THE PATIENT HAS TAPERED OFF CORTICOSTEROIDS DURING THE FIRST 24 WEEKS OF TYSABRI THERAPY.

# **NECITUMUMAB**

#### **Products Affected**

PORTRAZZA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **NERATINIB MALEATE**

#### **Products Affected**

NERLYNX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	EARLY-STAGE TUMOR (STAGE I-III) AND TUMOR IS HORMONE-RECEPTOR POSITIVE AND THE MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE

### **NILOTINIB**

#### **Products Affected**

 TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUSLY TREATED CML REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, Y253H, E255K/V, AND F359V/C/I.

# **NINTEDANIB**

#### **Products Affected**

• OFEV

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER. NOT APPROVED IF PATIENT DOES NOT HAVE A PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50 PERCENT OR HAS NOT OBTAINED LIVER FUNCTION TESTS
Required Medical Information	A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	

# **NIRAPARIB TOSYLATE**

#### **Products Affected**

· ZEJULA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **NITISINONE**

#### **Products Affected**

#### ORFADIN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF HEREDITARY TYROSINEMIA TYPE 1 AS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	ORFADIN SUSPENSION: TRIAL OF ORFADIN CAPSULES. RENEWAL: THE PATIENT'S URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.

# **NIVOLUMAB**

### **Products Affected**

OPDIVO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MELANOMA: OPDIVO IS NOT APPROVED FOR COMBINATION THERAPY WITH TAFINLAR, MEKINIST (TRAMETINIB), COTELLIC (COBIMETINIB), OR ZELBORAF.

# **OBETICHOLIC ACID**

### **Products Affected**

· OCALIVA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PATIENTS WITH COMPLETE BILIARY OBSTRUCTION.
Required Medical Information	DIAGNOSIS OF PRIMARY BILIARY CHOLANGITIS AS CONFIRMED BY AT LEAST TWO OF THE FOLLOWING CRITERIA: AN ALKALINE PHOSPHATASE LEVEL OF AT LEAST 1.5 TIMES THE UPPER LIMIT OF NORMAL (ULN), THE PRESENCE OF ANTIMITOCHONDRIAL ANTIBODIES AT A TITER OF 1:40 OR HIGHER, HISTOLOGIC EVIDENCE OF NON-SUPPURATIVE DESTRUCTIVE CHOLANGITIS AND DESTRUCTION OF INTERLOBULAR BILE DUCTS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST OR HEPATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: USED IN COMBINATION WITH URSODEOXYCHOLIC ACID (E.G., URSODIOL, URSO 250, URSO FORTE) IN ADULTS WITH AN INADEQUATE RESPONSE TO URSODEOXYCHOLIC ACID AT A DOSAGE OF 13-15 MG/KG/DAY FOR AT LEAST 1 YEAR, OR AS MONOTHERAPY IN ADULTS UNABLE TO TOLERATE URSODEOXYCHOLIC ACID. RENEWAL: PATIENT'S ALKALINE PHOSPHATASE LEVELS ARE LESS THAN 1.67-TIMES THE UPPER LIMIT OF NORMAL OR HAVE DECREASED BY AT LEAST 15% FROM BASELINE WHILE ON TREATMENT WITH OBETICHOLIC ACID.

# **OBINUTUZUMAB**

#### **Products Affected**

• GAZYVA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	

# **OCRELIZUMAB**

### **Products Affected**

OCREVUS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS: TRIAL OF TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, OR GLATIRAMER. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

### **OLAPARIB**

#### **Products Affected**

- LYNPARZA ORAL CAPSULE
- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **OLARATUMAB**

### **Products Affected**

#### · LARTRUVO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION.

# **OMACETAXINE**

### **Products Affected**

• SYNRIBO

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INDUCTION: 3 MONTHS. POST INDUCTION OR RENEWAL: 3 TO 12 MONTHS
Other Criteria	CML INDUCTION THERAPY: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING AGENTS: GLEEVEC, SPRYCEL, TASIGNA, BOSULIF OR ICLUSIG. APPROVAL FOR POST-INDUCTION THERAPY DURATION WILL DEPEND ON THE PATIENT'S HEMATOLOGIC RESPONSE, DEFINED AS AN ABSOLUTE NEUTROPHIL COUNT (ANC) GREATER THAN OR EQUAL TO 1.5 X 10^9/L, PLATELETS GREATER THAN OR EQUAL TO 100 X 10^9/L WITHOUT BLOOD BLASTS OR THE PATIENT HAS BONE MARROW BLASTS AT LESS THAN 5 PERCENT. APPROVAL IS FOR 12 MONTHS IF HEMATOLOGIC RESPONSE IS MET. IF NOT MET, APPROVAL IS FOR 3 MONTHS.

# **OMALIZUMAB**

### **Products Affected**

XOLAIR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL CRITERIA FOR ASTHMA: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, FEV1 LESS THAN 80%, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30IU/ML. RENEWAL CRITERIA FOR ASTHMA: PHYSICIAN ATTESTATION OF IMPROVEMENT IN ASTHMA EXACERBATIONS FROM BASELINE OR A REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A SPECIALIST IN ALLERGY, PULMONARY MEDICINE, DERMATOLOGY OR IMMUNOLOGY.
Coverage Duration	INITIAL: ASTHMA: 12 MOS. CHRONIC IDIOPATHIC URTICARIA: 6 MOS. RENEWAL FOR ALL INDICATIONS: 12 MOS.
Other Criteria	FOR CHRONIC IDIOPATHIC URTICARIA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO A MAXIMALLY TOLERATED DOSE OF AN H1 ANTI-HISTAMINE (SUCH AS CLARINEX OR XYZAL) AND PATIENT STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK.

# **OMBITASVIR-PARITAPREVIR-RITONAVIR**

#### **Products Affected**

#### TECHNIVIE

PA Criteria	Criteria Details
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	DECOMPENSATED CIRRHOSIS, MODERATE OR SEVERE
Criteria	LIVER IMPAIRMENT (CHILD-PUGH B OR C).
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber	GASTROENTEROLOGIST, INFECTIOUS DISEASE
Restrictions	SPECIALIST, PHYSICIAN SPECIALIZING IN THE
	TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A
	SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION
	FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage	CRITERIA WILL BE APPLIED CONSISTENT WITH
Duration	CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH
	CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A
	PREFERRED FORMULARY ALTERNATIVE INCLUDING
	HARVONI OR EPCLUSA WHEN THESE AGENTS ARE
	CONSIDERED ACCEPTABLE FOR TREATMENT OF THE
	SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. MUST
	BE USED CONCURRENTLY WITH 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 THREE TIMES DAILY FOR PAH), TRIAZOLAM,
	ORAL MIDAZOLAM, LOPINAVIR/RITONAVIR,
	RILPIVIRINE, SALMETEROL.

# OMBITASVIR-PARITAPREVIR-RITONAVIR-DASABUVIR

#### **Products Affected**

VIEKIRA PAK

#### • VIEKIRA XR

PA Criteria	Criteria Details
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	DECOMPENSATED CIRRHOSIS, MODERATE OR SEVERE
Criteria	LIVER IMPAIRMENT (CHILD-PUGH B OR C).
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber	GASTROENTEROLOGIST, INFECTIOUS DISEASE
Restrictions	SPECIALIST, PHYSICIAN SPECIALIZING IN THE
	TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A
	SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION
	FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage	CRITERIA WILL BE APPLIED CONSISTENT WITH
Duration	CURRENT AASLD/IDSA GUIDANCE.

CUR PREI HAR CON SPEC PATI FOLI PHEI RIFA ERG ESTE COM EVR JOHI EFA DAR	TERIA WILL BE APPLIED CONSISTENT WITH RENT AASLD/IDSA GUIDANCE. TRIAL OF A FERRED FORMULARY ALTERNATIVE INCLUDING VONI OR EPCLUSA WHEN THESE AGENTS ARE SIDERED ACCEPTABLE FOR TREATMENT OF THE CIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. ENT IS NOT CONCURRENTLY TAKING ANY OF THE LOWING: ALFUZOSIN, CARBAMAZEPINE, NYTOIN, PHENOBARBITAL, GEMFIBROZIL, AMPIN, ERGOTAMINE, DIHYDROERGOTAMINE, ONOVINE, METHYLERGONOVINE, ETHINYL RADIOL CONTAINING MEDICATIONS (SUCH AS IBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO A OR XULANE TRANSDERMAL PATCH SYSTEM), ST. N'S WORT, LOVASTATIN, SIMVASTATIN, PIMOZIDE, VIRENZ, REVATIO, TRIAZOLAM, ORAL MIDAZOLAM, UNAVIR/RITONAVIR, LOPINAVIR/RITONAVIR, TVIRINE, SALMETEROL.

# **OSIMERTINIB**

### **Products Affected**

· TAGRISSO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	METASTATIC NSCLC WITH EGFR T790M MUTATION: CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **OXYMETHOLONE**

#### **Products Affected**

• ANADROL-50

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	CARCINOMA OF THE PROSTATE OR BREAST IN MALE PATIENTS, CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, WOMEN WHO ARE OR MAY BECOME PREGNANT, NEPHROSIS OR THE NEPHROTIC PHASE OF NEPHRITIS, HYPERSENSITIVITY TO THE DRUG AND SEVERE HEPATIC DYSFUNCTION.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **PALBOCICLIB**

### **Products Affected**

• IBRANCE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **PALIVIZUMAB**

#### **Products Affected**

#### SYNAGIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	GESTATIONAL AGE
Age Restrictions	LESS THAN 24 MONTHS OF AGE.
Prescriber Restrictions	
Coverage Duration	1 MONTH TO 5 MONTHS. SEE OTHER CRITERIA FOR MORE INFORMATION.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT RECOMMENDATIONS FROM THE AMERICAN ACADEMY OF PEDIATRICS FOR PALIVIZUMAB PROPHYLAXIS FOR RESPIRATORY SYNCYTIAL VIRUS INFECTIONS. INITIAL: APPROVAL WILL BE FOR AT LEAST 1 MONTH AND NO GREATER THAN 5 MONTHS DEPENDENT UPON REMAINING LENGTH OF RESPIRATORY SYNCYTIAL VIRUS (RSV) SEASON. RENEWAL: ADDITIONAL 1 MONTH OF TREATMENT FOR CARDIOPULMONARY BYPASS SURGERY DURING RSV PROPHYLAXIS SEASON.

# **PANITUMUMAB**

#### **Products Affected**

VECTIBIX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **PANOBINOSTAT**

#### **Products Affected**

#### FARYDAK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: PATIENT HAS TOLERATED THE FIRST 8 CYCLES OF THERAPY WITHOUT UNRESOLVED SEVERE OR MEDICALLY SIGNIFICANT TOXICITY.

# PARATHYROID HORMONE

#### **Products Affected**

NATPARA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **PAZOPANIB**

#### **Products Affected**

VOTRIENT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

#### **Products Affected**

ADCIRCA

• sildenafil (antihypertensive) oral

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE
	EXCLUDED FROM PART D.
Exclusion	PATIENT CANNOT CONCURRENTLY OR
Criteria	INTERMITTENTLY BE TAKING ORAL ERECTILE
	DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY
	ORGANIC NITRATES IN ANY FORM, OR GUANYLATE
	CYCLASE (GC) STIMULATORS (ADEMPAS).
Required Medical	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL
Information	HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT
	HEART CATHETERIZATION. PATIENT HAS NYHA-WHO
	FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	
Prescriber	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A
Restrictions	CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP)
	OF AT LEAST 25 MMHG OR GREATER, PULMONARY
	CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR
	LESS, PULMONARY VASCULAR RESISTANCE (PVR)
	GREATER THAN 3 WOOD UNITS. REQUEST FOR ADCIRCA
	REQUIRE TRIAL OR CONTRAINDICATION TO REVATIO.
	RENEWAL: PATIENT SHOWS IMPROVEMENT FROM
	BASELINE IN THE 6-MINUTE WALK DISTANCE OR
	PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE
	WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION - IV

#### **Products Affected**

• sildenafil (antihypertensive) intravenous

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PATIENT CANNOT CONCURRENTLY OR INTERMITTENTLY BE TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE (GC) STIMULATORS (ADEMPAS).
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6- MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6- MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

# **PEG-INTERFERON ALFA-2B-SYLATRON**

#### **Products Affected**

SYLATRON

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	OVERALL DURATION OF THERAPY LIMITED TO 5 YEARS.

# **PEMBROLIZUMAB**

#### **Products Affected**

KEYTRUDA INTRAVENOUS RECON
 SOLN
 KEYTRUDA INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **PENICILLAMINE**

#### **Products Affected**

#### • CUPRIMINE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	RHEUMATOID ARTHRITIS: HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	WILSON'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST. CYSTINURIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	WILSON'S DISEASE: GENETIC TESTING FOR ATP7B MUTATIONS. CYSTINURIA: DIAGNOSIS REQUIRES THE PRESENCE OF NEPHROLITHIASIS AND 1 OR MORE OF THE FOLLOWING: STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN. REQUESTS FOR CUPRIMINE FOR THE TREATMENT OF WILSONS DISEASE, CYSTINURIA, AND RHEUMATOID ARTHRITIS REQUIRE A PREVIOUS TRIAL OF OR CONTRAINDICATION TO DEPEN.

# PENICILLAMINE-DEPEN

#### **Products Affected**

#### • DEPEN TITRATABS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	RHEUMATOID ARTHRITIS: HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	WILSON'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST. CYSTINURIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	WILSON'S DISEASE: GENETIC TESTING FOR ATP7B MUTATIONS. CYSTINURIA: DIAGNOSIS REQUIRES THE PRESENCE OF NEPHROLITHIASIS AND 1 OR MORE OF THE FOLLOWING: STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN.

# **PERTUZUMAB**

### **Products Affected**

• PERJETA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 5 MONTHS RENEWAL: 12 MONTHS
Other Criteria	

# **PIMAVANSERIN**

#### **Products Affected**

NUPLAZID

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (SUCH AS A PSYCHIATRIST).
Coverage Duration	INITIAL 12 MONTHS. RENEWAL 12 MONTHS.
Other Criteria	RENEWAL REQUIRES THAT THE PATIENT HAS EXPERIENCED AN IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.

# **PIRFENIDONE**

#### **Products Affected**

• ESBRIET ORAL CAPSULE

MG

• ESBRIET ORAL TABLET 267 MG, 801

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE
	EXCLUDED FROM PART D.
Exclusion	PATIENTS WITH KNOWN CAUSES OF INTERSTITIAL LUNG
Criteria	DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG
	TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE,
	HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC
	SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION,
	SARCOIDOSIS, BRONCHIOLITIS OBLITERANS
	ORGANIZING PNEUMONIA, HUMAN
	IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL
	HEPATITIS, AND CANCER). NOT APPROVED IF THE
	PATIENT HAS NOT OBTAINED LIVER FUNCTION TESTS.
Required Medical	PATIENT WITH USUAL INTERSTITIAL PNEUMONIA (UIP)
Information	PATTERN AS EVIDENCED BY HIGH-RESOLUTION
	COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A
	COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT
Age Restrictions	
Prescriber	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A
Restrictions	PULMONOLOGIST
Coverage	12 MONTHS
Duration	
Other Criteria	PATIENT HAS A PREDICTED FORCED VITAL CAPACITY
	(FVC) OF AT LEAST 50%.

# **POMALIDOMIDE**

#### **Products Affected**

POMALYST

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **PONATINIB**

#### **Products Affected**

• ICLUSIG ORAL TABLET 15 MG, 45 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **PRAMLINTIDE**

#### **Products Affected**

• SYMLINPEN 120

#### • SYMLINPEN 60

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **PYRIMETHAMINE**

### **Products Affected**

#### DARAPRIM

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D, ADDITIONAL CONSIDERATION FOR CHRONIC MAINTENANCE THERAPY FOR TOXOPLASMOSIS AND TOXOPLASMOSIS PROPHYLAXIS.
Exclusion Criteria	
Required Medical Information	MALARIA: PLASMODIA SUSCEPTIBLE TESTING. TOXOPLASMOSIS:CD4 LEVEL
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE MALARIA AND CHEMOPROPHYLAXIS: INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS. SEE OTHER CRITERIA FIELD

PA Criteria	Criteria Details
Other Criteria	INITIAL: ACUTE MALARIA TREATMENT AND MALARIA
	CHEMOPROPHYLAXIS REQUIRES THAT THE PATIENT
	HAS MALARIA SUSCEPTIBLE TO PYRIMETHAMINE AND A
	PREVIOUS TRIAL OF PLAQUENIL
	(HYDROXYCHLOROQUINE SULFATE) AND MALARONE
	(ATOVAQUONE/PROGUANIL) (UNLESS THESE REGIMENS
	ARE RESISTANT IN THE SPECIFIC REGION AS INDICATED
	BY REGIONAL PLASMODIA SUSCEPTIBILITY). PRIMARY
	PROPHYLAXIS OF TOXOPLASMOSIS IN PATIENTS WITH
	HIV REQUIRES PREVIOUS TRIAL OF OR
	CONTRAINDICATION TO BACTRIM (SMX/TMP). RENEWAL:
	CONTINUATION OF TREATMENT FOLLOWING ACUTE
	MALARIA REQUIRES PREVIOUS INFECTION WITH
	MALARIA SUSCEPTIBLE TO PYRIMETHAMINE WITH
	SUBSEQUENT CLINICAL CURE (ELIMINATION OF
	MALARIA SYMPTOMS DEFINED AS CHILLS, FEVER,
	SWEATS, GENERAL MALAISE) FOLLOWED BY SYMPTOMS
	OF RELAPSE. CONTINUATION OF MALARIA
	CHEMOPROPHYLAXIS REQUIRES THE PATIENT WILL BE
	TRAVELING TO OR RESIDING IN AN AREA WHERE
	PLASMODIA SUSCEPTIBLE TO PYRIMETHAMINE EXISTS
	(MALARIA MUST BE SENSITIVE TO
	PYRIMETHAMINE).CONTINUED TREATMENT OF
	TOXOPLASMOSIS REQUIRES ONE OF THE FOLLOWING: 1)
	PERSISTENT CLINICAL DISEASE (HEADACHE,
	NEUROLOGICAL SYMPTOMS, OR FEVER) AND
	PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE
	MASS LESIONS ON BRAIN IMAGING) OR 2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENT ANTI-
	RETROVIRAL THERAPY IF HIV POSITIVE. CONTINUATION
	OF PRIMARY PROPHYLAXIS FOR TOXOPLASMOSIS WITH
	HIV REQUIRES CD4 COUNT LESS THAN 200 CELLS/MM3
	AND CURRENT ANTI RETROVIRAL THERAPY.
	TOXOPLASMOSIS: INITIAL: 8 WEEKS, RENEWAL: 6
	MONTHS. PRIMARY PROPHYLAXIS OF TOXOPLASMOSIS:
	INITIAL AND RENEWAL IS 12 MONTHS.
	TATTITE AND REINEWAL IS 12 MONTHS.

# **QUININE SULFATE**

### **Products Affected**

• quinine sulfate

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **RAMUCIRUMAB**

#### **Products Affected**

CYRAMZA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **REGORAFENIB**

#### **Products Affected**

STIVARGA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR COLORECTAL CANCER: TRIAL OF OR CONTRAINDICATION TO AN ANTI-VEGF THERAPY SUCH AS AVASTIN OR ZALTRAP AND A FLUOROPYRIMIDINE-, OXALIPLATIN- AND IRINOTECAN-BASED CHEMOTHERAPY SUCH AS FOLFOX, FOLFOXIRI, FOLFIRI, CAPEOX, INFUSIONAL 5-FU/LV OR CAPECITABINE. IF APPLICABLE, A TRIAL OF OR CONTRAINDICATION TO AN ANTI-EGFR THERAPY SUCH AS ERBITUX OR VECTIBIX IS ALSO REQUIRED FOR KRAS WILD TYPE COLORECTAL CANCER. FOR GIST, A TRIAL OF OR CONTRAINDICATION TO GLEEVEC AND SUTENT IS REQUIRED.

# **RESLIZUMAB**

### **Products Affected**

· CINQAIR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	CONCURRENT USE OF XOLAIR
Required Medical Information	BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 400 CELLS/MCL WITHIN THE LAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE
Coverage Duration	INITIAL 24 WEEKS. RENEWAL 12 MONTHS
Other Criteria	INITIALTHERAPY: PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS. RENEWAL REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED AT LEAST A 25 PERCENT REDUCTION IN ASTHMA EXACERBATIONS (FOR EXAMPLE: HOSPITALIZATIONS, URGENT OR EMERGENT CARE VISITS, USE OF RESCUE MEDICATIONS, ETC.) FROM BASELINE.

# **RIBOCICLIB**

#### **Products Affected**

- KISQALI
- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5

MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **RIFAXIMIN**

#### **Products Affected**

• XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TRAVELERS' DIARRHEA/HEPATIC ENCEPHALOPATHY: 12 MOS. IBS-D: 12 WKS.
Other Criteria	FOR RIFAXIMIN 550 MG TABLETS ONLY: HEPATIC ENCEPHALOPATHY (HE): PREVIOUS TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY.

# **RIOCIGUAT**

#### **Products Affected**

ADEMPAS

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	INITIAL FOR PAH: PATIENT IS NOT CONCURRENTLY TAKING NITRATES OR NITRIC OXIDE DONORS (E.G. AMYL NITRATE), PHOSPHODIESTERASE INHIBITORS (E.G. SILDENAFIL, TADALAFIL, OR VARDENAFIL), OR NON-SPECIFIC PDE INHIBITORS (E.G. DIPYRIDAMOLE, THEOPHYLLINE). INITIAL FOR CTEPH: PATIENT IS NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH. PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. PATIENT IS NOT CONCURRENTLY OR INTERMITTENTLY TAKING NITRATES, NITRIC OXIDE DONORS OR ANY PDE INHIBITORS (E.G.VIAGRA, CIALIS, DIPYRIDAMOLE).
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS. DIAGNOSIS OF PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) WHO GROUP 4. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL FOR PAH: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. PREVIOUS TRIAL OF OR CONTRAINDICATION TO A PHOSPHODIESTERASE-5 (PDE-5) INHIBITOR, SUCH AS REVATIO OR ADCIRCA.
	RENEWAL FOR PAH AND CTEPH: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

# **RITUXIMAB**

### **Products Affected**

#### • RITUXAN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO. RENEWAL: 12 MONTHS. NHL: 1 YEAR. CLL: 6 MO. WG, MPA: 3 MONTH.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS: PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: ORENCIA, XELJANZ, CIMZIA OR ACTEMRA.

# **RITUXIMAB SQ**

### **Products Affected**

#### RITUXAN HYCELA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THE PATIENT HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE.

# **ROMIPLOSTIM**

#### **Products Affected**

NPLATE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	INITIAL: ADEQUATE RESPONSE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY. RENEWAL: NO CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10^9/L AT THE MAX DOSE OF 10 MCG/KG PER DAY FOR 4 WEEKS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITL: 2 MO., RENEW: IF NO RESPONSE AFTER INITIAL APPROVAL: 1 MO. AT MAX DOSE. IF RESPONSE: 12 MO.
Other Criteria	

# **RUCAPARIB**

#### **Products Affected**

• RUBRACA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **RUXOLITINIB**

### **Products Affected**

#### JAKAFI

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: IMPROVEMENT OR MAINTENANCE OF SYMPTOM IMPROVEMENT SUCH AS A 50% OR GREATER REDUCTION IN TOTAL SYMPTOM SCORE ON THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF) V2.0 OR 50% OR GREATER REDUCTION IN PALPABLE SPLEEN LENGTH, OR REDUCTION OF 35% OR GREATER FROM BASELINE SPLEEN VOLUME AFTER 6 MONTHS OF THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	

# SAFINAMIDE MESYLATE

### **Products Affected**

· XADAGO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **SARILUMAB**

### **Products Affected**

#### KEVZARA

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF HUMIRA AND ONE OF THE FOLLOWING PREFERRED AGENTS: ACTEMRA, CIMZIA, ORENCIA, OR XELJANZ.

# SEBELIPASE ALFA

#### **Products Affected**

#### KANUMA

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	BLOOD TEST OR DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT LYSOSOMAL ACID LIPASE DEFICIENCY (LAL) ENZYME ACTIVITY, OR A GENETIC TEST INDICATING THE PRESENCE OF ALTERED LIPA GENE(S).
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, HEPATOLOGIST, GASTROENTEROLOGIST, MEDICAL GENETICIST, LIPIDOLOGIST, OR A METABOLIC SPECIALIST.
Coverage Duration	LAL INITIAL 6 OR 12 MONTHS, SEE OTHER CRITERIA. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL)
	DEFICIENCY, AS CONFIRMED BY THE PRESENCE OF
	CLINICAL FEATURES (E.G., HEPATOMEGALY, ELEVATED
	SERUM TRANSAMINASES, DYSLIPIDEMIA,
	SPLENOMEGALY) PLUS ANY OF THE FOLLOWING: A
	BLOOD TEST INDICATING LOW OR ABSENT LEVELS OF
	LAL ENZYME ACTIVITY, A DRIED BLOOD SPOT TEST
	INDICATING LOW OR ABSENT LAL ENZYME ACTIVITY,
	OR A GENETIC TEST INDICATING THE BI-ALLELIC
	PRESENCE OF ALTERED LIPA GENE(S).
	RENEWAL:DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL)
	DEFICIENCY PRESENTING AFTER THE FIRST 6 MONTHS
	OF LIFE AND NOT CONSIDERED RAPIDLY PROGRESSIVE
	REQUIRES DOCUMENTED IMPROVEMENT IN ANY ONE
	OF THE FOLLOWING CLINICAL PARAMETERS
	ASSOCIATED WITH LYSOSOMAL ACID LIPASE (LAL)
	DEFICIENCY DURING THE PAST 6 MONTHS: A RELATIVE
	REDUCTION FROM BASELINE IN ANY ONE OF THE
	FOLLOWING LIPID LEVELS (LDL-C, NON-HDL-C, OR
	TRIGLYCERIDES), NORMALIZATION OF ASPARTATE
	AMINOTRANSFERASE (AST) BASED ON AGE- AND
	GENDER-SPECIFIC NORMAL RANGES, A DECREASE IN
	LIVER FAT CONTENT COMPARED TO BASELINE ASSESSED
	BY ABDOMINAL IMAGING (E.G., MULTI-ECHO GRADIENT
	ECHO [MEGE] MRI). DIAGNOSIS OF RAPIDLY
	PROGRESSIVE LYSOSOMAL ACID LIPASE (LAL)
	DEFICIENCY PRESENTING WITHIN THE FIRST 6 MONTHS
	OF LIFE: 12 MONTHS. A DIAGNOSIS OF LYSOSOMAL ACID
	LIPASE (LAL) DEFICIENCY PRESENTING AFTER THE
	FIRST 6 MONTHS OF LIFE AND NOT CONSIDERED
	RAPIDLY PROGRESSIVE: INITIAL: 6 MONTHS

# **SECUKINUMAB**

#### **Products Affected**

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA AND ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF HUMIRA.

# **SELEXIPAG**

#### **Products Affected**

 UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200
 MCG, 400 MCG, 600 MCG, 800 MCG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

# **SILTUXIMAB**

#### **Products Affected**

• SYLVANT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **SIMEPREVIR**

### **Products Affected**

· OLYSIO

PA Criteria	Criteria Details
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	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (FOR EXAMPLE 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.

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH
	CURRENT AASLD-IDSA GUIDANCE. TRIAL OF A
	PREFERRED FORMULARY ALTERNATIVE INCLUDING
	HARVONI OR EPCLUSA WHEN THESE AGENTS ARE
	CONSIDERED ACCEPTABLE FOR TREATMENT OF THE
	SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE.
	PATIENT MUST NOT BE TAKING ANY OF THE
	FOLLOWING INTERACTING MEDICATIONS:
	CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL,
	OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE,
	ERYTHROMYCIN (DOES NOT INCLUDE TOPICAL
	FORMULATIONS), CLARITHROMYCIN, TELITHROMYCIN,
	ITRACONAZOLE, KETOCONAZOLE, POSACONAZOLE,
	FLUCONAZOLE (DOES NOT INCLUDE TOPICAL
	FORMULATIONS), VORICONAZOLE, DEXAMETHASONE,
	CISAPRIDE, CYCLOSPORINE, ROSUVASTATIN DOSE
	ABOVE 10MG, ATORVASTATIN DOSE ABOVE 40MG, OR
	ANY OF THE FOLLOWING HIV MEDICATIONS:
	COBICISTAT-CONTAINING MEDS (E.G., STRIBILD), ANY
	HIV PROTEASE INHIBITOR (ATAZANAVIR,
	FOSAMPRENAVIR, LOPINAVIR, INDINAVIR, NELFINAVIR,
	SAQUINAVIR, OR TIPRANAVIR) RITONAVIR,
	DARUNAVIR/RITONAVIR, DELAVIRDINE, ETRAVIRINE,
	NEVIRAPINE, EFAVIRENZ). PATIENT MUST ALSO NOT BE
	TAKING AMIODARONE IF ON COMBINATION REGIMEN
	OF SOVALDI AND OLYSIO.

# **SOFOSBUVIR**

#### **Products Affected**

• SOVALDI

PA Criteria	Criteria Details
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	PATIENT WITH END STAGE RENAL DISEASE OR
Criteria	REQUIRES DIALYSIS.
Required Medical Information	
Age Restrictions	
Prescriber	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A
Restrictions	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	CRITERIA WILL BE APPLIED CONSISTENT WITH
Duration	CURRENT AASLD/IDSA GUIDANCE

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF 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).

### SOFOSBUVIR/VELPATASVIR

### **Products Affected**

#### • EPCLUSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL.
Age Restrictions	18 YEARS OF AGE AND OLDER.
Prescriber Restrictions	PRESCRIBED BY OR GIVEN 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	CRITERIA 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 PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR OR TOPOTECAN. PATIENT MUST NOT HAVE SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS. RIBAVIRIN USE REQUIRED FOR PATIENTS WITH DECOMPENSATED CIRRHOSIS.

### SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

#### **Products Affected**

VOSEVI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
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 Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN 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	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 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.

### **SOMATROPIN - GROWTH HORMONE**

#### **Products Affected**

- HUMATROPE
- OMNITROPE
- SAIZEN

- SAIZEN CLICK.EASY
- ZOMACTON

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES, GROWTH FAILURE WITH CLOSED EPIPHYSES.
Required Medical Information	INDUCTION - PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. RENEWAL: GROWTH VELOCITY AND/OR TARGET HEIGHT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF PREFERRED FORMULARY ALTERNATIVES NORDITROPIN AND GENOTROPIN PER FDA INDICATION. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

### **SOMATROPIN - SEROSTIM**

#### **Products Affected**

 SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	HIV/WASTING: MEETS CRITERIA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5% OVER 6 MONTHS, OR 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 20 KG PER METER SQUARED.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST (SBS), OR INFECTIOUS DISEASE SPECIALIST
Coverage Duration	3 MONTHS
Other Criteria	HIV/WASTING: CURRENTLY ON ANTIRETROVIRAL THERAPY. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

### **SOMATROPIN - ZORBTIVE**

### **Products Affected**

#### · ZORBTIVE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST
Coverage Duration	SHORT BOWEL: 4 WEEKS ONCE
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

# SOMATROPIN-NORDITROPIN AND GENOTROPIN

### **Products Affected**

- GENOTROPIN
- GENOTROPIN MINIQUICK

#### · NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES, GROWTH FAILURE WITH CLOSED EPIPHYSES.
Required Medical Information	INDUCTION - PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. RENEWAL: GROWTH VELOCITY AND/OR TARGET HEIGHT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E. INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

## SOMATROPIN-NUTROPIN AND NUTROPIN AQ

#### **Products Affected**

• NUTROPIN AQ NUSPIN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES, GROWTH FAILURE DUE TO CKD IF PATIENT HAS HAD A RENAL TRANSPLANT, OR GROWTH FAILURE WITH CLOSED EPIPHYSES.
Required Medical Information	INDUCTION - PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. RENEWAL: GROWTH VELOCITY AND/OR TARGET HEIGHT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: ENDOCRINOLOGIST. FOR GROWTH HORMONE FAILURE DUE TO CRI: NEPHROLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	ALL DIAGNOSES EXCEPT FOR CHRONIC KIDNEY DISEASE (CKD): INITIAL: PREVIOUS TRIAL OF PREFERRED FORMULARY ALTERNATIVES NORDITROPIN AND GENOTROPIN PER FDA INDICATION. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E. INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). FOR GROWTH FAILURE SECONDARY TO CKD: PATIENT HAS NOT RECEIVED A RENAL TRANSPLANT. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

### **SONIDEGIB**

### **Products Affected**

· ODOMZO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **SORAFENIB TOSYLATE**

#### **Products Affected**

NEXAVAR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### SUNITINIB MALATE

### **Products Affected**

• SUTENT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.

### **TADALAFIL**

### **Products Affected**

• CIALIS ORAL TABLET 2.5 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF ONE FORMULARY ALPHA BLOCKER SUCH AS DOXAZOSIN, TERAZOSIN, TAMSULOSIN OR ALFUZOSIN) AND ONE FORMULARY 5-ALPHA-REDUCTASE (SUCH AS FINASTERIDE OR DUTASTERIDE). APPLIES TO 2.5MG AND 5MG STRENGTHS ONLY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

### **TALIMOGENE**

#### **Products Affected**

• IMLYGIC INJECTION SUSPENSION 10EXP6 (1 MILLION) PFU/ML, 10EXP8 (100 MILLION) PFU/ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	HISTORY OF PRIMARY OR ACQUIRED IMMUNODEFICIENT STATES, LEUKEMIA, LYMPHOMA, OR AIDS. PATIENT IS NOT CURRENTLY RECEIVING IMMUNOSUPPRESSIVE THERAPY.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	IMLYGIC TO BE INJECTED INTO CUTANEOUS, SUBCUTANEOUS, AND OR NODAL LESIONS THAT ARE VISIBLE, PALPABLE, OR DETECTABLE BY ULTRASOUND GUIDANCE. NO CONCURRENT USE WITH PEMBROLIZUMAB, NIVOLUMAB, IPILIMUMAB, DABRAFENIB, TRAMETINIB, VEMURAFENIB, INTERLEUKIN-2, INTERFERON, DACARBAZINE, TEMOZOLOMIDE, PACLITAXEL, CARBOPLATIN, IMATINIB, MELPHALAN, IMIQUIMOD, OR RADIATION THERAPY.

### **TASIMELTEON**

### **Products Affected**

HETLIOZ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **TEDUGLUTIDE**

### **Products Affected**

• GATTEX 30-VIAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK.

### **TELOTRISTAT**

### **Products Affected**

XERMELO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **TEMOZOLOMIDE**

### **Products Affected**

• TEMODAR INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **TERIFLUNOMIDE**

### **Products Affected**

AUBAGIO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **TERIPARATIDE**

### **Products Affected**

FORTEO

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., ALENDRONATE, RISEDRONATE, IBANDRONATE).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **TESTOSTERONE**

#### **Products Affected**

- ANDRODERM
- ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)
- ANDROGEL TRANSDERMAL GEL

IN PACKET 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM)

- testosterone cypionate
- testosterone enanthate
- testosterone transdermal gel in packet

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL CONSIDERATION FOR GENDER DYSPHORIA.
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LAB CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 300 NG/DL OR 2) A LOW TOTAL SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB RESULT WITH A REFERENCE RANGE OBTAINED WITHIN 90 DAYS, OR 3) A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 PG/ML.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME OF MEMBERSHIP IN PLAN
Other Criteria	

### **TETRABENAZINE**

### **Products Affected**

• tetrabenazine

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	12 MONTHS
Other Criteria	

### TEZACAFTOR/IVACAFTOR

### **Products Affected**

#### SYMDEKO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.

### **THALIDOMIDE**

### **Products Affected**

• THALOMID

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **TOCILIZUMAB IV**

### **Products Affected**

### ACTEMRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RA, PJIA, OR SJIA: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	MODERATE TO SEVERE RHEUMATOID ARTHRITIS (RA)/POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA)/ SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: RA: 7 MONTHS. PJIA: 5 MOS. SJIA: 12 MOS. CRS: 1 MO. RENEWAL: 12 MOS FOR RA, PJIA, OR SJIA
Other Criteria	INITIAL: MODERATE TO SEVERE RA AND PJIA: PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. INITIAL SJIA: PREVIOUS TRIAL WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

### TOCILIZUMAB SQ

### **Products Affected**

### ACTEMRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RA RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	RA INITIAL: 7 MONTHS. RA RENEWAL: 12 MONTHS. GIANT CELL ARTERITIS: 12 MONTHS
Other Criteria	RA INITIAL: PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

### **TOFACITINIB**

### **Products Affected**

### XELJANZ

### • XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	INITIAL: RA: 6 MOS. PSA: 4 MOS. RENEWAL (ALL INDICATIONS): 12 MOS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA) AND PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

### **TOLVAPTAN**

### **Products Affected**

• JYNARQUE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **TOPICAL TRETINOIN**

#### **Products Affected**

• tretinoin topical cream

• tretinoin topical gel 0.01 %, 0.025 %

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **TRABECTEDIN**

### **Products Affected**

YONDELIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### TRAMETINIB DIMETHYL SULFOXIDE

#### **Products Affected**

 MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **TRASTUZUMAB**

### **Products Affected**

### • HERCEPTIN

PA Criteria	Criteria Details
<b>Covered Uses</b>	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	BREAST CANCER, METASTATIC BREAST CANCER, GASTRIC CANCER: HER2 POSITIVE
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION.

### TREPROSTINIL DIOLAMINE

### **Products Affected**

#### ORENITRAM

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PATIENT DOES NOT HAVE SEVERE HEPATIC IMPAIRMENT.
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. PREVIOUS OR CURRENT TREATMENT WITH ONE OF THE FOLLOWING AGENTS: A FORMULARY PHOSPHODIESTERASE-5 INHIBITOR (E.G., SILDENAFIL [GENERIC FOR REVATIO] OR ADCIRCA [TADALAFIL]) OR AN ENDOTHELIN RECEPTOR ANTAGONIST (E.G., TRACLEER [BOSENTAN], LETAIRIS [AMBRISENTAN], OR OPSUMIT [MACITENTAN]). TRIAL OF A FORMULARY PHOSPHODIESTERASE-5 INHIBITOR OR ENDOTHELIN RECEPTOR ANTAGONIST IS NOT REQUIRED IF THE PATIENT WAS PREVIOUSLY STABLE ON ORENITRAM. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

### TREPROSTINIL INHALED

### **Products Affected**

TYVASO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	THIS DRUG MAYBE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. NEBULIZER THERAPY IS COVERED UNDER PART B FOR PATIENTS WHO ARE USING THE MEDICATION VIA A NEBULIZER IN THEIR OWN HOME. THOSE WHO ARE NOT USING IT IN THEIR HOME WILL BE COVERED UNDER PART D. INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

### TREPROSTINIL SODIUM INJECTABLE

#### **Products Affected**

#### REMODULIN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	COVERED UNDER LOCAL COVERAGE POLICY OF APPLICABLE MEDICARE DMERC.
Required Medical Information	FORMULARY DRUG ADMINISTERED IN A LONG TERM CARE FACILITY TO A PATIENT WHOSE PART A COVERAGE HAS EXPIRED OR FORMULARY DRUG NOT ADMINISTERED VIA AN IMPLANTABLE PUMP OR AN EXTERNAL PUMP OR DRUG ADMINISTERED VIA AN IMPLANTABLE PUMP/AN EXTERNAL PUMP. DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
PA Criteria Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. CONTINUATION OF CURRENT REMODULIN THERAPY: PATIENT MUST HAVE NYHA/WHO FC II-IV SYMPTOMS. NEW REQUESTS FOR REMODULIN THERAPY: PATIENT MUST HAVE NYHA/WHO FC III-IV SYMPTOMS. NEW REQUESTS FOR REMODULIN THERAPY FOR PATIENTS WITH NYHA/WHO FC II SYMPTOMS REQUIRES A TRIAL OF OR CONTRAINDICATION TO A PHOSPHODIESTERASE-5 INHIBITOR (PDE-5) (E.G., REVATIO, ADCIRCA) OR AN ENDOTHELIN RECEPTOR ANTAGONIST (ERA) (E.G., LETAIRIS, OPSUMIT, TRACLEER). RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE
	FUNCTIONAL CLASS.

### TRIENTINE

### **Products Affected**

• trientine

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	KNOWN FAMILY HISTORY OF WILSON'S DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSON'S DISEASE. PLASMA COPPER-PROTEIN CERULOPLASMIN LESS THAN 20 MG/DL. LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250 MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE (DEPEN).

# TRIFLURIDINE/TIPIRACIL

#### **Products Affected**

 LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **URIDINE TRIACETATE**

### **Products Affected**

#### • XURIDEN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: DIAGNOSIS CONFIRMED BY 1) GENETIC MUTATION OF URIDINE MONOPHOSPHATE SYNTHASE (UMPS) GENE AND 2) ELEVATED URINE OROTIC ACID PER AGE-SPECIFIC REFERENCE RANGE. RENEWAL: IMPROVEMENT FROM BASELINE OR STABILIZATION OF AGE DEPENDENT HEMATOLOGIC PARAMETERS (E.G., NEUTROPHIL COUNT, NEUTROPHIL PERCENT, WBC COUNT, MEAN CORPUSCULAR VOLUME)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	

# **USTEKINUMAB**

### **Products Affected**

STELARA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL FOR PSORIATIC ARTHRITIS OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: DERMATOLOGIST. CROHN'S DISEASE: GASTROENTEROLOGIST.
Coverage Duration	INITIAL: PSA, PSO, CD: 4 MONTHS. CD WITH PREVIOUS DOSE IV: 2 MONTHS. RENEW ALL: 12 MO
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA, OTEZLA, OR COSENTYX. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: COSENTYX OR OTEZLA. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO PREFERRED TNF INHIBITORS: HUMIRA FOLLOWED BY CIMZIA.

# **USTEKINUMAB IV**

### **Products Affected**

#### STELARA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	2 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO THE PREFERRED TNF INHIBITORS: HUMIRA FOLLOWED BY CIMZIA. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# VALBENAZINE TOSYLATE

#### **Products Affected**

• INGREZZA ORAL CAPSULE 40 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PATIENT HAS A PRIOR HISTORY OF USING ANTIPSYCHOTIC MEDICATIONS OR METOCLOPRAMIDE PER PHYSICIAN ATTESTATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	

### **VANDETANIB**

#### **Products Affected**

• CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **VEMURAFENIB**

#### **Products Affected**

• ZELBORAF

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

### **VENETOCLAX**

#### **Products Affected**

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# VINCRISTINE SULFATE LIPOSOMAL

#### **Products Affected**

MARQIBO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

# **VISMODEGIB**

#### **Products Affected**

• ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

# **ZIV-AFLIBERCEPT**

#### **Products Affected**

ZALTRAP

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

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