Prior Authorization Criteria
Last Updated: March 20, 2018
Effective Date: April 1, 2018

2018 **Prior Authorizations**

(List of Prior Authorizations)

PLEASE READ CAREFULLY: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE PRIOR AUTHORIZATIONS ON DRUGS THAT WE COVER IN THIS PLAN.

Note to existing members: Beneficiaries must use network pharmacies to access their prescription drug benefit. "Benefits, List of Covered Drugs, pharmacy and provider networks and copayments may change from time to time throughout the year and on January 1 of each year."

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. You can get this information for free in other languages. Call 1-877-273-IEHP (4347), 8am – 8pm (PST) 7 days a week, including holidays.TTY/TDD users should call 1-800-718-4347. The call is free.

Usted puede obtener esta información gratis en otros idiomas. Llame al 1-877-273-IEHP (4347), 8am – 8pm (Hora del Pacífico), los 7 días de la semana, incluidos días festivos. Los usuarios de TTY/TDD deben llamar al 1-800-718-4347. La llamada es gratuita.

ABELCET

Products Affected

- **ABELCET**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.

ABILIFY DISCMELT

Products Affected

- *aripiprazole oral tablet, disintegrating*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Bipolar and Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

ABILIFY MAINTENA

Products Affected

- **ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 300 MG**
- **ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.

ABRAXANE

Products Affected

- **ABRAXANE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: conventional paclitaxel or docetaxol or to the standard hypersensitivity premedications.

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: calcipotriene, clobetasol, cyclosporine, fluocinonide, methotrexate, or Tazorac.

ACTEMRA

Products Affected

- **ACTEMRA INTRAVENOUS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.

ACTIMMUNE

Products Affected

- **ACTIMMUNE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Infectious disease specialist, Oncologist, Orthopedist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ADAGEN

Products Affected

- **ADAGEN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Adenosine Deaminase Deficiency must be confirmed by blood or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

ADCIRCA

Products Affected

- **ADCIRCA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of nitrates and PDE5 inhibitors.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: sildenafil.

ADEFOVIR

Products Affected

- *adefovir*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ADEMPAS

Products Affected

- **ADEMPAS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use of phosphodiesterase (PDE) inhibitors or nitrates
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year
Other Criteria	For Pulmonary Arterial Hypertension only: Failure or clinically significant adverse effects to the formulary alternative: sildenafil. Other indication(s) do not require failure or clinically significant adverse effects to sildenafil.

ADHD

Products Affected

- *dexmethylphenidate oral tablet*
- *dextroamphetamine oral tablet*
- *dextroamphetamine-amphetamine oral tablet*
- *methylphenidate hcl oral capsule, er biphasic 30-70*
- *methylphenidate hcl oral capsule, er biphasic 50-50 20 mg, 30 mg, 40 mg*
- *methylphenidate hcl oral solution*
- *methylphenidate hcl oral tablet*
- *methylphenidate hcl oral tablet extended release*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ADRIAMYCIN

Products Affected

- *adriamycin intravenous solution 20 mg/10 ml*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

AFINITOR

Products Affected

- **AFINITOR**
- **AFINITOR DISPERZ**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Advanced renal cell carcinoma: Failure or clinically significant adverse effects to one of the formulary alternatives: Nexavar or Sutent. Advanced hormone receptor-positive, HER2 negative breast cancer in postmenopausal women: Use in combination with exemestane and failure or clinically significant adverse effects to one of the formulary alternatives: anastrozole or letrozole.

ALDURAZYME

Products Affected

- **ALDURAZYME**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Mucopolysaccharidosis, Type I (Hurler and Hurler-Scheie forms) and Scheie form: diagnosis confirmed by measurement of alpha-L-iduronidase activity (enzymatic assay) or DNA testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

ALECENSA

Products Affected

- **ALECENSA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of anaplastic lymphoma kinase (ALK) positive
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Xalkori

ALIMTA

Products Affected

- **ALIMTA INTRAVENOUS RECON SOLN 500 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that ANC greater than 1500cells/m3, platelets greater than 100,000cells/m3, and CrCL greater than 45mL/min
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

ALIQOPA

Products Affected

- **ALIQOPA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of at least 2 prior systemic therapies
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

ALLI

Products Affected

- **ALLI 60 MG CAPSULE STARTER PACK**

PA Criteria	Criteria Details
Covered Uses	Obesity management including weight loss and weight maintenance when used in conjunction with a reduced-calorie diet.
Exclusion Criteria	N/A
Required Medical Information	BMI greater than or equal to 27 kg/m2 with one or more comorbidity (e.g. coronary heart disease, dyslipidemia, hypertension, type 2 diabetes mellitus, sleep apnea), OR BMI greater than or equal to 30 kg/m2. Reauthorization: Documented weight loss of 5% during the first 6 month period and lack of side effects. Therapy beyond the first year can be authorized every 6 months with documentation of weight maintenance and lack of side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months.
Other Criteria	N/A

ALUNBRIG

Products Affected

- **ALUNBRIG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of ALK positive.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

AMBISOME

Products Affected

- **AMBISOME**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.

AMITRIPTYLINE

Products Affected

- *amitriptyline*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

AMOXAPINE

Products Affected

- *amoxapine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.

AMPHOTERICIN B

Products Affected

- *amphotericin b*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

AMPYRA

Products Affected

- **AMPYRA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Concurrently on a disease-modifying agent for multiple sclerosis. Documentation of difficulty walking (such as timed 25-foot walk test: Patient must be able to walk 25 feet within 8-45 sec).
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

ANDROGEL PUMP

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Androderm, testosterone cypionate, testosterone enanthate or testosterone transdermal gel.

ANDROGENS

Products Affected

- **ANDRODERM**
- *testosterone transdermal gel in metered-dose pump*
- *testosterone transdermal solution in metered pump w/app*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: testosterone cypionate or testosterone enanthate.

APOKYN

Products Affected

- **APOKYN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: antiparkinson drugs such as amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline.

APTIOM

Products Affected

- **APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

ARCALYST

Products Affected

- **ARCALYST**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrently taking any tumor necrosis factor (TNF)-blocking agents such as Enbrel, Humira, or Remicade.
Required Medical Information	N/A
Age Restrictions	Approve if 12 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ARIPIPRAZOLE

Products Affected

- *aripiprazole oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Bipolar and Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

ARIPIPRAZOLE SOLUTION

Products Affected

- *aripiprazole oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of difficulty of swallowing
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	Bipolar and Schizophrenia: Failure or clinically significant adverse effects to one of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone. Depression: Failure or clinically significant adverse effects to one of the formulary alternatives: bupropion, citalopram, desvenlafaxine, duloxetine, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

ARRANON

Products Affected

- **ARRANON**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two prior systemic therapies.

ATGAM

Products Affected

- **ATGAM**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

ATOVAQUONE

Products Affected

- *atovaquone*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Pneumocystic pneumonia: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim/sulfamethoxazole.

AUBAGIO

Products Affected

- **AUBAGIO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

AUSTEDO

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	Concurrent use with an MAOI.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

AVASTIN

Products Affected

- **AVASTIN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Metastatic colorectal cancer: used in combination with intravenous 5-fluorouracil-based chemotherapy. Metastatic colorectal cancer in members who have progressed on a first-line Avastin-containing regimen: used in combination with fluoropyrimidine/irinotecan- or fluoropyrimidine/oxaliplatin-based chemotherapy. Nonsquamous non-small cell lung cancer that is recurrent or metastatic, unresectable, locally advanced: used in combination with paclitaxel and carboplatin. Metastatic renal cell carcinoma: used in combination with interferon alfa.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

AVONEX

Products Affected

- **AVONEX (WITH ALBUMIN)**
- **AVONEX INTRAMUSCULAR PEN INJECTOR KIT**
- **AVONEX INTRAMUSCULAR SYRINGE KIT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

AZACITIDINE

Products Affected

- *azacitidine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of CBC, liver chemistries, and serum creatine within the past month.
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

BARACLUDE

Products Affected

- **BARACLUDE ORAL SOLUTION**
- *entecavir*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Infectious diseases specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

BAVENCIO

Products Affected

- **BAVENCIO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

BELEODAQ

Products Affected

- **BELEODAQ**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

BENLYSTA

Products Affected

- **BENLYSTA INTRAVENOUS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: betamethasone, dexamethasone, hydrocortisone, hydroxychloroquine, methylprednisonlone, prednisolone, prednisone, or triamcinolone.

BENZTROPINE

Products Affected

- *benztropine oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Parkinsonism: Failure or clinically significant adverse effects to two of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline. Medication-induced movement disorder - extrapyramidal disease: Failure or clinically significant adverse effects to the formulary alternative: amantadine.

BETASERON

Products Affected

- **BETASERON SUBCUTANEOUS KIT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

BICNU

Products Affected

- **BICNU**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

BLEOMYCIN SULFATE

Products Affected

- *bleomycin injection recon soln 30 unit*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

BORTEZOMIB

Products Affected

- *bortezomib*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

BOSULIF

Products Affected

- **BOSULIF**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: Gleevec, Sprycel or Tasigna.

BOSULIF 400MG

Products Affected

- **BOSULIF**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

BRIVIACT

Products Affected

- **BRIVIACT INTRAVENOUS**
- **BRIVIACT ORAL SOLUTION**
- **BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

BUSULFAN

Products Affected

- *busulfan*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist, Transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

CABOMETYX

Products Affected

- **CABOMETYX**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of prior anti-angiogenic therapy
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

CALQUENCE

Products Affected

- **CALQUENCE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of at least one prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CANCIDAS

Products Affected

- **CANCIDAS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

CAPASTAT

Products Affected

- **CAPASTAT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

CAPRELSA

Products Affected

- **CAPRELSA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Congenital long QT syndrome.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CARBAGLU

Products Affected

- **CARBAGLU**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N-acetylglutamate synthase deficiency must be confirmed by FDA approved testing
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

CARBINOXAMINE

Products Affected

- *carbinoxamine maleate oral liquid*
- *carbinoxamine maleate oral tablet 4 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Allergic rhinitis: Failure or clinically significant adverse effects to two of the formulary alternatives: azelastine, cetirizine, flunisolide or levocetirizine. All other FDA-approved indications: Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk.

CARIMUNE NANOFILTERED

Products Affected

- *carimune nf nanofiltered intravenous recon soln 6 gram*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Approve under Part B for these types of Primary Humoral Immunodeficiency: Congenital agammaglobulinemia, Common variable immunodeficiency, Wiskott-Aldrich syndrome, X-linked agammaglobulinemia, Severe combined immunodeficiency. Subject to Part B vs Part D determination.

CARISOPRODOL

Products Affected

- *carisoprodol oral tablet 350 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk

CASPOFUNGIN

Products Affected

- *caspofungin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

CAYSTON

Products Affected

- **CAYSTON**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease specialist, Pulmonologist
Coverage Duration	4 weeks
Other Criteria	Subject to Part B vs Part D determination

CERDELGA

Products Affected

- **CERDELGA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of CYP2D6 metabolism as an extensive metabolizer (EM), intermediate metabolizer (IM) or poor metabolizer (PM) determined by a FDA-cleared test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CEREZYME

Products Affected

- **CEREZYME INTRAVENOUS RECON SOLN 400 UNIT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Gaucher disease, type 1, must be confirmed by blood or genetic testing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

CHOLBAM

Products Affected

- **CHOLBAM**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CIDOFOVIR

Products Affected

- *cidofovir*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

CINRYZE

Products Affected

- **CINRYZE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	N/A
Prescriber Restrictions	Allergist, immunologist, hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: danazol.

CLADRIBINE

Products Affected

- *cladribine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

CLEMASTINE

Products Affected

- *clemastine oral tablet 2.68 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Allergic rhinitis: Failure or clinically significant adverse effects to two of the formulary alternatives: azelastine, cetirizine, cromolyn, flunisolide, or levocetirizine. Cutaneous hypersensitivity, urticaria, or angioedema: Failure or clinically significant adverse effects to all of the formulary alternatives: cetirizine and levocetirizine.

CLOFARABINE

Products Affected

- *clofarabine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

CLOMIPRAMINE

Products Affected

- *clomipramine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: fluoxetine, fluvoxamine, paroxetine, or sertraline.

CLONIDINE ER

Products Affected

- *clonidine hcl oral tablet extended release 12 hr*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: guanfacine ER.

CLOZAPINE ODT

Products Affected

- *clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: clozapine tablet.

COMETRIQ

Products Affected

- **COMETRIQ**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Recent history of hemorrhage or hemoptysis.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

COPAXONE

Products Affected

- **COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CORLANOR

Products Affected

- **CORLANOR**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented New York Association (NYHA) class II to IV heart failure with an ejection fraction of less than or equal to 35% and sinus rhythm with a resting heart rate greater than or equal to 70 beats per minute. Documentation that patient is on maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication or a hypersensitivity to beta blocker. Documented concurrent use with an ACE inhibitor or ARB, unless both are not tolerated or contraindicated.
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

COSMEGEN

Products Affected

- **COSMEGEN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

COTELLIC

Products Affected

- **COTELLIC**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of BRAF V600E or V600K mutation
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

CUBICIN

Products Affected

- *daptomycin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

CYCLOBENZAPRINE

Products Affected

- *cyclobenzaprine oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk

CYCLOSET

Products Affected

- **CYCLOSET**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: glipizide, glimepiride, metformin, or pioglitazone.

CYPROHEPTADINE

Products Affected

- *cyproheptadine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Allergic rhinitis: Failure or clinically significant adverse effects to two of the formulary alternatives: azelastine, cetirizine, cromolyn, flunisolide, or levocetirizine. Pruritus or urticaria: Failure or clinically significant adverse effects to all of the formulary alternatives: cetirizine and levocetirizine.

CYRAMZA

Products Affected

- **CYRAMZA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Documentation of hemorrhage and gastrointestinal hemorrhage, or documentation of gastrointestinal perforation.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

CYSTAGON

Products Affected

- **CYSTAGON**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CYSTARAN

Products Affected

- **CYSTARAN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

CYTARABINE

Products Affected

- *cytarabine*
- *cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Neurologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

DACTINOMYCIN

Products Affected

- *dactinomycin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

DALIRESP

Products Affected

- **DALIRESP**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Advair Diskus, Anoro Ellipta, Serevent, Spiriva or Tudorza.

DARAPRIM

Products Affected

- **DARAPRIM**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, HIV specialist, Infectious Disease specialist, Oncologist, Transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Primary prophylaxis of toxoplasmic encephalitis: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim-sulfamethoxazole.

DARZALEX

Products Affected

- **DARZALEX**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination

DECITABINE

Products Affected

- *decitabine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

DEMSER

Products Affected

- **DEMSER**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Essential hypertension.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

DESIPRAMINE

Products Affected

- *desipramine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline or venlafaxine.

DIASTAT

Products Affected

- **DIASTAT**
- **DIASTAT ACUDIAL**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

DIAZEPAM SOLUTION

Products Affected

- *diazepam intensol*
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

DIGOXIN

Products Affected

- *digitek*
- *digoxin injection solution*
- *digoxin oral solution 50 mcg/ml*
- *digoxin oral tablet*
- **LANOXIN ORAL TABLET 125 MCG, 250 MCG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Average daily doses greater than 0.125mg require a clinical justification. Approve for average daily doses of 0.125mg or less.

DISOPYRAMIDE

Products Affected

- *disopyramide phosphate oral capsule*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: acebutolol, amiodarone, flecainide, mexiletine, procainamide, propafenone, quinidine, or sotalol.

DOCETAXEL

Products Affected

- *docetaxel intravenous solution 160 mg/16 ml (10 mg/ml), 80 mg/4 ml (20 mg/ml)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

DOXEPIN

Products Affected

- *doxepin oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	For the average daily dose of doxepin that is greater than 6 mg: Anxiety: Failure or clinically significant adverse effects to two of the formulary alternatives: buspirone, escitalopram, paroxetine, or venlafaxine. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

DRONABINOL

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Chemotherapy-induced nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, metoclopramide, ondansetron, or prochlorperazine.

ELAPRASE

Products Affected

- **ELAPRASE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Mucopolysaccharidosis, Type II (Hunter syndrome) must be confirmed by a blood, urine, or tissue test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

ELIDEL

Products Affected

- **ELIDEL**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the topical formulary alternatives: clobetasol, betamethasone, fluocinolone or fluocinonide and failure or clinically significant adverse effects to the formulary alternative: tacrolimus ointment.

ELIGARD

Products Affected

- **ELIGARD**
- **ELIGARD (3 MONTH)**
- **ELIGARD (4 MONTH)**
- **ELIGARD (6 MONTH)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

EMCYT

Products Affected

- **EMCYT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

EMEND

Products Affected

- *aprepitant*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to one of the formulary 5-HT3 antagonist alternatives: ondansetron or granisetron except when the member is on any chemotherapy.

EMFLAZA

Products Affected

- **EMFLAZA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: prednisone

EMPLICITI

Products Affected

- **EMPLICITI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination

EMSAM

Products Affected

- **EMSAM**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: phenelzine and tranylcypromine.

ENBREL

Products Affected

- **ENBREL**
- **ENBREL SURECLICK**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to two of the following: acitretin, cyclosporine, methotrexate or phototherapy

ENGERIX-B

Products Affected

- **ENGERIX-B (PF) INTRAMUSCULAR SYRINGE**
- **ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months.
Other Criteria	Subject to Part B vs Part D determination.

ENTRESTO

Products Affected

- **ENTRESTO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Left ventricular ejection fraction less than 40%.
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

EPCLUSA

Products Affected

- **EPCLUSA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment length is determined by FDA labeling or AASLD recommendation
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious disease specialist
Coverage Duration	12 weeks.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. For genotype 1 and 4 only: failure or clinically significant adverse effects to the formulary alternative: Zepatier.

EPIRUBICIN HCL

Products Affected

- *epirubicin intravenous solution 200 mg/100 ml*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

EPOGEN

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled hypertension
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodyspastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

ERBITUX

Products Affected

- **ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

ERGOLOID

Products Affected

- *ergoloid*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members with acute and chronic psychosis
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: donepezil, galantamine, or rivastigmine.

ERIVEDGE

Products Affected

- **ERIVEDGE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ERWINAZE

Products Affected

- **ERWINAZE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

ESBRIET

Products Affected

- **ESBRIET ORAL CAPSULE**
- **ESBRIET ORAL TABLET 267 MG, 801 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ESTROGENS

Products Affected

- *estradiol oral*
- *estradiol transdermal patch weekly*
- *estropipate*
- *jinteli*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to two of the formulary alternatives: alendronic acid, ibandronic acid, or risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to one of the formulary alternatives: Estrace cream or Premarin Cream.

EXJADE

Products Affected

- **EXJADE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

EXONDYS

Products Affected

- **EXONDYS 51**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of confirmed mutation of the Duchenne muscular dystrophy gene amenable to exon 51 skipping
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

FABRAZYME

Products Affected

- **FABRAZYME INTRAVENOUS RECON SOLN 35 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

FANAPT

Products Affected

- **FANAPT ORAL TABLET**
- **FANAPT ORAL TABLETS, DOSE PACK**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone or ziprasidone.

FARYDAK

Products Affected

- **FARYDAK**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Failure or clinically significant adverse effects to two prior regimens which include the formulary alternative: Velcade and an immunomodulatory agent.

FASLODEX

Products Affected

- **FASLODEX**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

FENTANYL LOZENGE

Products Affected

- *fentanyl citrate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute, intermittent, or postoperative pain.
Required Medical Information	Documentation of opioid tolerance taking around-the-clock opioid therapy consisting of at least 60mg of oral morphine daily, at least 25mg transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8mg oral hydromorphone daily, at least 25mg oral oxymorphone daily or an equianalgesic dose of another opioid daily for a week or longer for breakthrough pain of cancer. Patients must remain on around-the clock opioids when taking transmucosal immediate release fentanyl.
Age Restrictions	N/A
Prescriber Restrictions	Pain Specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

FERRIPROX

Products Affected

- **FERRIPROX**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Exjade.

FETZIMA

Products Affected

- **FETZIMA ORAL CAPSULE, EXT REL 24HR DOSE PACK**
- **FETZIMA ORAL CAPSULE, EXTENDED RELEASE 24 HR**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

FIRAZYR

Products Affected

- **FIRAZYR**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	N/A
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: danazol.

FIRMAGON

Products Affected

- **FIRMAGON KIT W DILUENT SYRINGE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

FOLOTYN

Products Affected

- **FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that ANC greater than 1000/mcL and platelet greater than 100,000/mcL for initiation of therapy
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination

FORTEO

Products Affected

- **FORTEO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone mineral density (BMD) T score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and a history of fractures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: alendronic acid, ibandronic acid, or risedronate. Medical justification required for treatment duration beyond 24 months.

FRAGMIN

Products Affected

- **FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI-XA UNIT/0.6 ML, 18,000 ANTI-XA UNIT/0.72 ML, 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI-XA UNIT/0.2 ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: enoxaparin, fondaparinux, or warfarin.

FYCOMPA

Products Affected

- **FYCOMPA ORAL SUSPENSION**
- **FYCOMPA ORAL TABLET**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

GAMMAGARD LIQUID

Products Affected

- *gammagard liquid*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Approve under Part B for these types of Primary Humoral Immunodeficiency: Congenital agammaglobulinemia, Common variable immunodeficiency, Wiskott-Aldrich syndrome, X-linked agammaglobulinemia, Severe combined immunodeficiency. Subject to Part B vs Part D determination.

GAMMAPLEX

Products Affected

- **GAMMAPLEX**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Approve under Part B for these types of Primary Humoral Immunodeficiency: Congenital agammaglobulinemia, Common variable immunodeficiency, Wiskott-Aldrich syndrome, X-linked agammaglobulinemia, Severe combined immunodeficiency. Subject to Part B vs Part D determination.

GARDASIL 9

Products Affected

- **GARDASIL 9 (PF)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if 9 to 26 years of age.
Prescriber Restrictions	N/A
Coverage Duration	6 months.
Other Criteria	Subject to Part B vs Part D determination

GATTEX

Products Affected

- **GATTEX 30-VIAL**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented dependence on parenteral nutrition support for at least 12 months
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

GEMCITABINE

Products Affected

- *gemcitabine intravenous recon soln 1 gram*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

GENOTROPIN

Products Affected

- **GENOTROPIN**
- **GENOTROPIN MINIQUICK**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	AGHD(initial): diagnosis confirmed as a result of past diagnosis of childhood-onset GHD, or adult-onset GHD with documentation of hormone deficiency due to hypothalamic-pituitary disease from organic or known causes (eg: damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and documentation of one growth-hormone stimulant test (eg: insulin tolerance test, arginine/GHRH,glucagon,arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or documentated deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IFG-1/somatomedinC below age and gender adjusted normal range as provided by physicians lab. AGHD(reauthorization): Documentation of positive experience by the patient.
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GEODON SOLUTION

Products Affected

- **GEODON INTRAMUSCULAR**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

GILENYA

Products Affected

- **GILENYA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Class III or IV heart failure, decompensated heart failure requiring hospitalization, myocardial infarction, stroke, transient ischemic attack or unstable angina within the last 6 months. Concomitant use of Class Ia or Class III anti-arrhythmic drugs. Mobitz type II second-degree or third-degree atrioventricular block, or sick-sinus syndrome unless the patient has a functional pacemaker. QT interval at baseline 500 ms or greater.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GILOTRIF

Products Affected

- **GILOTRIF**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GLATIRAMER

Products Affected

- *glatiramer*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GLATOPA

Products Affected

- *glatopa*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GLEEVEC

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	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GLYBURIDE

Products Affected

- *glyburide micronized*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: glipizide and glimepiride.

GOCOVRI

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	N/A
Required Medical Information	Documentation of concurrent levodopa therapy.
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GUANFACINE

Products Affected

- *guanfacine oral tablet*
- *guanfacine oral tablet extended release 24 hr*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Hypertension: Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide. ADHD: Failure or clinically significant adverse effects to two of the formulary alternatives: amphetamine/dextroamphetamine, dexmethylphenidate, dextroamphetamine, or methylphenidate.

HALAVEN

Products Affected

- **HALAVEN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

HARVONI

Products Affected

- **HARVONI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment length is determined by FDA labeling or AASLD recommendation
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious disease specialist
Coverage Duration	12 to 24 weeks dependent on cirrhosis, liver transplant status, or previous treatment.
Other Criteria	N/A

HERCEPTIN

Products Affected

- **HERCEPTIN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of HER2 overexpression
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

HETLIOZ

Products Affected

- **HETLIOZ**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist, Sleep specialist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

HEXALEN

Products Affected

- **HEXALEN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

HUMIRA

Products Affected

- **HUMIRA**
- **HUMIRA PEN**
- **HUMIRA PEN CROHN'S-UC-HS START**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Gastroenterologist, Ophthalmologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to two of the formulary alternatives: acitretin, cyclosporine, methotrexate or phototherapy. Crohn's disease and Ulcerative colitis: Failure or clinically significant adverse effects to two of the formulary alternatives: budesonide, mesalamine or sulfasalazine.

HUMIRA PEDIATRIC CROHNS

Products Affected

- **HUMIRA PEDIATRIC CROHN'S START**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Greater or equal to 6 years of age
Prescriber Restrictions	Gastroenterologist, Pediatrician
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

HUMIRA PSORIASIS

Products Affected

- **HUMIRA PEN PSORIASIS-UVEITIS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Rheumatologist, Ophthalmologist, Gastroenterologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Plaque psoriasis: Failure or clinically significant adverse effects to two of the following: acitretin, cyclosporine, methotrexate or phototherapy.

HYDROXYZINE

Products Affected

- *hydroxyzine hcl intramuscular*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine pamoate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Urticaria: Failure or clinically significant adverse effects to all of the formulary alternatives: cetirizine and levocetirizine. Nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, ondansetron, or prochlorperazine. Anxiety: Failure or clinically significant adverse effects to two of the formulary alternatives: buspirone, escitalopram, paroxetine, or venlafaxine. Pruritus: Failure or clinically significant adverse effects to one of the formulary topical alternatives: betamethasone or triamcinolone.

IBANDRONIC ACID

Products Affected

- *ibandronate intravenous solution*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: alendronic acid, ibandronic acid oral tablet, or risedronate.

IBRANCE

Products Affected

- **IBRANCE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

ICLUSIG

Products Affected

- **ICLUSIG ORAL TABLET 15 MG, 45 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of formulary alternatives: Bosulif, Gleevec, Sprycel or Tasigna except when the member has a diagnosis of Chronic Myeloid Leukemia T315l-positive or Ph+ALL T315-positive.

IDARUBICIN

Products Affected

- *idarubicin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

IDHIFA

Products Affected

- **IDHIFA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of isocitrate dehydrogenase-2 (IDH2) mutation as detected by a FDA approved test
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ILARIS

Products Affected

- **ILARIS (PF) SUBCUTANEOUS RECON SOLN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent treatment with one of the following: Tumor necrosis factor inhibitors (eg: etanercept, adalimumab, infliximab) or Interleukin-1 inhibitioes (eg: rilonacept, anakinra)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Allergist, Immunologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

IMBRUVICA

Products Affected

- **IMBRUVICA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one prior systemic therapy except when the member has a diagnosis of Chronic Lymphocytic Leukemia with 17p deletion.

IMFINZI

Products Affected

- **IMFINZI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

IMIPRAMINE

Products Affected

- *imipramine hcl*
- *imipramine pamoate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	For Depression Only: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

INCRELEX

Products Affected

- **INCRELEX**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

INDOMETHACIN

Products Affected

- *indomethacin oral capsule*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, flurbiprofen, ibuprofen, meloxicam, nabumetone, naproxen, or sulindac.

INFLECTRA

Products Affected

- **INFLECTRA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Gastroenterologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira. Crohn's Disease and Ulcerative Colitis: Failure or clinically significant adverse effects to the formulary alternative: Humira. Plaque Psoriasis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira. Ankylosing spondylitis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira. Psoriatic arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.

INLYTA

Products Affected

- **INLYTA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: Afinitor, Avastin, Nexavar, Sutent or Torisel.

INTRALIPID

Products Affected

- **INTRALIPID INTRAVENOUS EMULSION 30 %**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Subject to Part B vs Part D determination.

INVANZ

Products Affected

- **INVANZ INJECTION**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

INVEGA SUSTENNA

Products Affected

- **INVEGA SUSTENNA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: oral Invega or oral risperidone.

INVEGA TRINZA

Products Affected

- **INVEGA TRINZA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: oral paliperidone or oral risperidone and failure or clinically significant adverse effects to the formulary alternative: Invega Sustenna.

IRESSA

Products Affected

- **IRESSA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of EGFR exon 19 deletion or exon 21 (L858R) substitution mutation detected by a FDA approved genetic test
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

ISOTRETINOIN

Products Affected

- *claravis*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

ISTODAX

Products Affected

- **ISTODAX**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

JAKAFI

Products Affected

- **JAKAFI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to t the formulary alternative: hydroxyurea

JEVTANA

Products Affected

- **JEVTANA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of concurrent use of prednisone
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

JUXTAPID

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	Hepatic impairment, moderate or severe (Child-Pugh category B or C)
Required Medical Information	Concurrent use with other lipid-lowering treatments
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: atorvastatin, lovastatin, pravastatin, simvastatin, Vytorin, or Zetia.

KADCYLA

Products Affected

- **KADCYLA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of Left Ventricular Ejection Fraction (LVEF)
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

KALYDECO

Products Affected

- **KALYDECO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Cystic Fibrosis mutation must be confirmed by DNA testing
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

KANUMA

Products Affected

- **KANUMA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination

KEVEYIS

Products Affected

- **KEVEYIS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination

KEYTRUDA

Products Affected

- **KEYTRUDA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

KINERET

Products Affected

- **KINERET**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Pediatrician, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.

KISQALI

Products Affected

- **KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

KISQALI FEMARA

Products Affected

- **KISQALI FEMARA CO-PACK**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of HER2 negative. Documentation of hormone receptor positive.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

KORLYM

Products Affected

- **KORLYM**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use of simvastatin, lovastatin and CYP3A substrates with narrow therapeutic ranges (e.g. cyclosporine, fentanyl, sirolimus, etc.). History of unexplained vaginal bleeding or endometrial hyperplasia with atypia or endometrial carcinoma.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

KUVAN

Products Affected

- **KUVAN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

KYNAMRO

Products Affected

- **KYNAMRO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate or severe hepatic impairment (Child-Pugh B or C) or active liver disease.
Required Medical Information	Concurrent use with other lipid-lowering treatments
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: atorvastatin, lovastatin, pravastatin, simvastatin, Vytorin, or Zetia.

KYPROLIS

Products Affected

- **KYPROLIS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

LARTRUVO

Products Affected

- **LARTRUVO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

LATUDA

Products Affected

- **LATUDA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone or ziprasidone.

LAZANDA

Products Affected

- **LAZANDA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute or postoperative pain, including headache/migraine or dental pain.
Required Medical Information	Documentation of opioid tolerance taking around-the-clock opioid therapy consisting of at least 60mg of oral morphine daily, at least 25mg transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8mg oral hydromorphone daily, at least 25mg oral oxymorphone daily or an equianalgesic dose of another opioid daily for a week or longer for breakthrough pain of cancer.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Pain specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LENVIMA

Products Affected

- **LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1/DAY), 14 MG/DAY(10 MG X 1-4 MG X 1), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

LETAIRIS

Products Affected

- **LETAIRIS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: sildenafil.

LEUKINE

Products Affected

- **LEUKINE INJECTION RECON SOLN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Excessive leukemia myeloid blasts in the bone marrow or peripheral blood equal to or greater than 10%.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	3 months.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Zarxio.

LEUPROLIDE ACETATE

Products Affected

- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LEVALBUTEROL

Products Affected

- *levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml, 1.25 mg/3 ml*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: albuterol inhalant solution.

LEVOLEUCOVORIN

Products Affected

- *levoleucovorin intravenous solution*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: leucovorin. Levoleucovorin may be approved when leucovorin is not available.

LIDOCAINE PATCH

Products Affected

- *lidocaine topical adhesive patch, medicated*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternatives: gabapentin

LINZESS

Products Affected

- **LINZESS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: lactulose and polyethylene glycol.

LONSURF

Products Affected

- **LONSURF**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of KRAS gene type (e.g. wild type)
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Failure or clinically significant adverse effects to one of the following: 5-fluorouracil, capecitabine, oxaliplatin, irinotecan, Avastin or Zaltrap. If tumor expresses the KRAS wild type gene: Failure or clinically significant adverse effects to Erbitux or Vectibix

LUMIZYME

Products Affected

- **LUMIZYME**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination.

LUPRON DEPOT

Products Affected

- **LUPRON DEPOT**
- **LUPRON DEPOT (3 MONTH)**
- **LUPRON DEPOT (4 MONTH)**
- **LUPRON DEPOT (6 MONTH)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Endometriosis: Patient has had surgical ablation to prevent recurrence, or history of failure, contraindication, or intolerance to oral contraceptives.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LUPRON DEPOT-PED

Products Affected

- **LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 30 MG**
- **LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LYNPARZA

Products Affected

- **LYNPARZA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of BRCA gene mutation detected by a FDA approved genetic test.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LYNPARZA TABLET

Products Affected

- **LYNPARZA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Deleterious or suspected deleterious germline BRCA-mutated advanced ovarian cancer only: Documentation of BRCA gene mutation detected by a FDA approved genetic test.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LYRICA

Products Affected

- **LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG**
- **LYRICA ORAL SOLUTION**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Postherpetic neuralgia: Failure or clinically significant adverse effects to the formulary alternative: gabapentin. Diabetic neuropathy: Failure or clinically significant adverse effects to all of the formulary alternatives: duloxetine and gabapentin. Fibromyalgia: Failure or clinically significant adverse effects to two of the formulary alternatives: duloxetine, gabapentin or Savella.

MAKENA

Products Affected

- **MAKENA INTRAMUSCULAR OIL 250 MG/ML (1 ML)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Up to 21 weeks of use per pregnancy
Other Criteria	Subject to Part B vs Part D determination

MATULANE

Products Affected

- **MATULANE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

MAVYRET

Products Affected

- **MAVYRET**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment length is determined by FDA labeling or AASLD recommendation
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious disease specialist
Coverage Duration	8 - 16 weeks.
Other Criteria	N/A

MEGESTROL

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Cachexia associated with AIDS: Failure or clinically significant adverse effects to all of the formulary alternatives: dronabinol and oxandrolone.

MEKINIST

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	N/A
Required Medical Information	Documentation of BRAF V600E or V600K mutation by a FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

MEPROBAMATE

Products Affected

- *meprobamate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to at least two of the formulary alternatives: buspirone, duloxetine, escitalopram, paroxetine, or venlafaxine.

METHOCARBAMOL

Products Affected

- *methocarbamol oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk

METHOXSALEN

Products Affected

- *methoxsalen*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: calcipotriene, clobetasol, cyclosporine, fluocinonide, methotrexate, or tazarotene.

METHYLDOPA

Products Affected

- *methyldopa*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide.

METHYLDOPA/HYDROCHLOROTHIAZIDE

Products Affected

- *methyldopa-hydrochlorothiazide*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide.

MITOMYCIN

Products Affected

- *mitomycin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

MODAFINIL

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Narcolepsy: Failure or clinically significant adverse effects to all of the formulary alternatives: dextroamphetamine and methylphenidate.

MOZOBIL

Products Affected

- **MOZOBIL**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

MULTAQ

Products Affected

- **MULTAQ**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

MUSTARGEN

Products Affected

- **MUSTARGEN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

MYCAMINE

Products Affected

- **MYCAMINE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

MYLOTARG

Products Affected

- **MYLOTARG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

NAGLAZYME

Products Affected

- **NAGLAZYME**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

NATPARA

Products Affected

- **NATPARA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of serum calcium greater than 7.5 mg/dL and 25-hydroxyvitamin D above 10 ng/mL
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

NERLYNX

Products Affected

- **NERLYNX**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

NEULASTA

Products Affected

- **NEULASTA SUBCUTANEOUS SYRINGE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Infectious disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to formulary alternative: Zarxio

NEUPOGEN

Products Affected

- **NEUPOGEN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Infectious disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to formulary alternative: Zarxio

NEUPRO

Products Affected

- **NEUPRO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Parkinson's Disease: Failure or clinically significant adverse effects to two of the formulary alternatives: carbidopa/levodopa, pramipexole, ropinirole, or selegiline. Restless Legs Syndrome: Failure or clinically significant adverse effects to all of the formulary alternatives: pramipexole and ropinirole.

NEXAVAR

Products Affected

- **NEXAVAR**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

NINLARO

Products Affected

- **NINLARO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

NIPENT

Products Affected

- **NIPENT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination

NITROFURANTOIN

Products Affected

- *nitrofurantoin*
- *nitrofurantoin macrocrystal*
- *nitrofurantoin monohyd/m-cryst*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	CrCL less than 60ml/min.
Required Medical Information	Documentation of culture and sensitivity indicating that nitrofurantoin is the only drug of choice for all reauthorizations.
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Initial request: 90 days of the cumulative day supply. Reauthorization: Length of therapy.
Other Criteria	Prophylaxis of UTI: Failure or clinically significant adverse effects to the formulary alternative: sulfamethoxazole/trimethoprim

NORTHERA

Products Affected

- **NORTHERA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

NOXAFIL

Products Affected

- **NOXAFIL ORAL SUSPENSION**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: fluconazole, itraconazole, or voriconazole.

NUCALA

Products Affected

- **NUCALA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Allergist, Immunologist, Pulmonologist
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to two of the formulary alternatives: Advair, Asmanex, budesonide, Flovent, or Qvar

NUEDEXTA

Products Affected

- **NUEDEXTA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

NULOJIX

Products Affected

- **NULOJIX**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist, transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

NUPLAZID

Products Affected

- **NUPLAZID**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

NUTRILIPID

Products Affected

- **NUTRILIPID**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Subject to Part B vs Part D determination.

OCALIVA

Products Affected

- **OCALIVA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	a. Documented inadequate response to ursodiol monotherapy for greater than or equal to 1 year b. Use in combination with ursodiol

OCTREOTIDE

Products Affected

- *octreotide acetate injection solution*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

ODOMZO

Products Affected

- **ODOMZO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

OFEV

Products Affected

- **OFEV**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of idiopathic pulmonary fibrosis confirmed by the presence of usual interstitial pneumonia on high resolution computed tomography (HRCT) and/or surgical lung biopsy.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Will not be used in combination with Esbriet.

OLANZAPINE SOLUTION

Products Affected

- *olanzapine intramuscular*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

OMNITROPE

Products Affected

- **OMNITROPE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	AGHD(initial): diagnosis confirmed as a result of past diagnosis of childhood-onset GHD, or adult-onset GHD with documentation of hormone deficiency due to hypothalamic-pituitary disease from organic or known causes (eg: damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and documentation of one growth-hormone stimulant test (eg: insulin tolerance test, arginine/GHRH,glucagon,arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or documentated deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IFG-1/somatomedinC below age and gender adjusted normal range as provided by physicians lab. AGHD(reauthorization): Documentation of positive experience by the patient.
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ONFI

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

OPDIVO

Products Affected

- **OPDIVO INTRAVENOUS SOLUTION 100 MG/10 ML, 40 MG/4 ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

OPSUMIT

Products Affected

- **OPSUMIT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: sildenafil.

ORENCIA

Products Affected

- **ORENCIA CLICKJECT**
- **ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.

ORENCIA VIAL

Products Affected

- **ORENCIA (WITH MALTOSE)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.

ORFADIN

Products Affected

- **ORFADIN ORAL CAPSULE 10 MG, 2 MG, 5 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ORKAMBI

Products Affected

- **ORKAMBI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

OXALIPLATIN

Products Affected

- *oxaliplatin intravenous recon soln 100 mg*
- *oxaliplatin intravenous solution 100 mg/20 ml*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

OXANDROLONE

Products Affected

- *oxandrolone*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

PACLITAXEL

Products Affected

- *paclitaxel*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	HIV specialist, Infectious disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

PALIPERIDONE

Products Affected

- *paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 6 mg, 9 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone or ziprasidone.

PAMIDRONATE

Products Affected

- *pamidronate intravenous solution*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

PANRETIN

Products Affected

- **PANRETIN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, HIV specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

PEGASYS

Products Affected

- **PEGASYS PROCLICK**
- **PEGASYS SUBCUTANEOUS SOLUTION**
- **PEGASYS SUBCUTANEOUS SYRINGE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Hepatitis C: Treatment length is determined by FDA labeling or AASLD recommendation
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

PERJETA

Products Affected

- **PERJETA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

PHENOBARBITAL

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

PHENTERMINE

Products Affected

- *phentermine 15 mg capsule*
- *phentermine 30 mg capsule*
- *phentermine 37.5 mg tablet*

PA Criteria	Criteria Details
Covered Uses	Short-term use, adjunct in a regimen of weight reduction based on exercise, behavioral modification and caloric restriction in the management of exogenous obesity for patients with an initial body mass index (BMI) greater than or equal to 30kg/m2, or greater or equal to 27 kg/m2 in the presence of other risk factors (e.g. hypertension, diabetes, hyperlipidemia).
Exclusion Criteria	N/A
Required Medical Information	BMI greater than or equal to 27 kg/m2 with one or more comorbidity (e.g. coronary heart disease, dyslipidemia, hypertension, type 2 diabetes mellitus, sleep apnea), OR BMI greater than or equal to 30 kg/m2. Reauthorization: Documented weight loss of 5% during the first 3 month period and lack of side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	N/A

PLEGRIDY

Products Affected

- **PLEGRIDY SUBCUTANEOUS PEN INJECTOR**
- **PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

POMALYST

Products Affected

- **POMALYST**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Revlimid and Velcade.

PREMARIN TABLETS

Products Affected

- **PREMARIN ORAL**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to two of the formulary alternatives: alendronic acid, ibandronic acid, or risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to one of the formulary alternatives: Estrace cream or Premarin Cream. Other indication(s): Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol transdermal patch, estradiol tablet or estropipate.

PREMPRO TABLETS

Products Affected

- **PREMPRO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to two of the formulary alternatives: alendronic acid, ibandronic acid, or risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to one of the formulary alternatives: Estrace cream or Premarin Cream. Other indication(s): Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol transdermal patch, estradiol tablet or estropipate.

PREVYMIS

Products Affected

- **PREVYMIS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist, Transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

PROCRIT

Products Affected

- **PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled hypertension
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodyspastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

PROCYSBI

Products Affected

- **PROCYSBI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Cystagon.

PROLEUKIN

Products Affected

- **PROLEUKIN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

PROLIA

Products Affected

- **PROLIA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone mineral density (BMD) T score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and a history of fractures
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Osteoporosis: Failure or clinically significant adverse effects to one of the formulary alternatives: alendronic acid, ibandronic acid, or risedronate.

PROMACTA

Products Affected

- **PROMACTA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist/Oncologist/Gastroenterologist/Hepatologist/Infectious Disease
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

PROMETHAZINE

Products Affected

- *promethazine injection solution*
- *promethazine oral*
- *promethazine rectal suppository 12.5 mg, 25 mg*
- *promethegan rectal suppository 25 mg, 50 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Allergy: Failure or clinically significant adverse effects to one of the formulary alternatives: cetirizine and levocetirizine. Nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, ondansetron, or prochlorperazine.

PROTRIPTYLINE

Products Affected

- *protriptyline*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.

PURIXAN

Products Affected

- **PURIXAN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

QUININE

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Prevention or treatment of nocturnal leg cramps.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	10 days.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: chloroquine or hydroxychloroquine.

RADICAVA PIGGYBACK

Products Affected

- **RADICAVA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Documentation of sulfite sensitivity.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: riluzole.

RANEXA

Products Affected

- **RANEXA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with strong CYP3A inhibitors or CYP3A inducers.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

RAVICTI

Products Affected

- **RAVICTI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

RAYALDEE

Products Affected

- **RAYALDEE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Stage 5 chronic kidney disease or end stage renal disease on dialysis
Required Medical Information	Documented serum total 25-hydroxyvitamin D levels less than 30 ng/mL
Age Restrictions	N/A
Prescriber Restrictions	Nephrologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

REBIF

Products Affected

- **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	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

RELISTOR

Products Affected

- **RELISTOR SUBCUTANEOUS SOLUTION**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of opioid use for at least 4 weeks prior to the initiation of therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: lactulose and polyethylene glycol.

REMICADE

Products Affected

- **REMICADE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Gastroenterologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira. Crohn's Disease and Ulcerative Colitis: Failure or clinically significant adverse effects to the formulary alternative: Humira. Plaque Psoriasis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira. Ankylosing spondylitis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira. Psoriatic arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.

REMODULIN

Products Affected

- **REMODULIN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

RENFLEXIS

Products Affected

- **RENFLEXIS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Gastroenterologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to one of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, methotrexate, or sulfasalazine and failure or clinically significant adverse effects to one of the formulary alternatives: Enbrel or Humira. Crohn's Disease and Ulcerative Colitis: Failure or clinically significant adverse effects to the formulary alternative: budesonide, mesalamine or sulfasalazine and failure or clinically significant adverse effects to the formulary alternative: Humira. Plaque Psoriasis: Failure or clinically significant adverse effects to the formulary alternative: cyclosporine and failure or clinically significant adverse effects to one of the formulary alternatives: Enbrel or Humira. Ankylosing spondylitis: Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or Sulindac and failure or clinically significant adverse effects to one of the formulary alternatives: Enbrel or Humira. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate and failure or clinically significant adverse effects to one of the formulary alternatives: Enbrel or Humira.

REPATHA

Products Affected

- **REPATHA PUSHTRONEX**
- **REPATHA SURECLICK**
- **REPATHA SYRINGE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of current LDL levels and the concurrent use of a maximally tolerated statin therapy, unless intolerant or contraindicated to statin therapy.
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Endocrinologist, Lipid specialist
Coverage Duration	Until the end of calendar year
Other Criteria	Primary Hyperlipidemia: Clinically significant adverse effects, contraindication, intolerance or failure to high-intensity statin.

REVLIMID

Products Affected

- **REVLIMID**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

REXULTI

Products Affected

- **REXULTI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

RIBAVIRIN

Products Affected

- *ribavirin oral capsule*
- *ribavirin oral tablet 200 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Hepatitis C: Treatment length is determined by FDA labeling or AASLD recommendation
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

RISPERDAL CONSTA

Products Affected

- **RISPERDAL CONSTA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: oral risperidone.

RITUXAN

Products Affected

- **RITUXAN**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Hematologist, Neurologist, Oncologist, Ophthalmologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

RUBRACA

Products Affected

- **RUBRACA ORAL TABLET 200 MG, 300 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

RYDAPT

Products Affected

- **RYDAPT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia: Documentation of FLT3 mutation positive and concurrent use with cytarabine and daunorubicin.
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SABRIL

Products Affected

- **SABRIL ORAL POWDER IN PACKET**
- **SABRIL ORAL TABLET**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Refractory Complex Partial Seizures only: Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, Lorazepam, oxcarbazepine, Phenytoin, tiagabine, topiramate, or zonisamide

SANDOSTATIN

Products Affected

- **SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

SAPHRIS

Products Affected

- **SAPHRIS (BLACK CHERRY)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone, or ziprasidone.

SAVELLA

Products Affected

- **SAVELLA ORAL TABLET**
- **SAVELLA ORAL TABLETS,DOSE PACK**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: duloxetine and gabapentin.

SIGNIFOR

Products Affected

- **SIGNIFOR**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination

SIGNIFOR LAR

Products Affected

- **SIGNIFOR LAR**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination

SILDENAFIL

Products Affected

- *sildenafil (antihypertensive) oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of nitrates and PDE5 inhibitors.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SIMULECT

Products Affected

- **SIMULECT INTRAVENOUS RECON SOLN 20 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

SIRTURO

Products Affected

- **SIRTURO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease specialist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

SOLARAZE

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: fluorouracil topical cream, fluorouracil topical solution or imiquimod topical.

SOMATULINE DEPOT

Products Affected

- **SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist/Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: octreotide.

SOMAVERT

Products Affected

- **SOMAVERT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: octreotide.

SPORANOX

Products Affected

- **SPORANOX ORAL SOLUTION**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SPRITAM

Products Affected

- **SPRITAM**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: levetiracetam oral solution

SPRYCEL

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	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

STELARA

Products Affected

- **STELARA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Gastroenterologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Crohn's Disease: Failure or clinically significant adverse effects to the formulary alternative: Humira. Plaque Psoriasis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira. Psoriatic arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.

STIVARGA

Products Affected

- **STIVARGA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Metastatic colon cancer: Failure or clinically significant adverse effects to the alternatives: fluoropyrimidine-, oxaliplatin-, irinotecan-containing chemotherapy, and anti-VEGF therapy. If KRAS wild type, documented previous use of an anti-EGFR therapy. Gastrointestinal stromal tumor (GIST): Failure or clinically significant adverse effects to all the formulary alternatives: Gleevec and Sutent.

STRENSIQ

Products Affected

- **STRENSIQ**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	80mg/0.8 ml vial: Patient's weight must be greater than or equal to 40kg.

SUTENT

Products Affected

- **SUTENT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Gastrointestinal stromal tumor (GIST): Failure or clinically significant adverse effects to the formulary alternative: Gleevec.

SYLATRON

Products Affected

- **SYLATRON**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SYLVANT

Products Affected

- **SYLVANT INTRAVENOUS RECON SOLN 100 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Human immunodeficiency virus (HIV) positive and human herpesvirus-8 (HHV-8) positive.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SYMLIN

Products Affected

- **SYMLINPEN 120**
- **SYMLINPEN 60**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Confirmed gastroparesis.
Required Medical Information	Documentation of a history of HbA1C scores of 7% or higher after at least 3 months of optimal therapy with insulin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SYNAGIS

Products Affected

- **SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SYNAREL

Products Affected

- **SYNAREL**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SYNRIBO

Products Affected

- **SYNRIBO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Bosulif, Gleevec, Iclusig, Sprycel or Tasigna.

SYPRINE

Products Affected

- **SYPRINE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Biliary cirrhosis, rheumatoid arthritis.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Depen.

TABLOID

Products Affected

- **TABLOID**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist/Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TACROLIMUS OINTMENT

Products Affected

- *tacrolimus topical*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the topical formulary alternatives: clobetasol, betamethasone, fluocinolone, or fluocinonide.

TAFINLAR

Products Affected

- **TAFINLAR**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of BRAF V600E mutation by a FDA approved test when Tafinlar is used as monotherapy. Documentation of BRAF V600E or V600K mutation by a FDA approved test when Tafinlar is used with Mekinist.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TAGRISSO

Products Affected

- **TAGRISSO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of epidermal growth factor receptor (EGFR) T790M mutation-positive
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

TARCEVA

Products Affected

- **TARCEVA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TASIGNA

Products Affected

- **TASIGNA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Gleevec except when the member has a diagnosis of Ph+CML in chronic phase.

TASMAR

Products Affected

- *tolcapone*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of concurrent use with levodopa and carbidopa.
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline.

TAZORAC

Products Affected

- *tazarotene*
- **TAZORAC TOPICAL CREAM 0.05 %**
- **TAZORAC TOPICAL GEL**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Plaque psoriasis: Failure or clinically significant adverse effects to one of the topical formulary alternatives: calcipotriene, clobetasol or fluocinonide. Acne vulgaris: Failure or clinically significant adverse effects to two of the formulary alternatives: benzoyl peroxide/clindamycin topical, benzyl peroxide/erythromycin topical, clindamycin topical, doxycycline oral, erythromycin topical, minocycline oral, tetracycline oral or tretinoin topical.

TECENTRIQ

Products Affected

- **TECENTRIQ**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For urothelial carcinoma: Documentation that patient is not eligible for cisplatin-containing chemotherapy, or with progression during or after platinum-containing chemotherapy, or within 12 months of neoadjucant or adjuvant chemotherapy. For non-small cell lung cancer: Documentation of progression during or after platinum-based chemotherapy. Patients with ALK or EGRF genomic tumor aberrations should have disease progression on FDA approved therapy for these aberrations.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination

TECFIDERA

Products Affected

- **TECFIDERA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

TESTOSTERONE

Products Affected

- *testosterone cypionate*
- *testosterone enanthate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of testosterone levels below the lab reference range.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

THALOMID

Products Affected

- **THALOMID**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

THIORIDAZINE

Products Affected

- *thioridazine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone.

THIOTEPA

Products Affected

- *thiotepa*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Subject to Part B vs Part D determination.

TIGECYCLINE

Products Affected

- *tigecycline*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

TOBI PODHALER

Products Affected

- **TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TOBRAMYCIN SOLUTION

Products Affected

- *tobramycin in 0.225 % nacl*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TORISEL

Products Affected

- **TORISEL**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TRACLEER

Products Affected

- **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	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TREANDA

Products Affected

- **TREANDA INTRAVENOUS RECON SOLN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Indolent B-Cell Non-Hodgkin Lymphoma (NHL): Failure or clinically significant adverse effects to the formulary alternative: Rituxan.

TRIHEXYPHENIDYL

Products Affected

- *trihexyphenidyl*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Parkinsonism: Failure or clinically significant adverse effects to one of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline. Medication-induced movement disorder - extrapyramidal disease: Failure or clinically significant adverse effects to the formulary alternative: amantadine.

TRIMIPRAMINE

Products Affected

- *trimipramine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.

TRINTELLIX

Products Affected

- **TRINTELLIX**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, or sertraline.

TYKERB

Products Affected

- **TYKERB**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TYMLOS

Products Affected

- **TYMLOS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone mineral density (BMD) T score of -2.5 or less based on BMD measurements from lumbar spine or hip (including femoral neck).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: alendronic acid, ibandronic acid, or risedronate. Medical justification required for treatment duration beyond 24 months.

TYSABRI

Products Affected

- **TYSABRI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Progressive multifocal leukoencephalopathy (PML).
Required Medical Information	Crohn's Disease, maintenance reauthorization: Documentation of remission or partial response.
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Multiple Sclerosis: Failure or clinically significant adverse effects to one of the formulary alternatives: Avonex, Betaseron, glatiramer or Rebif and failure or clinically adverse effects to one of the formulary alternatives: Aubagio or Gilenya. Crohn's disease: Failure or clinically significant adverse effects to the formulary alternative: Humira.

UPTRAVI

Products Affected

- **UPTRAVI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

VALCHLOR

Products Affected

- **VALCHLOR**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternative: calcipotriene, clobetasol or fluocinonide and failure or clinically significant adverse effects to one of the formulary alternatives: imiquimod or Tazorac.

VANCOMYCIN CAPSULE

Products Affected

- *vancomycin oral capsule*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Reauthorization: Documentation of C. Difficile positive stool
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: metronidazole. Reauth for 1st occurrence: Ok to approve 56/14 days. Reauth for 2nd reoccurence: Ok to approve up to 6 week tapered dose.

VECTIBIX

Products Affected

- **VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of wild-type KRAS mutation
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

VELCADE

Products Affected

- **VELCADE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VEMLIDY

Products Affected

- **VEMLIDY**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hepatologist, Gastroenterologist, Infectious disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VENCLEXTA

Products Affected

- **VENCLEXTA**
- **VENCLEXTA STARTING PACK**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of 17p deletion and documentation of at least one prior therapy
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VERSACLOZ

Products Affected

- **VERSACLOZ**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: clozapine.

VERZENIO

Products Affected

- **VERZENIO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of Hormone receptor (HR) positive. Documentation of HER2 negative.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VIGABATRIN

Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Refractory Complex Partial Seizures only: Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, Lorazepam, oxcarbazepine, Phenytoin, tiagabine, topiramate, or zonisamide

VIIBRYD

Products Affected

- **VIIBRYD ORAL TABLET**
- **VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, paroxetine, or sertraline.

VIMPAT

Products Affected

- **VIMPAT INTRAVENOUS**
- **VIMPAT ORAL SOLUTION**
- **VIMPAT ORAL TABLET**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

VINBLASTINE

Products Affected

- *vinblastine intravenous solution*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

VINCRISTINE

Products Affected

- *vincristine intravenous solution 1 mg/ml*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

VORICONAZOLE

Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VOSEVI

Products Affected

- **VOSEVI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment length is determined by FDA labeling or AASLD recommendation
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious disease specialist
Coverage Duration	12 weeks.
Other Criteria	N/A

VOTRIENT

Products Affected

- **VOTRIENT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VPRIV

Products Affected

- **VPRIV**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Gaucher disease, type 1, must be confirmed by blood or genetic testing
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

VRAYLAR

Products Affected

- **VRAYLAR ORAL CAPSULE**
- **VRAYLAR ORAL CAPSULE,DOSE PACK**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Bipolar and Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone.

VYXEOS

Products Affected

- **VYXEOS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

XALKORI

Products Affected

- **XALKORI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic, anaplastic lymphoma kinase (ALK)-positive Non-Small Cell Lung Cancer detected by an FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

XATMEP

Products Affected

- **XATMEP**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Pediatrician, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

XENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

XERMELO

Products Affected

- **XERMELO**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of four or more bowel movements daily despite the use of octreotide
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist, Gastroenterologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

XGEVA

Products Affected

- **XGEVA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

XIFAXAN

Products Affected

- **XIFAXAN**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Hepatic encephalopathy: Failure or clinically significant adverse effects to the formulary alternative: lactulose. Irritable bowel syndrome with diarrhea: Failure or clinically significant adverse effects to the formulary alternative: loperamide. Traveler's diarrhea: Failure or clinically significant adverse effects to the formulary alternative: ciprofloxacin.

XOLAIR

Products Affected

- **XOLAIR**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Asthma (Initial): Forced expiratory volume in one second or peak expiratory flow less than or equal to 80% of predicted level, or measures of asthma control indicate uncontrolled asthma (eg, Asthma Control Test [ACT] score 19 or less).Baseline (pre-Xolair treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 700 IU/mL. Positive skin test or in vitro reactivity to a perennial aeroallergen.
Age Restrictions	N/A
Prescriber Restrictions	Allergist, Dermatologist, Immunologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

XTANDI

Products Affected

- **XTANDI**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

XYREM

Products Affected

- **XYREM**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Daytime excessive sleepiness in patients with narcolepsy: Failure or clinically significant adverse effects to the formulary alternative: modafinil.

YERVOY

Products Affected

- **YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

YONDELIS

Products Affected

- **YONDELIS**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

ZALEPLON

Products Affected

- *zaleplon*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: lorazepam, Rozerem, temazepam, trazodone, or triazolam.Reauthorizations: Approved until the end of calendar year.64 years age or younger: Approved until the end of calendar year.

ZALTRAP

Products Affected

- **ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ZANOSAR

Products Affected

- **ZANOSAR**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ZAVESCA

Products Affected

- **ZAVESCA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: Cerezyme or Cerdelga.

ZEJULA

Products Affected

- **ZEJULA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ZELBORAF

Products Affected

- **ZELBORAF**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Wild-type BRAF melanoma.
Required Medical Information	Documentation of BRAF V600E mutation by a FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ZEPATIER

Products Affected

- **ZEPATIER**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment length is determined by FDA labeling or AASLD recommendation
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious disease specialist
Coverage Duration	12 to 16 weeks dependent on genotype and polymorphism, cirrohsis, or previous treatment
Other Criteria	For genotype 1a: Documentation for NS5A polymorphism testing

ZINBRYTA

Products Affected

- **ZINBRYTA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Aubagio, Avonex, Betaseron, Gilenya, glatiramer, Rebif or Tecfidera

ZOLEDRONIC ACID

Products Affected

- *zoledronic acid intravenous solution*
- *zoledronic acid-mannitol-water*
- **ZOMETA INTRAVENOUS PIGGYBACK**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone mineral density (BMD) T score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and a history of fractures
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Osteoporosis: Failure or clinically significant adverse effects to one of the formulary alternatives: alendronic acid, ibandronic acid, or risedronate.

ZOLINZA

Products Affected

- **ZOLINZA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two prior systemic therapies.

ZOLPIDEM

Products Affected

- *zolpidem oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: lorazepam, Rozerem, temazepam, trazodone, or triazolam.Reauthorizations: Approved until the end of calendar year.64 years age or younger: Approved until the end of calendar year.

ZYDELIG

Products Affected

- **ZYDELIG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two prior systemic therapies.

ZYKADIA

Products Affected

- **ZYKADIA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Xalkori.

ZYPREXA RELPREVV

Products Affected

- **ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year
Other Criteria	The member has a documented history of receiving oral olanzapine without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta

ZYTIGA

Products Affected

- **ZYTIGA ORAL TABLET 250 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ZYVOX

Products Affected

- *linezolid intravenous*
- *linezolid oral suspension for reconstitution*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- *acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml*
- **AMINOSYN II 8.5 %-ELECTROLYTES INTRAVENOUS PARENTERAL SOLUTION 8.5 %**
- **AMINOSYN-HBC 7% INTRAVENOUS PARENTERAL SOLUTION 7 %**
- *azathioprine oral tablet 50 mg*
- *azathioprine sodium injection recon soln 100 mg*
- *budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml*
- *calcitriol intravenous solution 1 mcg/ml*
- *calcitriol oral capsule 0.25 mcg, 0.5 mcg*
- *calcitriol oral solution 1 mcg/ml*
- *carboplatin intravenous solution 10 mg/ml*
- *chlorpromazine oral tablet 25 mg*
- *cisplatin intravenous solution 1 mg/ml*
- **CLINIMIX 4.25%/D10W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- **CLINIMIX 4.25%/D5W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- **CLINIMIX 4.25%-D20W SULF-FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- **CLINIMIX 4.25%-D25W SULF-FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- **CLINIMIX E 4.25%/D10W SUL FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- **CLINIMIX E 4.25%/D25W SUL FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- **CLINIMIX E 4.25%/D5W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- *clinisol sf 15 % intravenous parenteral solution 15 %*
- *colistin (colistimethate na) injection recon soln 150 mg*
- *cromolyn inhalation solution for nebulization 20 mg/2 ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclosporine intravenous solution 250 mg/5 ml*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *dacarbazine intravenous recon soln 200 mg*
- *daunorubicin intravenous solution 5 mg/ml*
- **DEPO-MEDROL INJECTION SUSPENSION 20 MG/ML**
- *dexamethasone sodium phosphate injection solution 10 mg/ml*
- *dextrose 10 % in water (d10w) intravenous parenteral solution 10 %*
- *doxorubicin intravenous solution 50 mg/25 ml*
- **DURAMORPH (PF) INJECTION SOLUTION 0.5 MG/ML, 1 MG/ML**
- **ELITEK INTRAVENOUS RECON SOLN 1.5 MG, 7.5 MG**
- *etoposide intravenous solution 20 mg/ml*
- *fluorouracil intravenous solution 5 gram/100 ml*
- *ganciclovir sodium intravenous recon soln 500 mg*
- *granisetron (pf) intravenous solution 100 mcg/ml*
- *granisetron hcl intravenous solution 1 mg/ml (1 ml)*
- *granisetron hcl oral tablet 1 mg*
- *heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml), 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)*
- *heparin (porcine) injection solution 1,000 unit/ml, 10,000 unit/ml, 20,000 unit/ml, 5,000 unit/ml*
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml*
- **ISOLYTE-S INTRAVENOUS PARENTERAL SOLUTION**

- *leucovorin calcium injection recon soln 100 mg, 350 mg*
- *levocarnitine oral tablet 330 mg*
- *mesna intravenous solution 100 mg/ml*
- *methotrexate sodium (pf) injection recon soln 1 gram*
- *methotrexate sodium (pf) injection solution 25 mg/ml, 25 mg/ml (10 ml)*
- *methotrexate sodium injection solution 25 mg/ml*
- *methylprednisolone acetate injection suspension 40 mg/ml, 80 mg/ml*
- *methylprednisolone sodium succ intravenous recon soln 1,000 mg*
- *mitoxantrone intravenous concentrate 2 mg/ml*
- *mycophenolate mofetil hcl intravenous recon soln 500 mg*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension for reconstitution 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet,delayed release (dr/ec) 180 mg, 360 mg*
- **NEBUPENT INHALATION RECON SOLN 300 MG**
- *ondansetron hcl oral solution 4 mg/5 ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet, disintegrating 4 mg, 8 mg*
- **PLASMA-LYTE 148 INTRAVENOUS PARENTERAL SOLUTION**
- **PLASMA-LYTE A INTRAVENOUS PARENTERAL SOLUTION**
- *prednisone oral tablet 50 mg*
- **PROGRAF INTRAVENOUS SOLUTION 5 MG/ML**
- **PROSOL 20 % INTRAVENOUS PARENTERAL SOLUTION**
- **PULMOZYME INHALATION SOLUTION 1 MG/ML**
- **RAPAMUNE ORAL SOLUTION 1 MG/ML**
- **RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML**
- **RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML**
- **SENSIPAR ORAL TABLET 30 MG, 60 MG, 90 MG**
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- **SOLU-CORTEF (PF) INJECTION RECON SOLN 100 MG/2 ML, 250 MG/2 ML**
- **SOLU-MEDROL (PF) INJECTION RECON SOLN 125 MG/2 ML, 40 MG/ML**
- **SOLU-MEDROL (PF) INTRAVENOUS RECON SOLN 1,000 MG/8 ML, 500 MG/4 ML**
- **SOLU-MEDROL INTRAVENOUS RECON SOLN 2 GRAM**
- **SYNERCID INTRAVENOUS RECON SOLN 500 MG**
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- **THYMOGLOBULIN INTRAVENOUS RECON SOLN 25 MG**
- **TRAVASOL 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %**
- **TRISENOX INTRAVENOUS SOLUTION 10 MG/10 ML, 2 MG/ML**
- *vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg*
- *vinorelbine intravenous solution 50 mg/5 ml*
- **ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG**
- **ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG**

Details

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.

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