

MEDICATION(S)

MENEST 0.3 MG TABLET, MENEST 0.625 MG TABLET, MENEST 1.25 MG TABLET

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

AGE RESTRICTION

PA applies to patients 65 years or older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of therapy.

MEDICATION(S)

ORKAMBI

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene. The presence of the mutation was documented by an FDA-cleared cystic fibrosis mutation test or Clinical Laboratory Improvement Amendments-approved facility.

AGE RESTRICTION

CF (Initial): Patient is 6 years of age or older

PRESCRIBER RESTRICTION

CF (Initial): Prescribed by or in consultation with a specialist affiliated with a CF care center

COVERAGE DURATION

CF (initial, reauth): 12 months

OTHER CRITERIA

CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations)

OTEZLA (S)

MEDICATION(S)

OTEZLA 28 DAY STARTER PACK, OTEZLA 30 MG TABLET

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Psoriatic arthritis (PsA, initial): Diagnosis of active PsA. Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. PsA, plaque psoriasis (initial): Trial and failure, contraindication, or intolerance to both Humira and Enbrel, OR for continuation of prior Otezla therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION

Initial, Reauth: 12 months

OTHER CRITERIA

Reauthorization (all indications): Documentation of positive clinical response to Otezla therapy.

OXANDRIN (S): THIS CRITERIA IS CURRENTLY UNDER REVIEW BY CMS

MEDICATION(S)

OXANDROLONE 10 MG TABLET, OXANDROLONE 2.5 MG TABLET

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Promote weight gain (initial): Medication will be used as an adjunct therapy to promote weight gain AND One of the following: Extensive surgery, Chronic infections, Severe trauma, Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons AND Trial and failure, contraindication, or intolerance to nutritional supplements AND a nutritional consult was performed. Counterbalance protein catabolism (initial): Oxandrin will be used to counterbalance protein catabolism associated with chronic corticosteroid administration. Bone pain (initial): Diagnosis of bone pain associated with osteoporosis.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

bone pain (initial, reauth): 1 month. Others (initial, reauth): 3 months

OTHER CRITERIA

All diagnoses (reauth): patient has experienced an objective improvement (i.e. weight gain, increase in lead body mass, or reduction in muscle pain/weakness)

PART D VS PART B

MEDICATION(S)

ABELCET, ACETYLCYSTEINE 10% VIAL, ACETYLCYSTEINE 20% VIAL, ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML VIAL, ADRIAMYCIN 20 MG/10 ML VIAL, ADRUCIL 500 MG/10 ML VIAL, ALBUTEROL 15 MG/3 ML SOLUTION, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL 20 MG/4 ML SOLUTION, ALBUTEROL 5 MG/ML SOLUTION, ALBUTEROL SUL 0.63 MG/3 ML SOL, ALBUTEROL SUL 1.25 MG/3 ML SOL, ALBUTEROL SUL 2.5 MG/3 ML SOLN, AMBISOME, AMINO ACIDS 15% SOLUTION, AMINOSYN II 10% IV SOLUTION, AMINOSYN II 7% IV SOLUTION, AMINOSYN II WITH ELECTROLYTES, AMINOSYN WITH ELECTROLYTES, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-RF, AMPHOTERICIN B 50 MG VIAL, ANZEMET 100 MG TABLET, ANZEMET 50 MG TABLET, APREPITANT, ASTAGRAF XL, ATGAM, AZASAN, AZATHIOPRINE 50 MG TABLET, AZATHIOPRINE SODIUM, BETHKIS, BLEOMYCIN SULFATE 30 UNIT VIAL, BROVANA, BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, CELLCEPT 500 MG VIAL, CLADRIBINE, CLINIMIX, CLINIMIX E, CROMOLYN 20 MG/2 ML NEB SOLN, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 100 MG/ML SOLN, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE 50 MG/ML AMPUL, CYCLOSPORINE MODIFIED, CYTARABINE 2 G/20 ML VIAL, CYTARABINE 20 MG/ML VIAL, DOXORUBICIN 50 MG/25 ML VIAL, DOXORUBICIN HCL LIPOSOME, EMEND 125 MG CAPSULE, EMEND 125 MG POWDER PACKET, EMEND 40 MG CAPSULE, EMEND 80 MG CAPSULE, EMEND TRIPACK, ENGERIX-B 20 MCG/ML SYRN, ENGERIX-B PEDIATRIC-ADOLESCENT, ENVARUS XR, FLUOROURACIL 1,000 MG/20 ML VL, FLUOROURACIL 2,500 MG/50 ML VL, FLUOROURACIL 2.5 GM/50 ML BTL, FLUOROURACIL 2.5 GM/50 ML VIAL, FLUOROURACIL 5 GM/100 ML VIAL, FLUOROURACIL 5,000 MG/100 ML, FLUOROURACIL 500 MG/10 ML VIAL, FREAMINE HBC, GABLOFEN 40,000 MCG/20 ML VIAL, GANCICLOVIR SODIUM, GENGRAF, GRANISETRON HCL 1 MG TABLET, HEPATAMINE, HYPERRAB S-D, IMO GAM RABIES-HT, IMOVAX RABIES VACCINE, INTRALIPID 20% IV FAT EMUL, IPRATROPIUM BR 0.02% SOLN, IPRATROPIUM-ALBUTEROL, IRINOTECAN HCL 100 MG/5 ML VL, LEVALBUTEROL CONCENTRATE, LEVALBUTEROL 0.31 MG/3 ML SOL, LEVALBUTEROL 0.63 MG/3 ML SOL, LEVALBUTEROL 1.25 MG/3 ML SOL, LIORESAL INTRATHECAL, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID, NEBUPENT, NEPHRAMINE, NUTRILIPID, ONDANSETRON 4 MG/5 ML SOLUTION, ONDANSETRON HCL 24 MG TABLET, ONDANSETRON HCL 4 MG TABLET, ONDANSETRON HCL 8 MG TABLET, ONDANSETRON ODT, OXALIPLATIN 100 MG/20 ML VIAL, PERFOROMIST, PREMASOL, PROCALAMINE, PROGRAF 5 MG/ML AMPULE, PROSOL, RABAVERT, RAPAMUNE 1 MG/ML ORAL SOLN, RECOMBIVAX HB 10 MCG/ML SYR, RECOMBIVAX HB 10 MCG/ML VIAL, RECOMBIVAX HB 40 MCG/ML VIAL, RECOMBIVAX HB 5 MCG/0.5 ML SYR, SANDIMMUNE 100 MG/ML SOLN, SENSIPAR, SIMULECT 20 MG VIAL, SIROLIMUS 0.5 MG TABLET, SIROLIMUS 1 MG TABLET, SIROLIMUS 2 MG TABLET, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 1 MG

CAPSULE, TACROLIMUS 5 MG CAPSULE, THYMOGLOBULIN, TOBRAMYCIN 300 MG/5 ML AMPULE, TRAVASOL, TRIMETHOBENZAMIDE 300 MG CAP, TROPHAMINE 10% IV SOLUTION, TWINRIX VACCINE VIAL, VECTIBIX 100 MG/5 ML VIAL, VINBLASTINE SULFATE, VINCASAR PFS 1 MG/ML VIAL, VINCRISTINE 1 MG/ML VIAL

DETAILS

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

PEGASYS (S)

MEDICATION(S)

PEGASYS, PEGASYS PROCLICK

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Chronic hepatitis B: Diagnosis of chronic hepatitis B infection, and patient is without decompensated liver disease. Chronic Hepatitis C: Criteria will be applied consistent with current AASLD-IDSA guidance

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

HepB: 48 wks. HepC: Initial: 28 wks. Reauth: 20 wks.

OTHER CRITERIA

N/A

MEDICATION(S)

DICLOFENAC 1.5% TOPICAL SOLN

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Initial, reauth: History of severe allergic-type reactions after taking aspirin or other non-steroidal anti-inflammatory (NSAIDs), including urticaria and asthma (aspirin-sensitive asthma).

REQUIRED MEDICAL INFORMATION

Osteoarthritis of the knees (initial): Diagnosis of osteoarthritis of the knees and diclofenac will not be used in the treatment of peri-operative pain in the setting of coronary artery bypass graft surgery. Patient meets one of the following: 1) Treatment failure with at least two prescription strength oral non-steroidal anti-inflammatory drugs (NSAIDs) OR 2) Documented swallowing disorder OR 3) History of peptic ulcer disease/gastrointestinal bleed OR 4) Patient is older than 65 years of age with one additional risk factor for gastrointestinal adverse events (e.g. use of anticoagulants, chronic corticosteroids).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial, reauth: 12 months

OTHER CRITERIA

Osteoarthritis of the knees (reauth): Patient has experienced a response to therapy (e.g., improvement in pain symptoms of osteoarthritis).

PERJETA (S)

MEDICATION(S)

PERJETA

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Metastatic breast cancer: Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive metastatic breast cancer. One of the following: a) patient has not received prior anti-HER2 therapy or chemotherapy for metastatic disease AND used in combination with Herceptin (trastuzumab) and a taxane (eg, docetaxel, paclitaxel), OR b) patient was previously treated with chemotherapy and Herceptin (trastuzumab) without Perjeta AND used in combination with Herceptin (trastuzumab). Non-metastatic breast cancer: One of the following diagnoses: HER2-positive early stage breast cancer, HER2-positive locally advanced breast cancer, or HER2-positive inflammatory breast cancer. Used in combination with both Herceptin (trastuzumab) and a taxane (eg, docetaxel, paclitaxel).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

All Uses: Prescribed by or in consultation with an oncologist.

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

POMALYST (S)

MEDICATION(S)

POMALYST

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Multiple Myeloma (MM): Diagnosis of MM. Used in combination with dexamethasone. Patient has received two prior therapies, including Revlimid (lenalidomide) and a proteasome inhibitor [eg, Velcade (bortezomib) or Kyprolis (carfilzomib)] or has a contraindication or intolerance to Revlimid and proteasome inhibitors. Patient has experienced disease progression on or within 60 days of completion of last therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist/hematologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

PRALUENT (S)

MEDICATION(S)

PRALUENT PEN

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Initial: Submission of medical records (eg, chart notes, laboratory values) documenting one of the following diagnoses: Heterozygous familial hypercholesterolemia (HeFH) as confirmed by one of the following: (1) Documented assessment of patient using Dutch Lipid Clinic Network diagnostic criteria with a cumulative score greater than or equal to 9 points (ie, definite FH), (2) Presence of tendinous xanthomas in patient, first degree relative, or second degree relative, AND Untreated/pre-treatment LDL-C greater than 190 mg/dL in an adult, (3) Genetic confirmation of a mutation in the LDL receptor, ApoB, or PCSK9. OR Atherosclerotic cardiovascular disease (ASCVD) as confirmed by acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin. One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 30 days: (1) LDL-C greater than or equal to 100 mg/dL with ASCVD. (2) LDL-C greater than or equal to 130 mg/dL without ASCVD.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Initial, reauth: Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist

COVERAGE DURATION

Initial: 6 months. Reauth: 12 months

OTHER CRITERIA

HeFH/ASCVD: Initial: One of the following: (1) Patient has been receiving at least 12 consecutive weeks of one high-intensity statin therapy and will continue to receive a HIGH-INTENSITY statin [ie, atorvastatin 40-80 mg, Crestor (rosuvastatin) 20-40 mg] at maximally tolerated dose, OR (2) Both of the following: A) Patient is unable to tolerate high-intensity statin as evidenced by intolerable and

persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN]), AND B) One of the following: a) Patient has been receiving at least 12 consecutive weeks of one moderate-intensity or low-intensity statin therapy and will continue to receive a MODERATE-INTENSITY or LOW-INTENSITY statin [ie, atorvastatin 10-20 mg, Crestor (rosuvastatin) 5-10 mg, simvastatin 10-40 mg, pravastatin 10-80 mg, lovastatin 20-40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 20-40 mg, or Livalo (pitavastatin) 1-4 mg] at maximally tolerated dose, OR b) Patient is unable to tolerate moderate-intensity or low-intensity statin as evidenced by intolerable and persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN]), OR (3) Submission of medical records documenting patient has a labeled contraindication to all statins, OR (4) Patient has experienced rhabdomyolysis on one statin therapy. Reauth: Patient continues to receive statin at the maximally tolerated dose (unless patient has documented inability to take statins). Submission of medical records (eg, laboratory values) documenting a sustained LDL-C reduction from pre-treatment baseline (ie, prior to Praluent therapy) while on Praluent therapy. Initial, reauth: Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.

PROCYSBI (S)

MEDICATION(S)

PROCYSBI

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Nephropathic cystinosis: Diagnosis of nephropathic cystinosis, confirmed by elevated leukocyte cystine levels (LCL) or genetic analysis of the CTNS gene AND Trial and failure or intolerance to therapy with Cystagon (immediate-release cysteamine bitartrate).

AGE RESTRICTION

2 years of age or older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

PROLIA (S)

MEDICATION(S)

PROLIA

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Postmenopausal osteoporosis (PMO) (initial): Diagnosis (dx) of PMO. History (hx) of vertebral compression fractures (fx), or fx of the hip, or distal radius resulting from minimal trauma, or bone mineral density score (BMD) indicative of osteoporosis (OP): T-score less than or equal to -2.5 (2.5 standard deviations [SD] or greater below the mean for young adults). PMO, prophylaxis (initial): For prevention of PMO. BMD scan indicative of osteopenia: T-score -1.0 to -2.5. Nonmetastatic prostate cancer (NMPC) bone loss (initial): Dx of NMPC. Pt is 70 years or older, or less than 70 years old with BMD T-score below -1.0 (1.0 SD or greater below the mean for young adults) or hx of vertebral compression fx or fx of the hip or distal radius resulting from minimal trauma. NMPC (reauth): No evidence of metastases. Breast cancer (BC) bone loss (initial): Dx of BC. BMD T-score below -1.0 (1.0 SD or greater below the mean for young adults) or hx of vertebral compression fx or fx of the hip or distal radius resulting from minimal trauma. OP in men (initial): Pt is a male with OP. Hx of vertebral compression fx or fx of the hip or distal radius resulting from minimal trauma, or BMD indicative of OP: T-score less than or equal to -2.0 (2.0 SD or greater below the mean for young adults).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

All uses (initial, reauth): 12 months

OTHER CRITERIA

NMPC bone loss (initial and reauth): Receiving androgen deprivation therapy (ADT) from luteinizing hormone/gonadotropin releasing hormone (LHRH/GnRH) agonist [e.g., Eligard/Lupron (leuprolide), Trelstar (triptorelin), Vantas (histrelin), Zoladex (goserelin)] or bilateral orchiectomy (i.e. surgical

castration). BC bone loss (initial and reauth): Pt is receiving aromatase inhibitor (AI) therapy [e.g., Arimidex (anastrozole), Aromasin (exemestane), Femara (letrozole)]. All indications except NMPC (initial): One of the following A) Patient has a documented trial and therapeutic failure with a bisphosphonate, where therapeutic failure is defined as new fractures in compliant patients on therapy for at least 6 months, failure to produce a clinically significant change in a biochemical marker(s) of bone turnover, or significant loss of bone mineral density on follow-up scans after 12 to 24 months of therapy or B) Patient has a documented contraindication or intolerance to bisphosphonate therapy, or is unable to comply with appropriate administration recommendations for oral or injectable bisphosphonate therapy. All indications (renewal):The patient is benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, or improved biochemical markers, etc.)

PROMACTA (S)

MEDICATION(S)

PROMACTA

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Chronic immune (idiopathic) thrombocytopenic purpura (ITP) (initial): Diagnosis of relapsed/refractory chronic ITP for greater than 6 months. Baseline platelet count is less than 50,000/mcL. Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding. One of the following: A) Trial and failure, intolerance, contraindication to corticosteroids or immune globulin OR B) Trial and failure or contraindication to splenectomy. Chronic hepatitis C (initial): Diagnosis of chronic hepatitis C. Patient has thrombocytopenia defined as platelets less than 90,000/mcL for initiation (pre-treatment) of interferon therapy. Severe aplastic anemia (initial): Diagnosis of severe aplastic anemia. Patient has a platelet count less than 30,000/mcL. Trial and failure, intolerance, or contraindication to immunosuppressive therapy with antithymocyte globulin and cyclosporine.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

ITP (init, reauth): 12mo. HepC: 9wks (init), 24wks (reauth). Aplas anemia (init, reauth): 16wks.

OTHER CRITERIA

ITP (reauth): After at least 4 weeks of therapy at the maximum weekly dose (10 mcg/kg), the platelet count increased to a sufficient level to avoid clinically important bleeding. Hepatitis C (reauth): Platelets less than 75,000/mcL for maintenance of optimal interferon-based therapy. Aplastic anemia (reauth): Patient has experienced an increase in platelet count.

PROVIGIL (S)

MEDICATION(S)

MODAFINIL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Obstructive sleep apnea/hypopnea syndrome (OSAHS) (Initial): Diagnosis (dx) of OSAHS defined by one of the following: 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), and 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work sleep disorder (SWSD) (Initial): Dx of SWSD confirmed by symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, or sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). No other medical condition or medication accounts for the symptoms. Narcolepsy (initial): Dx of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming that a sleep study is not feasible). MS Fatigue (initial): Dx of multiple sclerosis (MS). Patient is experiencing fatigue. Depression (initial): Treatment-resistant depression defined as diagnosis of major depressive disorder (MDD) or bipolar depression, AND trial and failure, contraindication, or intolerance to at least two antidepressants from different classes (eg, SSRIs, SNRIs, bupropion). Used as adjunctive therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

OSAHS/MS/dep(init), SWSD (init,reauth): 3 mo. OSAHS/dep(reauth): 12mo. MS (reauth): 6mo. Other:

12mo
PAGE 214

LAST UPDATED 09/2017

OTHER CRITERIA

OSAHS (Reauth): Documentation of positive clinical response to prior therapy. SWSD (Reauth): Documentation of positive clinical response to prior therapy. Patient still requires treatment for SWSD. Narcolepsy (reauth): Documentation of positive clinical response to prior therapy. MS Fatigue (reauth): Patient is experiencing relief of fatigue with modafinil therapy. Idiopathic Hypersomnia (reauth): Documentation of positive clinical response to modafinil therapy. Depression (reauth): Documentation of positive clinical response to modafinil therapy. Used as adjunctive therapy.

PULMOZYME (S)

MEDICATION(S)

PULMOZYME

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Cystic Fibrosis (CF) (Initial, Reauth): Diagnosis of CF

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

CF (initial, reauth): 12 months

OTHER CRITERIA

Part B vs D determination applies. CF (reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).

QUALAQUIN (S)

MEDICATION(S)

QUININE SULFATE 324 MG CAPSULE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Malaria: Diagnosis of uncomplicated malaria. One of the following: 1) Treatment in areas of chloroquine-sensitive malaria, and trial and failure, contraindication, or intolerance to chloroquine or hydroxychloroquine, OR 2) Treatment in areas of chloroquine-resistant malaria. Not used for the treatment or prevention of nocturnal leg cramps.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

7 days

OTHER CRITERIA

N/A

RAVICTI (S)

MEDICATION(S)

RAVICTI

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Urea cycle disorders (UCDs) (Initial): Diagnosis of UCDs.

AGE RESTRICTION

UCDs (Initial): Age greater than 2 months

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

UCDs (Initial, reauth): 12 months

OTHER CRITERIA

UCDs (reauth): Documentation of positive clinical response to Ravicti therapy.

REGRANEX (S)

MEDICATION(S)

REGRANEX

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Diabetic neuropathic ulcers: Patient has a lower extremity diabetic neuropathic ulcer. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

5 months

OTHER CRITERIA

N/A

RELISTOR (S)

MEDICATION(S)

RELISTOR 12 MG/0.6 ML KIT, RELISTOR 12 MG/0.6 ML SYRINGE, RELISTOR 12 MG/0.6 ML VIAL, RELISTOR 8 MG/0.4 ML SYRINGE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Opioid-induced constipation (OIC) (Initial): Diagnosis of OIC. Patient has used opioid medication for a minimum of 4 weeks. Patient is experiencing fewer than 3 bowel movements in a week or no bowel movement for longer than 2 days. One of the following: A) Patient is an adult with a diagnosis of chronic non-cancer pain AND patient had a trial and failure, contraindication, or intolerance to Amitiza (lubiprostone), OR B) Patient is receiving palliative care for an advanced illness.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

OIC (initial, reauth): 4 months

OTHER CRITERIA

OIC (Reauth): Diagnosis of OIC. One of the following: A) Patient is an adult with a diagnosis of chronic non-cancer pain, OR B) Both of the following: Patient is receiving palliative care for an advanced illness AND Patient has responded to therapy (e.g., increase in bowel movements).

RELISTOR TABLETS (S)

MEDICATION(S)

RELISTOR 150 MG TABLET

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Opioid-induced constipation (OIC) (non-cancer pain, initial): Diagnosis of OIC. Patient is an adult with a diagnosis of chronic non-cancer pain. Patient has used an opioid medication for a minimum of 4 weeks. Patient is experiencing fewer than 3 bowel movements in a week or no bowel movement for longer than 2 days. Trial and failure, contraindication, or intolerance to Amitiza (lubiprostone).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

OIC (Reauth): Diagnosis of OIC. Patient is an adult with a diagnosis of chronic non-cancer pain. Documentation of a positive clinical response to Relistor therapy (e.g., increase in bowel movements).

REMICADE (S)

MEDICATION(S)

REMICADE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (Initial): Diagnosis (Dx) of moderately to severely active CD or FCD. Failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine, Imuran (azathioprine), corticosteroid (eg, prednisone, methylprednisolone), methotrexate (Rheumatrex/Trexall). Ulcerative colitis (UC) (Initial): Dx of moderately to severely active UC. Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies: 6-mercaptopurine, Imuran (azathioprine), corticosteroid (eg, prednisone, methylprednisolone), aminosalicylate [eg, mesalamine (Asacol/Pentasa/Rowasa), Dipentum (olsalazine), Azulfidine (sulfasalazine)]. Rheumatoid arthritis (RA) (Initial): Dx of moderately to severely active RA. One of the following: Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall), OR TF/C/I to methotrexate (Rheumatrex/Trexall). Ankylosing spondylitis (AS) (Initial): Dx of active AS. TF/C/I to two NSAIDs. Psoriatic arthritis (PsA) (Initial): Dx of active PsA. Plaque psoriasis (Initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. Sarcoidosis (initial): TF/C/I to one immunosuppressant [eg, methotrexate (Rheumatrex/Trexall), cyclophosphamide, or azathioprine (Imuran)] AND TF/C/I to one corticosteroid (eg, prednisone). All indications (Initial): Patient is not receiving Remicade in combination with a biologic DMARD [eg, Enbrel (etanercept), Rituxan (rituximab), Orencia (abatacept), Kineret (anakinra)]. Patient is not receiving Remicade in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

CD, FCD, UC (Initial): Prescribed by or in consultation with a gastroenterologist. RA, AS (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with rheumatologist or dermatologist. Plaque Psoriasis (Initial): Prescribed by or in consultation with a dermatologist. Sarcoidosis (Initial): Prescribed by or in consultation with a pulmonologist, dermatologist, ophthalmologist.

COVERAGE DURATION

All indications (initial, reauth): 12 months

OTHER CRITERIA

Reauthorization for all indications: Documentation of positive clinical response to infliximab therapy. All indications (re-auth): Excluded if patient is receiving infliximab in combination with a Biologic Disease Modifying Antirheumatic Drug (DMARD) [eg, Enbrel (etanercept), Orencia (abatacept), Rituxan (rituximab), Kineret (anakinra), Cimzia (certolizumab)] or Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

REMODULIN (S)

MEDICATION(S)

REMODULIN

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.

COVERAGE DURATION

PAH: Initial: 6 months. Reauth: 12 months.

OTHER CRITERIA

Subject to Part B vs. D Review. PAH (Reauth): Documentation of positive clinical response to therapy.

REPATHA (S)

MEDICATION(S)

REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

HeFH/ASCVD (initial): Submission of medical records (eg, chart notes, laboratory values) documenting one of the following diagnoses: Heterozygous familial hypercholesterolemia (HeFH) as confirmed by one of the following: (1) Documented assessment of patient using Dutch Lipid Clinic Network diagnostic criteria with a cumulative score greater than or equal to 9 points (ie, definite FH), or (2) Presence of tendinous xanthomas in patient, first degree relative, or second degree relative, AND Untreated/pre-treatment LDL-C greater than 190 mg/dL in an adult, or (3) Genetic confirmation of a mutation in the LDL receptor, ApoB, or PCSK9. OR Atherosclerotic cardiovascular disease (ASCVD) as confirmed by acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin. HoFH (initial): Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of homozygous familial hypercholesterolemia as confirmed by one of the following: (1) Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH), or (2) either untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL, AND either xanthoma before 10 years of age or evidence of heterozygous familial hypercholesterolemia in both parents.

HeFH/ASCVD/HoFH (initial): One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 30 days: (1) LDL-C greater than or equal to 100 mg/dL with ASCVD, or (2) LDL-C greater than or equal to 130 mg/dL without ASCVD.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

HeFH/ASCVD/HoFH (init, reauth): Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist

COVERAGE DURATION

HeFH/ASCVD (init): 6 mon. HoFH (init): 3 mon. HeFH/ASCVD/HoFH (reauth): 12 mon.

OTHER CRITERIA

One of the following: (1) Patient has been receiving at least 12 consecutive weeks of one maximally-tolerated statin therapy and will continue to receive a statin at maximally tolerated dose, or (2) Patient is unable to tolerate statin as evidenced by intolerable and persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN]), or (3) Submission of medical records documenting patient has a labeled contraindication to all statins, or (4) Patient has experienced rhabdomyolysis on one statin therapy. HoFH (initial): One of the following: (1) Patient has been receiving at least 12 consecutive weeks of one maximally-tolerated statin therapy and will continue to receive a statin at maximally tolerated dose, or (2) both of the following: a) One of the following: 1. Patient is unable to tolerate statin as evidenced by intolerable and persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN]), or 2. Submission of medical records documenting patient has a labeled contraindication to all statins, or 3. Patient has experienced rhabdomyolysis on one statin therapy, AND b) patient has been receiving at least 12 consecutive weeks of other LDL-C lowering prescription therapy and will continue to receive an LDL-C lowering prescription therapy. HeFH/ASCVD (reauth): Patient continues to receive statin at the maximally tolerated dose (unless patient has documented inability to take statins). HoFH (reauth): Patient continues to receive statin at the maximally tolerated dose (or other LDL-C lowering prescription therapy if patient is unable to take a statin). HeFH/ASCVD/HoFH (reauth): Submission of medical records (eg, laboratory values) documenting a sustained LDL-C reduction from pre-treatment baseline (ie, prior to Repatha therapy) while on Repatha therapy. HeFH/ASCVD/HoFH (Initial, reauth): Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. HoFH (Initial, reauth): Not used in combination with Juxtapid (lomitapide) or Kynamro (mipomersen).

REVATIO (S)

MEDICATION(S)

REVATIO 10 MG/ML ORAL SUSP, SILDENAFIL, SILDENAFIL 10 MG/12.5 ML VIAL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. For Revatio injection only (Initial): Patient is temporarily unable to take oral medications. For Revatio oral suspension only (initial, reauth): One of the following: A) Intolerance to generic Revatio tablets, OR B) Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to one of the following: age, oral-motor difficulties, or dysphagia.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.

COVERAGE DURATION

PAH: Initial: 6 months. Reauth: 12 months.

OTHER CRITERIA

PAH (Reauth): Documentation of positive clinical response to therapy

REVLIMID (S)

MEDICATION(S)

REVLIMID

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Multiple myeloma (MM): Diagnosis of MM. Either used as 1) combination therapy with dexamethasone, or 2) maintenance therapy following autologous hematopoietic stem cell transplantation (auto-HSCT). Myelodysplastic syndromes (MDS): Patient has transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with a deletion. Mantle cell lymphoma (MCL): Diagnosis of MCL. Disease has relapsed, refractory, or progressed after at least one prior therapy (eg, bortezomib, bendamustine, cladribine, rituximab).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist/hematologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

RILUTEK (S)

MEDICATION(S)

RILUZOLE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Amyotrophic lateral sclerosis (ALS): Diagnosis of amyotrophic lateral sclerosis (ALS)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

ALS: 12 months

OTHER CRITERIA

N/A

RITUXAN (S)

MEDICATION(S)

RITUXAN

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Rheumatoid Arthritis (RA) (init): Patient is not receiving Rituxan in combination with a biologic DMARD [eg, Enbrel (etanercept), Orencia (abatacept), Kineret (anakinra)]. Patient is not receiving Rituxan in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

REQUIRED MEDICAL INFORMATION

Non-Hodgkin's Lymphoma (NHL): As first-line treatment of diffuse large B-cell, CD20-positive, NHL in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens, or as first-line treatment of follicular, CD20-positive, B-cell NHL in combination with chemotherapy, or as a single-agent maintenance therapy for the treatment of follicular, CD20-positive, B-cell NHL in patients achieving a complete or partial response to Rituxan in combination with chemotherapy, or for the treatment of low-grade, CD20-positive, B-cell NHL in patients with stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy or who achieve a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy, or diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma. Rheumatoid Arthritis (RA) (init): Concurrently on or contraindication, or intolerance to methotrexate. Trial and failure, contraindication, or intolerance (TF/C/I) to a TNF antagonist (eg, adalimumab, etanercept, infliximab). Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): Patient is concurrently on glucocorticoids (eg, prednisone) OR contraindication or intolerance to glucocorticoids (eg, prednisone). Immune or idiopathic thrombocytopenic purpura (ITP): TF/C/I to one of the following: corticosteroids, immunoglobulins, or splenectomy. Documented platelet count of less than $50 \times 10^9 /L$.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

ITP: Prescribed by or in consultation with a hematologist or oncologist. RA: Prescribed by or in consultation with a rheumatologist. WG, MPA: Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist.

COVERAGE DURATION

All uses except RA, WG, MPA: 12 mos. RA: 3 months. WG, MPA: 3 months only.

OTHER CRITERIA

Approve for continuation of prior therapy.

RUBRACA (S)

MEDICATION(S)

RUBRACA 200 MG TABLET, RUBRACA 300 MG TABLET

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Ovarian cancer: Diagnosis of advanced ovarian cancer. Presence of deleterious BRCA mutation as detected by an FDA-approved diagnostic test (e.g., FoundationFocus CDxBRCA Assay) or performed at a Clinical Laboratory Improvement Amendments-approved facility. Trial and failure, contraindication, or intolerance to two or more chemotherapies (e.g., cisplatin, carboplatin).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy

RUCONEST (S)

MEDICATION(S)

RUCONEST

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Treatment of hereditary angioedema (HAE) attacks: Diagnosis of HAE. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks (eg, Berinert, Firazyr, or Kalbitor).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

HAE: Prescribed by an immunologist, allergist, or rheumatologist

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

RYDAPT (S)

MEDICATION(S)

RYDAPT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Acute Myeloid Leukemia (AML): Newly diagnosed acute myeloid leukemia (AML), FMS-like tyrosine kinase 3 (FLT3) mutation-positive as detected by a U.S. Food and Drug Administration (FDA)-approved test, used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. Aggressive Systemic Mastocytosis (ASM), Systemic Mastocytosis with Associated Hematological Neoplasm (SM-AHN), Mast Cell Leukemia (MCL): Diagnosis of one of the following: aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

All indications: Prescribed by or in consultation with a hematologist or oncologist.

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy

SABRIL (S)

MEDICATION(S)

SABRIL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Complex Partial Seizures (CPS): For use as adjunctive therapy. Failure, contraindication, or intolerance to two formulary anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)]. Infantile Spasms (IS): Diagnosis of infantile spasms.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

SANDOSTATIN (S)

MEDICATION(S)

OCTREOTIDE 1,000 MCG/5 ML VIAL, OCTREOTIDE 1,000 MCG/ML VIAL, OCTREOTIDE 5,000 MCG/5 ML VIAL, OCTREOTIDE ACET 0.05 MG/ML VL, OCTREOTIDE ACET 100 MCG/ML AMP, OCTREOTIDE ACET 100 MCG/ML VL, OCTREOTIDE ACET 200 MCG/ML VL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE ACET 50 MCG/ML VIAL, OCTREOTIDE ACET 500 MCG/ML AMP, OCTREOTIDE ACET 500 MCG/ML VL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Acromegaly (initial): Diagnosis of acromegaly AND One of the following: A) History of failure to surgical resection and/or pituitary irradiation OR B) patient is not a candidate for surgical resection or pituitary irradiation AND Trial and failure or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses. Carcinoid tumor (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea and flushing episodes. Vasoactive intestinal peptide tumor (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

All Uses (Initial and reauth): 12 months

OTHER CRITERIA

Acromegaly (reauth): Patient has had a clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size). Carcinoid tumor (reauth): patient has improvement in number of diarrhea and flushing episodes. Vasoactive intestinal peptide tumor (reauth): patient has improvement in number of diarrhea episodes.

SANDOSTATIN LAR (S)

MEDICATION(S)

SANDOSTATIN LAR, SANDOSTATIN LAR DEPOT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Acromegaly (initial): Diagnosis of acromegaly AND One of the following: A) Failure to surgical resection and/or pituitary irradiation OR B) patient is not a candidate for surgical resection or pituitary irradiation AND Trial and failure or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses AND Patient had a trial of short-acting octreotide and responded to and tolerated therapy. Carcinoid tumor (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea and flushing episodes AND Patient had a trial of short-acting octreotide and responded to and tolerated therapy. Vasoactive peptide tumor (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea AND Patient had a trial of short-acting octreotide and responded to and tolerated therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

All Uses (Initial and reauth): 12 months

OTHER CRITERIA

Acromegaly (reauth): Patient has had a clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size). Carcinoid tumor (reauth): patient has improvement in number of diarrhea and flushing episodes. Vasoactive intestinal peptide tumor (reauth): patient has improvement in number of diarrhea episodes.

SEROSTIM (S)

MEDICATION(S)

SEROSTIM

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

HIV wasting (Initial): Diagnosis of HIV-associated wasting syndrome or cachexia, and one of the following: unintentional weight loss greater than 10% over the last 12 months, or unintentional weight loss greater than 7.5% over the last 6 months, or loss of 5% body cell mass (BCM) within 6 months, or body mass index (BMI) less than 20 kg/m², or patient is male and has BCM less than 35% of total body weight (TBW) and BMI less than 27 kg/m², or patient is female and has BCM less than 23% of TBW and BMI less than 27 kg/m². Nutritional evaluation since onset of wasting first occurred. Anti-retroviral tx has been optimized to decrease the viral load. Patient has not had weight loss as a result of other underlying treatable conditions (eg, depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes). Patient has tried and had an inadequate response or intolerance to dronabinol or megestrol acetate.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Initial, Reauth: Prescribed by or in consultation with an infectious disease specialist.

COVERAGE DURATION

Initial: 3 months, Reauth: 6 months

OTHER CRITERIA

HIV wasting (reauth): Evidence of positive response to therapy. One of the following targets or goals has not been achieved: weight, BCM, BMI. Patient is currently receiving treatment with antiretrovirals.

SIGNIFOR (S)

MEDICATION(S)

SIGNIFOR

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Cushing's disease (initial): Diagnosis of Cushings disease AND failure to or patient is not a candidate for pituitary surgery.

AGE RESTRICTION

Initial: 18 years of age or older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 3 months. Reauth: 12 months.

OTHER CRITERIA

Cushing's disease (reauth): a clinically meaningful reduction in 24-hour urinary free cortisol levels or improvement in signs or symptoms of the disease

SIGNIFOR LAR (S)

MEDICATION(S)

SIGNIFOR LAR

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Acromegaly (initial): Diagnosis of acromegaly AND failure to surgery or patient is not a candidate for surgery

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial: 6 months. Reauth: 12 months.

OTHER CRITERIA

Acromegaly (reauth): patients growth hormone (GH) level or insulin-like growth factor 1 (IGF-1) level for age and gender has normalized/improved

SIMPONI (S)

MEDICATION(S)

SIMPONI

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall) OR trial and failure, contraindication, or intolerance (TF/C/I) to methotrexate (Rheumatrex/Trexall). One of the following: TF/C/I to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: TF/C/I to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: TF/C/I to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Patient is corticosteroid dependent (ie, an inability to successfully taper corticosteroids without a return of the symptoms of UC), OR TF/C/I to one of the following: oral aminosalicylate, oral corticosteroid, azathioprine, 6-mercaptopurine. One of the following: TF/C/I to Humira (adalimumab), OR for continuation of prior Simponi therapy. All indications (Initial, reauth): Patient is not receiving Simponi in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)]. Patient is not receiving Simponi in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

RA, AS (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. UC (Initial): Prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION

UC (Initial): 12 weeks. UC (Reauth): 12 months. RA, AS, PsA (Initial, reauth): 12 months

OTHER CRITERIA

All indications (Reauth): Documentation of positive clinical response to Simponi therapy.

SIMPONI ARIA (S)

MEDICATION(S)

SIMPONI ARIA

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall), OR trial and failure, contraindication, or intolerance to methotrexate (Rheumatrex/Trexall). One of the following: trial and failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi Aria therapy. Patient is not receiving Simponi Aria in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)]. Patient is not receiving Simponi Aria in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

RA (Initial): Prescribed by or in consultation with a rheumatologist.

COVERAGE DURATION

RA (Initial, reauth): 12 months

OTHER CRITERIA

RA (Reauth): Documentation of positive clinical response to Simponi Aria therapy. Patient is not receiving Simponi Aria in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)]. Patient is not receiving Simponi Aria in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

SIMVASTATIN (S)

MEDICATION(S)

SIMVASTATIN 80 MG TABLET

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Patient has been taking simvastatin 80 mg per day chronically (12 months or more) and no evidence of muscle toxicity/myopathy (eg, muscle pain, muscle tenderness, muscle weakness) on simvastatin 80 mg per day.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

SOMATULINE DEPOT (S)

MEDICATION(S)

SOMATULINE DEPOT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Acromegaly (initial): Diagnosis of acromegaly AND One of the following: A) Failure to one of the following: surgery or radiotherapy, OR B) not a candidate for one of the following: surgery or radiotherapy. Gastroenteropancreatic neuroendocrine tumors (GEP-NETs) (initial): Diagnosis of unresectable, well- or moderately-differentiated, locally advanced or metastatic GEP-NETs

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

All Indications (Initial and reauth): 12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

SOMAVERT (S)

MEDICATION(S)

SOMAVERT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Acromegaly (initial): Diagnosis of acromegaly AND Failure to surgery and/or radiation therapy and/or other medical therapies (such as dopamine agonists [e.g., bromocriptine, cabergoline]) unless patient is not a candidate for these treatment options AND trial and failure or intolerance to generic octreotide (a somatostatin analogue)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial and reauth: 12 months

OTHER CRITERIA

Acromegaly (reauth): Patient has experienced an objective response to therapy (biochemical control, decrease or normalization of IGF-1 levels).

SOVALDI (S)

MEDICATION(S)

SOVALDI

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Criteria will be applied consistent with current AASLD/IDSA guideline. For genotype (GT) 1 patients, Sovaldi plus Olysio: Patient is without decompensated liver disease (defined as Child-Pugh Class B or C). All GT1 (except Sovaldi plus Olysio therapy, or Sovaldi plus Daklinza therapy in post-liver transplant (tx) patients) and GT4: 1) trial and failure, intolerance or contraindication (TF//C) to both of the following: Harvoni and Zepatier therapy OR 2) For continuation of prior Sovaldi therapy. For GT2 (except in 1) post-liver tx patients, or 2) patients 12 to 17 years of age or 3) both of the following: a) patients weighing at least 35 kg and b) less than 18 years of age) or GT3 patients (except in 1) patients 12 to 17 years of age or 2) both of the following: a) patients weighing at least 35 kg and b) less than 18 years of age), using Sovaldi plus ribavirin: TF//C to Epclusa OR for continuation of prior Sovaldi therapy. All Sovaldi plus Olysio therapy: one of the following: 1) TF//C to Harvoni and Zepatier OR 2) both of the following: a) trial and failure of a NS5A-containing regimen (e.g., Harvoni, Epclusa, OR Zepatier) AND b) the patient has NS5A inhibitor resistant-associated variants detected using commercially available assays, OR 3) For continuation of prior Sovaldi plus Olysio therapy. All Sovaldi plus Daklinza therapy: One of the following: 1) Patient has not failed a prior HCV NS5A-containing regimen (eg, Daklinza) therapy, OR 2) patient has failed prior therapy with an NS5A-containing regimen AND submission of medical records (eg, chart notes) documenting that the patient does not have NS5A inhibitor resistance-associated variants detected using commercially available assays. For GT2 and GT3 (except post-liver tx patients) patients, using Sovaldi plus Daklinza: TF//C to Epclusa OR for continuation of prior Sovaldi therapy. For GT1 post-liver tx patients using Sovaldi plus Daklinza, TF//C to Harvoni OR for continuation of prior Sovaldi therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine

COVERAGE DURATION

12 to 48 wks. Criteria will be applied consistent with current AASLD/IDSA guideline

OTHER CRITERIA

N/A

SPORANOX (S): THIS CRITERIA IS CURRENTLY UNDER REVIEW BY CMS

MEDICATION(S)

ITRACONAZOLE 100 MG CAPSULE, SPORANOX 10 MG/ML SOLUTION

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

One of the following: 1) patient has a systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis), OR 2) patient is resistant to topical antifungal treatment and has one of the following diagnoses: a) tinea corporis (ringworm), OR b) tinea cruris (jock itch), OR c) tinea pedis (athletes foot), OR d) tinea capitis (scalp ringworm), OR e) pityriasis versicolor, OR 3) all of the following: a) patient has a diagnosis of onychomycosis confirmed by one of the following (CAPSULE ONLY): i) positive potassium hydroxide (KOH) preparation, OR ii) culture, OR iii) histology, AND b) the patients condition is causing debility or a disruption in their activities of daily living, AND c) patient has had a trial and inadequate response, intolerance or hypersensitivity to oral terbinafine, OR 4) patient has a diagnosis of candidiasis (esophageal or oropharyngeal) that is refractory to treatment with fluconazole (ORAL SOLUTION ONLY).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

systemic fungal infxn:(candidiasis,fingernail onycho.):1 mo.(toenail onycho, other):3mo.

OTHER CRITERIA

N/A

SPRYCEL (S)

MEDICATION(S)

SPRYCEL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia (CML): Diagnosis of Ph+ CML. Ph+ acute lymphoblastic leukemia (ALL): Diagnosis of Ph+ ALL.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

All Uses: Prescribed by or in consultation with an oncologist or hematologist

COVERAGE DURATION

All Uses: 12 months

OTHER CRITERIA

All Uses: Approve for continuation of prior therapy.

STELARA (IV) (S)

MEDICATION(S)

STELARA 130 MG/26 ML VIAL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Diagnosis of moderately to severely active Crohn's disease. One of the following: a) trial and failure, contraindication, or intolerance to Humira (adalimumab), or (b) trial and failure, contraindication, or intolerance to treatment with at least one immunomodulator or corticosteroid [e.g., Purinethol (6-mercaptopurine), Imuran (azathioprine), Sandimmune (cyclosporine A), Prograf (tacrolimus), MTX (methotrexate)]. Patient is not receiving Stelara in combination a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION

One time

OTHER CRITERIA

Stelara is to be administered as an intravenous induction dose. Stelara induction dosing is in accordance with the United States Food and Drug Administration approved labeled dosing for Crohn's Disease: 260 mg for patients weighing 55 kg or less, 390 mg for patients weighing more than 55 kg to 85 kg, or 520 mg for patients weighing more than 85 kg.

STELARA (S)

MEDICATION(S)

STELARA 45 MG/0.5 ML SYRINGE, STELARA 90 MG/ML SYRINGE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. Plaque psoriasis (Initial): One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to Enbrel (etanercept) OR Humira (adalimumab) OR b) for continuation of prior Stelara therapy. PsA (Initial): One of the following: a) TF/C/I to Enbrel (etanercept) and Humira (adalimumab) OR b) for continuation of prior Stelara therapy. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohns disease. One of the following: a) TF/C/I to Humira (adalimumab) OR b) TF/C/I to treatment with at least one immunomodulator or corticosteroid [e.g., Purinethol (6-mercaptopurine), Imuran (azathioprine), Sandimmune (cyclosporine A), Prograf (tacrolimus), MTX (methotrexate)], OR c) for continuation of prior Stelara therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD (initial): Prescribed by or in consultation with a gastroenterologist.

COVERAGE DURATION

All uses (Initial, reauth): 12 months

OTHER CRITERIA

Reauthorization (all indications): Documentation of positive clinical response to Stelara therapy. All

indications (initial, reauth): Patient is not receiving Stelara in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

STIVARGA (S)

MEDICATION(S)

STIVARGA

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Metastatic colorectal cancer (mCRC): All of the following: 1) diagnosis of mCRC, AND 2) trial and failure, contraindication or intolerance to fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, AND 3) trial and failure, contraindication or intolerance to an anti-VEGF therapy (e.g. Avastin [bevacizumab]), AND 4) one of the following: a) KRAS mutation, OR b) both of the following: KRAS wild-type and trial and failure, contraindication or intolerance to an anti-EGFR therapy [e.g. Vectibix (panitumumab), Erbitux (cetuximab)]. Gastrointestinal stromal tumor (GIST): All of the following: 1) diagnosis of locally advanced, unresectable or metastatic GIST, AND 2) trial and failure, contraindication or intolerance to both of the following: a) Gleevec (imatinib mesylate), AND b) Sutent (sunitinib malate).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

STRENSIQ (S)

MEDICATION(S)

STRENSIQ

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Hypophosphatasia: Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia AND for patients requesting the 80 mg/0.8 mL vial only: Patient's weight is greater than or equal to 40 kg

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Hypophosphatasia: Prescribed by or in consultation with a specialist experienced in the treatment of inborn errors of metabolism or endocrinologist

COVERAGE DURATION

Hypophosphatasia: 12 months

OTHER CRITERIA

N/A

SUTENT (S)

MEDICATION(S)

SUTENT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renal cell carcinoma: Diagnosis of advanced or metastatic renal cell carcinoma. Gastrointestinal stromal tumor (GIST): Diagnosis of GIST after disease progression on or intolerance to Gleevec (imatinib). Pancreatic neuroendocrine tumors: Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumor that is unresectable locally advanced or metastatic disease.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

All Indications: Prescribed by or in consultation with an oncologist

COVERAGE DURATION

All Indications: 12 months

OTHER CRITERIA

All Indications: Approve for continuation of prior therapy

SYLATRON (S)

MEDICATION(S)

SYLATRON, SYLATRON 4-PACK

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Melanoma: Diagnosis of melanoma with microscopic or gross nodal involvement AND The prescribed medication will be used as adjuvant therapy within 84 days of definitive surgical resection, including complete lymphadenectomy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy

SYLVANT (S)

MEDICATION(S)

SYLVANT 100 MG VIAL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Multicentric Castleman's disease (MCD) (Initial): Diagnosis of MCD. Patient is human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

MCD (Initial): Prescribed by or in consultation with hematologist/oncologist or rheumatologist.

COVERAGE DURATION

MCD (initial, reauth): 6 months

OTHER CRITERIA

MCD (reauth): Documentation of positive clinical response to Sylvant therapy. Patient is HIV negative and HHV-8 negative.

SYMLIN (S)

MEDICATION(S)

SYMLINPEN 120, SYMLINPEN 60

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

Gastroparesis.

REQUIRED MEDICAL INFORMATION

One of the following diagnoses: A) Type 1 diabetes OR B) Type 2 diabetes.

AGE RESTRICTION

18 years of age or older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

SYNAGIS (S)

MEDICATION(S)

SYNAGIS 50 MG/0.5 ML VIAL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Patient will use palivizumab for immunoprophylaxis of respiratory syncytial virus (RSV) during the peak months of infection in the patients geographic region AND Patient meets one of the following criteria: 1) Infants born at 28 weeks, six days gestation or earlier and who are younger than 12 months of age at the start of the RSV season OR 2) Diagnosis of chronic lung disease of prematurity, born before 32 weeks, 0 days gestation, received greater than 21% oxygen for at least the first 28 days after birth, and one of the following: a) 12 months of age or younger at the start of the RSV season OR b) greater than 12 months of age to 24 months of age at the start of the RSV season and received medical support (i.e., chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) within 6 months before the start of the second RSV season. OR 3) Patient is 12 months of age or younger at the start of the RSV season and has one of the following: a) acyanotic heart failure that will require a cardiac surgical procedure and the patient is receiving medication to control congestive heart failure, OR b) moderate to severe pulmonary hypertension OR c) cyanotic heart defect. OR 4) patient is younger than 24 months of age and will or has undergone a cardiac transplantation during the RSV season. OR 5) Patient is 12 months of age or younger at the start of the RSV season with a congenital abnormality or neuromuscular disorder and has an impaired ability to clear secretions from the upper airway due to an ineffective cough. OR 6) Patient is younger than 24 months of age with a lymphocyte count below the normal range for patients age and has received or will receive a solid organ transplant, hematopoietic stem cell transplant recipient, or chemotherapy during the RSV season.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with a pediatric specialist (i.e., pulmonologist, neonatologist, neurologist, cardiologist, pediatric intensivist, or infectious disease specialist).

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve 5 doses based on patient body weight for all other indications.

SYNRIBO (S)

MEDICATION(S)

SYNRIBO

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Chronic myelogenous leukemia (CML): Diagnosis of CML in the chronic or accelerated phase AND Patient has tried and has had resistance, relapse, inadequate response, intolerance or is contraindicated to TWO tyrosine kinase inhibitors (i.e., Gleevec [imatinib], Sprycel, Tassigna, and Bosulif, Iclusig)

AGE RESTRICTION

CML: 18 years of age or older

PRESCRIBER RESTRICTION

CML: Prescribed by or in consultation with a hematologist/oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy

TAFINLAR (S)

MEDICATION(S)

TAFINLAR

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT) as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist.

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

TAGRISSE (S)

MEDICATION(S)

TAGRISSE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Tumors are positive for epidermal growth factor receptor (EGFR) T790M mutation. The patient has experienced disease progression on or after one of the following EGFR Tyrosine Kinase Inhibitors (TKIs): Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist.

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

TALTZ (S)

MEDICATION(S)

TALTZ AUTOINJECTOR, TALTZ SYRINGE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Trial and failure, contraindication, or intolerance to both Cosentyx (secukinumab) and either Enbrel (etanercept) or Humira (adalimumab), OR for continuation of prior Taltz therapy. Patient is not receiving Taltz in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist.

COVERAGE DURATION

Initial, reauth: 12 months

OTHER CRITERIA

Plaque psoriasis (Reauth): Documentation of positive clinical response to Taltz therapy. Patient is not receiving Taltz in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

TARCEVA (S)

MEDICATION(S)

TARCEVA

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Non-small cell lung cancer (NSCLC): Diagnosis of locally advanced or metastatic (Stage III or IV) NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. Pancreatic Cancer: Diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer AND TARCEVA will be used in combination with gemcitabine.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

All Indications: Prescribed by or in consultation with an oncologist

COVERAGE DURATION

All Indications: 12 months

OTHER CRITERIA

All Indications: Approve for continuation of prior therapy.

TARGRETIN (S)

MEDICATION(S)

BEXAROTENE, TARGRETIN 1% GEL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Cutaneous T-Cell Lymphoma (CTCL): Diagnosis of CTCL. Trial and failure, contraindication, or intolerance to at least one prior therapy (including skin-directed therapies [eg, corticosteroids {ie, clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate}] or systemic therapies [eg, interferons]).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist or dermatologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

TASIGNA (S)

MEDICATION(S)

TASIGNA

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Chronic myelogenous leukemia (CML): Diagnosis of Ph+ CML

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist or hematologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

TAZORAC (S)

MEDICATION(S)

TAZORAC

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Acne vulgaris (initial): Diagnosis of acne vulgaris AND History of failure or intolerance to at least two topical acne products (e.g., tretinoin, adapalene, benzoyl peroxide, clindamycin, erythromycin, or azelaic acid). Plaque psoriasis (initial): Diagnosis of stable moderate to severe plaque psoriasis AND Patient has body surface area (BSA) involvement of less than 20 percent AND History of failure or intolerance to at least two topical psoriasis product (e.g., medium to high potency corticosteroids and/or vitamin D analogs).

AGE RESTRICTION

Acne (initial): 12 years of age or older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

All uses (Initial and reauth): 12 months

OTHER CRITERIA

Acne, Plaque psoriasis (reauth): Documentation of positive clinical response to therapy .

TECENTRIQ (S)

MEDICATION(S)

TECENTRIQ

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Urothelial Carcinoma: Diagnosis of locally advanced or metastatic urothelial carcinoma. One of the following: A) Patient is not eligible for cisplatin-containing chemotherapy, B) Patient has disease progression during or following any platinum-containing chemotherapy, OR C) Patient has disease progression within 12 months of neoadjuvant or adjuvant chemotherapy. Non-Small Cell Lung Cancer: All of the following: A) Diagnosis of metastatic non-small cell lung cancer (NSCLC), and B) Patient has disease progression during or following platinum-containing chemotherapy, and C) One of the following: 1) Patient does not have epidermal growth factor receptor (EGFR) mutation or anaplastic lymphoma kinase (ALK) rearrangement OR 2) Both of the following: patient has an EGFR mutation AND trial and failure, contraindication, or intolerance to at least one anti-EGFR therapy (e.g., Gilotrif [afatinib], Iressa [gefitinib], Tarceva [erlotinib]) OR 3) Both of the following: patient has ALK rearrangement AND trial and failure, contraindication, or intolerance to at least one ALK inhibitor (e.g., Xalkori [crizotinib]).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist.

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

TECFIDERA (S)

MEDICATION(S)

TECFIDERA

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

TECHNIVIE (S)

MEDICATION(S)

TECHNIVIE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

All of the following: A) Criteria will be applied consistent with current AASLD/IDSA guideline, AND B) Patient is not receiving Technivie in combination with another HCV direct acting antiviral agent [eg, Harvoni (ledipasvir-sofosbuvir), Sovaldi (sofosbuvir), Olysio (simeprevir)], AND C) ONE of the following: Trial and failure, intolerance or contraindication to Harvoni and Zepatier therapy OR patient is currently on Technivie therapy.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine

COVERAGE DURATION

12 wks. Criteria will be applied consistent with current AASLD/IDSA guideline

OTHER CRITERIA

N/A

TESTOSTERONE (S)

MEDICATION(S)

ANDRODERM, ANDROGEL 1.62% GEL PUMP, ANDROGEL 1.62%(1.25G) GEL PCKT, ANDROGEL 1.62%(2.5G) GEL PCKT, STRIANT, TESTOSTERON CYP 1,000 MG/10 ML, TESTOSTERON CYP 2,000 MG/10 ML, TESTOSTERONE CYP 100 MG/ML, TESTOSTERONE CYP 200 MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than reference range for the lab OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome). Gender Identity Disorder (GID) (off-label): Dx of GID. Patient is a female-to-male transsexual.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GID: 12 mo.

OTHER CRITERIA

HG (Reauth): 1) Total serum T level within or below the normal limits of the reporting lab, or 2) Total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Calculated free or bioavailable T level within or below the normal limits of the reporting lab, or calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.

TESTOSTERONE ENANTHATE (S)

MEDICATION(S)

TESTOSTERON ENAN 1,000 MG/5 ML, TESTOSTERONE ENAN 200 MG/ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than reference range for the lab OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome). Delayed puberty (DP): Dx of DP AND male patient at birth. Breast cancer (BC): Dx of inoperable BC AND used for palliative treatment AND female patient at birth. Gender Identity Disorder (GID) (off-label): Dx of GID. Patient is a female-to-male transsexual.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

HG(init): (New to T tx:6 mo. Cont T tx:12 mo), (reauth): 12 mo. BC, GID: 12 mo. DP: 6 mo.

OTHER CRITERIA

HG (Reauth): 1) Total serum T level within or below the normal limits of the reporting lab, or 2) Total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Calculated free or bioavailable T level within or below the normal limits of the reporting lab, or calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.

THALOMID (S)

MEDICATION(S)

THALOMID

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Multiple myeloma (MM): Diagnosis of MM. Used in combination with dexamethasone, unless the patient has an intolerance to steroids. Erythema nodosum leprosum (ENL): Diagnosis of moderate to severe ENL with cutaneous manifestations. Thalomid is not used as monotherapy if moderate to severe neuritis is present.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

MM: Prescribed by or in consultation with an oncologist/hematologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

TOPICAL RETINOID (S)

MEDICATION(S)

AVITA, TRETINOIN 0.01% GEL, TRETINOIN 0.025% CREAM, TRETINOIN 0.025% GEL, TRETINOIN 0.05% CREAM, TRETINOIN 0.05% GEL, TRETINOIN 0.1% CREAM, TRETINOIN MICROSPHERE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

One of the following: Acne: Diagnosis of acne.

AGE RESTRICTION

PA applies to members 26 years of age or older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

TRELSTAR (S)

MEDICATION(S)

TRELSTAR 22.5 MG SYRINGE, TRELSTAR 22.5 MG VIAL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Trial and failure, contraindication, or intolerance to Lupron Depot (7.5 mg, 22.5 mg, 30 mg, and 45 mg).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

TRETINOIN/CLINDAMYCIN (S)

MEDICATION(S)

CLINDAMYCIN PHOS-TRETINOIN

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Acne: Diagnosis of acne.

AGE RESTRICTION

PA applies to members 26 years of age or older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

TYKERB (S)

MEDICATION(S)

TYKERB

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Breast Cancer: Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive metastatic or recurrent breast cancer. Used in combination with one of the following: Herceptin (trastuzumab), Xeloda (capecitabine), or aromatase inhibitors [eg, Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)].

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist.

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

TYSABRI (S)

MEDICATION(S)

TYSABRI

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses). Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following: Aubagio (teriflunomide), Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone or Glatopa (glatiramer acetate), Extavia (interferon beta-1b), Gilenya (fingolimod), Rebif (interferon beta-1a), or Tecfidera (dimethyl fumarate). Patient is not taking Tysabri in combination with another MS agent [eg, Aubagio (teriflunomide), Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone (glatiramer acetate), Glatopa (glatiramer acetate), Extavia (interferon beta-1b), Gilenya (fingolimod), Lemtrada (alemtuzumab), Rebif (interferon beta-1a), or Tecfidera (dimethyl fumarate)]. Crohn's Disease (CD) (initial): Diagnosis of moderate to severe CD with evidence of inflammation (eg, elevated C-reactive protein [CRP], elevated erythrocyte sedimentation rate, presence of fecal leukocytes). Inadequate response or intolerance to one of the following conventional therapies: corticosteroids, 6-mercaptopurine (6MP [Purinethol], azathioprine (Imuran), methotrexate, aminosalicylates (eg, sulfasalazine, mesalamine, olsalazine). Inadequate response or intolerance to a TNF-inhibitor (eg, Cimzia [certolizumab pegol], Humira [adalimumab], Remicade [infliximab]). CD (initial and reauth): Patient is not taking Tysabri in combination with an immunosuppressant (eg, 6-MP, azathioprine, cyclosporine, or methotrexate) or a TNF-inhibitor (eg, Enbrel [etanercept], Humira [adalimumab], or Remicade [infliximab]).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

MS: 12mo. CD (Init): 3 mo. CD (Reauth): 6 mo if not on steroids. Otherwise, 3 mo.

OTHER CRITERIA

CD (reauth): Diagnostic and/or clinical documentation (eg, improved disease activity index) that indicates patient has experienced clinical benefit from receiving (induction) Tysabri therapy by week 12.

UPTRAVI (S)

MEDICATION(S)

UPTRAVI

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Pulmonary arterial hypertension (PAH) (initial): Diagnosis of PAH AND Patient is symptomatic AND One of the following: a) Diagnosis of PAH was confirmed by right heart catheterization OR b) patient is currently on any therapy for the diagnosis of PAH. One of the following: a) History of trial and failure, contraindication, or intolerance to a PDE5 inhibitor (ie, Adcirca, Revatio) or Adempas (riociguat), and History of trial and failure, contraindication, or intolerance to an endothelin receptor antagonist [e.g. Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)] OR b) For continuation of prior Uptravi therapy. Not taken in combination with a prostanoid/prostacyclin analogue (eg, epoprostenol, iloprost, treprostinil).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist

COVERAGE DURATION

Initial: 6 months Reauth: 12 months

OTHER CRITERIA

PAH (Reauth): Documentation of positive clinical response to Uptravi therapy. Not taken in combination with a prostanoid/prostacyclin analogue (eg, epoprostenol, iloprost, treprostinil)

VALCHLOR (S)

MEDICATION(S)

VALCHLOR

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Mycosis fungoides-type cutaneous T-cell lymphoma (MF-CTCL) (initial): All of the following: 1) diagnosis of Stage IA MF-CTCL, OR diagnosis of Stage IB MF-CTCL, AND 2) patient has received at least one prior skin-directed therapy [e.g., topical corticosteroids, bexarotene topical gel (Targretin topical gel), topical nitrogen mustard, etc.].

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with an oncologist or dermatologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

VELCADE (S)

MEDICATION(S)

VELCADE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Multiple myeloma (MM): Diagnosis of MM. Mantle cell lymphoma (MCL): Diagnosis of MCL.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

MM, MCL: Prescribed by or in consultation with an oncologist/hematologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

VENCLEXTA (S)

MEDICATION(S)

VENCLEXTA, VENCLEXTA STARTING PACK

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL): Diagnosis of CLL or SLL with 17p deletion or TP53 mutation. Patient has received at least one prior therapy for CLL/SLL [e.g., Cytosan (cyclophosphamide), Fludara (fludarabine), Rituxan (rituximab)].

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed by or in consultation with a hematologist or oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

VENTAVIS (S)

MEDICATION(S)

VENTAVIS

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.

COVERAGE DURATION

PAH (Initial): 6 months. (Reauth): 12 months

OTHER CRITERIA

Subject to Part B vs D review. PAH (Reauth): Documentation of positive clinical response to therapy.

VIVITROL (S)

MEDICATION(S)

VIVITROL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Alcohol dependence (init): History of alcohol dependence and confirmed abstinence at treatment initiation. Opioid dependence (init): History of opioid dependence and confirmed opioid detoxification at treatment initiation.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Alcohol dependence, opioid dependence (init, reauth): 24 weeks

OTHER CRITERIA

Alcohol dependence, opioid dependence (reauth): Confirmation of clinical benefit to the patient.

VOTRIENT (S)

MEDICATION(S)

VOTRIENT

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Renal cell carcinoma (RCC): Diagnosis of advanced/metastatic RCC. Soft tissue sarcoma: Diagnosis of advanced soft tissue sarcoma and patient received at least one prior chemotherapy (e.g., ifosfamide, doxorubicin, cisplatin, dacarbazine, docetaxel, oxaliplatin, etc.)

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

All Uses: Prescribed by or in consultation with an oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

MEDICATION(S)

VPRIV

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Gaucher disease: Diagnosis of type 1 Gaucher disease. Patient has evidence of symptomatic disease (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Gaucher disease: 12 months

OTHER CRITERIA

N/A

XALKORI (S)

MEDICATION(S)

XALKORI

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Non-small cell lung cancer (NSCLC): Diagnosis of locally advanced or metastatic (stage IIIB or IV) NSCLC AND One of the following: A) Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility or B) Patient has MET amplification- or ROS1 rearrangements-positive tumor as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

NSCLC: Prescribed by or in consultation with an oncologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy

XELJANZ (S)

MEDICATION(S)

XELJANZ, XELJANZ XR

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-IV-TR 300.29 for specific phobia diagnostic criteria), OR for continuation of prior tofacitinib therapy. Patient is not receiving tofacitinib in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving tofacitinib in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

RA (Initial): Prescribed by or in consultation with a rheumatologist

COVERAGE DURATION

RA (initial, reauth): 12 months

OTHER CRITERIA

RA (Reauth): Documentation of positive clinical response to tofacitinib therapy. Patient is not receiving tofacitinib in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving tofacitinib in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine).

XENAZINE (S)

MEDICATION(S)

TETRABENAZINE

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Chorea associated with Huntington's Disease (HD) (Initial): Diagnosis of chorea in patients with Huntington's disease. Tardive dyskinesia (Initial): Patient has stereotypies associated with tardive dyskinesia. Tourette's syndrome (Initial): Patient has tics associated with Tourette's syndrome. Failure, contraindication, or intolerance to Haldol (haloperidol).

AGE RESTRICTION

Tardive dyskinesia (Initial): Age greater than or equal to 18 years.

PRESCRIBER RESTRICTION

HD (Initial): Prescribed by or in consultation with a neurologist. Tardive dyskinesia, Tourette's syndrome (Initial): Prescribed by or in consultation with neurologist or psychiatrist.

COVERAGE DURATION

All indications: (Initial) 3 months, (Reauth) 12 months.

OTHER CRITERIA

All indications (Reauth): Documentation of clinical response and benefit from therapy.

XEOMIN (S)

MEDICATION(S)

XEOMIN 50 UNIT VIAL

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Cervical Dystonia (CD) (init): Diagnosis of CD (also known as spasmodic torticollis). Blepharospasm (initial): Diagnosis of blepharospasm. History of previous use of Botox (onabotulinumtoxinA) for the treatment of blepharospasm. Upper limb spasticity (ULS) (init): Diagnosis of upper limb spasticity.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

All indications (init, reauth): 3 months (for 1 dose)

OTHER CRITERIA

All indications (reauth): Confirmed improvement in symptoms with initial Xeomin treatment. At least 3 months have elapsed since the last treatment with Xeomin

XGEVA (S)

MEDICATION(S)

XGEVA

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Bone metastasis from solid tumors (BMST): Both of the following: 1) diagnosis of solid tumors (eg, breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer), AND 2) documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Both of the following: 1) diagnosis of giant cell tumor of bone AND 2) One of the following: a) tumor is unresectable, OR b) surgical resection is likely to result in severe morbidity. Hypercalcemia of malignancy (HCM): Both of the following: 1) diagnosis of hypercalcemia of malignancy, AND 2) Trial and failure, contraindication, or intolerance to one intravenous bisphosphonate (eg, Aredia (pamidronate), Zometa (zoledronic acid)).

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

GCTB, HCM: Prescribed by or in consultation with an oncologist

COVERAGE DURATION

BMST, GCTB: 12 mo. HCM: 2 mo.

OTHER CRITERIA

Approve for continuation of prior therapy.

XIFAXAN (S)

MEDICATION(S)

XIFAXAN

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Travelers' diarrhea (TD) (200 mg strength only): Diagnosis of travelers' diarrhea, AND one of the following: a) Trial and failure, contraindication, or intolerance to one of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin) OR b) resistance to all of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin). Prophylaxis of hepatic encephalopathy (HE) recurrence (550mg strength only): Used for the prophylaxis of hepatic encephalopathy recurrence, AND trial and failure, contraindication or intolerance to lactulose. Irritable bowel syndrome with diarrhea (IBS-D) (550mg strength only) (initial): Diagnosis of IBS-D, AND trial and failure, contraindication or intolerance to an antidiarrheal agent [eg, loperamide].

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

TD: One time only. HE: 6 months. IBS-D (initial, reauth): 2 weeks.

OTHER CRITERIA

IBS-D (reauth): Patient experiences IBS-D symptom recurrence AND patient has not already received 3 treatment courses of Xifaxan for IBS-D in their lifetime.

XIIDRA (S)

MEDICATION(S)

XIIDRA

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Initial: Diagnosis of dry eye disease. Patient has suppressed tear production due to ocular inflammation as determined by at least one of the following diagnostic tests: Schirmer test (aqueous tear production and clearance), tear break-up time, ocular surface dye staining, tear film osmolarity, or fluorescein clearance test/tear function test. Failure, contraindication, or intolerance to Restasis at an optimal dose and frequency for at least 2 weeks

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial, reauth: 12 months

OTHER CRITERIA

Reauth: Documentation of positive clinical response to Xiidra therapy (e.g., increased tear production or improvement in dry eye symptoms).

XTANDI (S)

MEDICATION(S)

XTANDI

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Metastatic castration-resistant prostate cancer (mCRPC): Diagnosis of mCRPC.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Prescribed or in consultation with an oncologist or urologist

COVERAGE DURATION

12 months

OTHER CRITERIA

Approve for continuation of prior therapy.

XYREM (S)

MEDICATION(S)

XYREM

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND trial and failure, contraindication, or intolerance to one of the following: 1) amphetamine-based stimulant (eg, amphetamine, dextroamphetamine), OR 2) methylphenidate-based stimulant.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

All uses (initial, reauth): 12 months

OTHER CRITERIA

Narcolepsy Type 1 (reauth): Documentation demonstrating a reduction in the frequency of cataplexy attacks associated with Xyrem therapy, OR documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with Xyrem therapy. Narcolepsy Type 2 (reauth): Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with Xyrem therapy.

