Health Alliance MEDICARE℠

Medications Requiring Preauthorization

Effective: 9/1/2017

The following list outlines medications that require review by the clinical pharmacist, and in some cases, a Health Alliance Medicare medical director. If your doctor asks for coverage of a drug that requires preauthorization, he or she must provide documentation to meet criteria for that particular medication. Providers must request preauthorization from Health Alliance Medicare for drugs on this list.

This list is subject to change.

To request a written copy of the coverage criteria, please contact Health Alliance Medicare Services at 1-800-965-4022 for Illinois members, 1-877-917-8550 for Iowa and Nebraska members and 1-877-750-3350 for Washington members. TTY users, please call 711. Representatives are available 8 a.m. to 8 p.m., Monday through Friday.

Health Alliance Medicare is a Medicare Advantage Organization with a Medicare contract. Enrollment in Health Alliance Medicare depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits and copayments/co-insurance may change on January 1 of each year.

This information is available for free in other languages. Please call our customer service number at 1-877-933-2564 (TTY: 711), 8 a.m. to 8 p.m. daily from October 1 to February 14 and weekdays the rest of the year.

Esta información está disponible sin cargo en otros idiomas. Para obtener información adicional, llamar a nuestro número de servicio al cliente al 1-877-933-2564 (TTY: 711). Nuestro horario es de 8 a.m. a 8 p.m., los 7 días de la semana, 1 de octubre a 14 de febrero, y lunes a viernes el resto del año.

ABELCET

Products Affected

- Abelcet

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3MO AT A TIME
Other Criteria	ASPERGILLOSIS, INVASIVE,BLASTOMYCOSIS, PTS REFR TO OR INTOL OF CONVENT AMPH B,CANDIDIASIS,CRYPTOCOCCOSIS,LEISHMANIASIS, PTS REFR TO OR INTOL OF CONVENT AMPH B,PULM ASPERGILLOSIS CHRONIC (CAVITARY OR NECROTIZING), SALVAGE TX,SYSTEMIC MYCOSIS, PTS REFR TO OR INTOL OF CONVENT AMPH B . ALSO BVD DECISIONS

ABILIFY

Products Affected

- Abilify Maintena

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	NEW STARTS TO THERAPY WITH ABILIFY (ARIPIPRAZOLE), REQUIRE A TRIAL OF ONE TIER 1 ATYPICAL ANTIPSYCHOTIC. ALSO BVD DECISIONS

ACTEMRA

Products Affected

- Actemra

PA Criteria	Criteria Details
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 FOR CONTINUATION OF PRIOR ACTEMRA THERAPY. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA) (INITIAL): DIAGNOSIS OF ACTIVE SJIA. FAILURE, CONTRAINDICATION, OR INTOLERANCE TO ONE NSAID OR SYSTEMIC GLUCOCORTICOID. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA) (INITIAL): DIAGNOSIS OF ACTIVE PJIA. ONE OF THE FOLLOWING: FAILURE, CONTRAINDICATION, OR INTOLERANCE TO BOTH ENBREL (ETANERCEPT) AND HUMIRA (ADALIMUMAB), OR FOR CONTINUATION OF PRIOR ACTEMRA THERAPY. ALL INDICATIONS (INITIAL, REAUTH): PATIENT IS NOT RECEIVING ACTEMRA IN COMBINATION WITH A BIOLOGIC DMARD [EG, ENBREL (ETANERCEPT), HUMIRA (ADALIMUMAB), CIMZIA (CERTOLIZUMAB).
Age Restrictions	N/A
Prescriber Restrictions	ALL USES (INITIAL): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	ALL USES (INITIAL, REAUTH): 12 MONTHS
Other Criteria	ALL USES (REAUTH): DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO ACTEMRA THERAPY.

ADAGEN

Products Affected

- Adagen

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PATIENT HAS NOT HAD A BONE MARROW BUT IS ELIGIBLE FOR A TRANSPLANTATION, THROMBOCYTOPENIA
Required Medical Information	DETERMINATION OF ADA DEFICIENCY. DX OF SEVERE COMBINED IMMUNODEFICIENCY DISEASE (SCID). DOCUMENTATION PATIENT IS NOT A CANDIDATE FOR OR WHO HAS FAILED BONE MARROW TRANSPLANTATION
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YR AT A TIME
Other Criteria	DOCUMENTATION OF SCID ASSOCIATED WITH ADA DEFICIENCY. THE PATIENT HAS EITHER HAD A BONE MARROW TRANSPLANT AND HAS NOT RESPONDED OR IS NOT ELIGIBLE FOR A BONE MARROW TRANSPLANT.

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PATIENTS WITH SEVERE HEPATIC DISEASE, CREATININE CLEARANCE LESS THAN 15 ML/MIN OR ON DIALYSIS, PREGNANT PATIENTS
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST OR CARDIOLOGIST
Coverage Duration	1YR AT A TIME
Other Criteria	DOCUMENTATION OF PREVIOUS MEDICATIONS USED, RESULTS OF ACUTE VASOREACTIVITY TESTING

ALDURAZYME

Products Affected

- Aldurazyme

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	ENZYME ASSAY DEMONSTRATING DEFICIENCY OF ALPHA-L-IDURONIDASE ENZYME ACTIVITY OR DNA TESTING
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YR AT A TIME
Other Criteria	FOR PATIENTS WITH HURLER AND HURLER-SCHEIE FORMS OF MPS I AND FOR PATIENTS WITH THE SCHEIE FORM WHO HAVE MODERATE-TO-SEVERE SYMPTOMS

ALFERON N

Products Affected

- Alferon N

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	ANAPHYLACTIC SENSITIVITY TO EGG PROTEIN, NEOMYCIN, MOUSE IGG OR HYPERSENSITIVITY TO ALFA INTERFERON PRODUCTS
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2MO AT A TIME
Other Criteria	CONDYLOMA ACUMINATUM, REFRACTORY OR RECURRING EXTERNAL GENITAL WARTS. ALSO BVD DECISIONS

AMBISOME

Products Affected

- Ambisome

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3MO AT A TIME
Other Criteria	ASPERGILLOSIS, INV,CANDIDIASIS,CRYPTOCOCCAL MENINGITIS - HIV INF,CRYPTOCOCCOSIS,FEB NEUT, EMP ANTIFUNGAL TX,PULM ASPERGILLOSIS, CHR (CAVITARY OR NECROTIZING), SALVAGE TX,VISCERAL LEISHMANIASIS. ALSO BVD DECISIONS

AMPYRA

Products Affected

- Ampyra

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	SEIZURES, RENAL IMPAIRMENT WITH A CRCL LESS THAN 50 ML/MIN OR WHEELCHAIR BOUND
Required Medical Information	BASELINE TIMED 25-FOOT WALK COMPLETED WITHIN 8-45 SECONDS,PATIENT MUST BE CURRENTLY AMBULATORY. CONTINUATION APPROVAL BASED ON RESULTS OF TIMED 25 FOOT WALK OR STATEMENT OF CLINICAL IMPROVEMENT
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	3 MONTHS AT A TIME INITIAL THEN EVERY 12 MONTHS BASED ON THERAPEUTIC RESPONSE
Other Criteria	PT MUST BE AMBULATORY WITH NO HISTORY OF SEIZURES

ANADROL-50

Products Affected

- Anadrol-50

PA Criteria	Criteria Details
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	ANEMIA (INITIAL): DIAGNOSIS OF ANEMIA CAUSED BY DEFICIENCT RED CELL PRODUCTION AND HISTORY OF FAILURE OR INTOLERANCE TO STANDARD THERAPIES FOR ANEMIA (IE, ERYTHROPOIESIS-STIMULATING AGENTS, IMMUNOSUPPRESSANTS) AND TREATMENT WILL NOT REPLACE OTHER SUPPORTIVE MEASURES (E.G., TRANSFUSION, CORRECTION OF IRON, FOLIC ACID, VITAMIN B12 OR PYRIDOXINE DEFICIENCY, ANTIBACTERIAL THERAPY, CORTICOSTEROIDS)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	INITIAL AND REAUTH: 12 MONTHS
Other Criteria	ANEMIA (REAUTH): PATIENT HAS EXPERIENCED AN OBJECTIVE IMPROVEMENT IN ANEMIA (E.G., INCREASED HEMOGLOBIN, INCREASED RETICULOCYTE COUNT, REDUCTION/ELIMINATION FOR NEED OF BLOOD TRANSFUSIONS)

APOKYN

Products Affected

- Apokyn INJ 30MG/3ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	CONCOMITANTLY ON A 5HT3 ANTAGONIST
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	N/A

ARALAST

Products Affected

- Aralast Np INJ 1000MG, 500MG, 800MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	HIGH-RISK PHENOTYPE (E.G. PIZZ, PIZNULL, PINULLNULL), PLASMA AAT LEVEL BELOW 11 MICROMOL/L (CORRESPONDING TO 80 MG/DL), FEV1 LESS THAN 80% OF PREDICTED
Age Restrictions	18YO OR OLDER
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	ABILITY TO COMPLY WITH THE PROTOCOL FOR ADMINISTRATION, COVERAGE IS LIMITED TO A DOSAGE OF 60 MG/KG WEEKLY OR 250 MG/KG MONTHLY. ALSO BVD DECISIONS

ARANESP

Products Affected

- Aranesp Albumin Free INJ 100MCG/0.5ML, 100MCG/ML, 10MCG/0.4ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 25MCG/0.42ML, 25MCG/ML, 300MCG/0.6ML, 300MCG/ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	ANEMIA ASSOCIATED WITH ARF, ANEMIA ASSOCIATED WITH CHF, ANEMIA IN CHRONIC DISEASES, INCLUDING: LYMPHOPROLIFERATIVE DISORDERS (I.E., MULTIPLE MYELOMA, NON-HODGKINS LYMPHOMA, AND CHRONIC LYMPHOCYTIC LEUKEMIA), CANCER OR WITH HX OF CANCER WHO IS NOT CURRENTLY UNDERGOING CURRENT CHEMO BUT HAS ANEMIA ASSOCIATED WITH ANY OF THE FOLLOWING: PRIOR CHEMOTHERAPY, PRIOR RADIATION THERAPY, CURRENT TX W RADIATION, MALIGNANCY. ANEMIA IN A WOMAN WITH POSTPARTUM IRON DEFICIENCY ANEMIA, ANEMIA SECONDARY TO AUTOLOGOUS BLOOD DONATION, ATHLETIC PERFORMANCE ENHANCEMENT, CASTLEMAN DISEASE, CHEMO-INDUCED ANEMIA BEYOND 8 WEEKS IN ABSENCE OF RESPONSE, CKD TARGET GREATER THAN 13, GAUCHER DISEASE, NON-CRITICALLY ILL INDIVIDUAL REQUIRING CORRECTION OF ANEMIA, PAROXYSMAL NOCTURNAL HEMOGLOBINURIA,PRURITIS (UREMIC) IN THE ABSENCE OF ANEMIA, SICKLE-CELL ANEMIA
Required Medical Information	ADQUATE IRON STORES SHOWN BY SERUM IRON AND SERUM FERRITIN WITHIN NORMAL RANGE
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	6 MOS FOR ANEMIA W CKD. 2 MOS FOR OTHER DX
Other Criteria	FOR THE TREATMENT OF ANEMIA IN THE PRESENCE OF ADEQUATE IRON STORES (I.E. NORMAL TRANSFERRIN OR SERUM FERRITIN LEVEL) FOR ANY OF THE FOLLOWING INDICATIONS: CKD ON OR NOT ON DIALYSIS, WITH A HEMOGLOBIN (HGB) LESS OR EQUAL TO 10 G/DL, CHEMO INDUCED ANEMIA WITH A HGB APPROACHING OR LESS THAN OR EQUAL TO 10 G/DL WHEN ADDITIONAL CHEMOTHERAPY IS ANTICIPATED FOR AT LEAST ANOTHER 2 MONTHS. ALSO BVD DECISIONS

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	DISCONTINUATION WITH SERIOUS INFECTIONS, CONCURRENT USE OF TNFS (INCREASED INFECTION RISK), LATENT TB
Required Medical Information	N/A
Age Restrictions	OVER 11 YO
Prescriber Restrictions	RHEUMATOLOGIST, DERMATOLOGIST, IMMUNOLOGIST
Coverage Duration	INITIAL REVIEW=4 MONTHS, 2ND REVIEW=6 MONTHS, 3RD REVIEW AND MORE=12 MONTHS.
Other Criteria	DIAGNOSIS OF CRYOPORIN ASSOCIATED PERIODIC SYNDROMES (CAPS): FAMILIAL COLD AUTO-INFLAMMATORY SYNDROME (FCAS) OR MUCKLE-WELLS SYNDROME

BERINERT

Products Affected

- Berinert

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF HEREDITARY ANGIOEDEMA (HAE) CONFIRMED USING SERUM COMPLEMENT FACTOR 4 (C4), CI INHIBITOR (C1NH) ANTIGENIC, AND C1NH FUNCTIONAL LEVELS (IF AVAILABLE) TAKEN AT DIFFERENT TIMES (SECOND TEST CONFIRMS DIAGNOSIS)
Age Restrictions	N/A
Prescriber Restrictions	PHYSICIAN SPECIALIZING IN ALLERGY OR IMMUNOLOGY MEDICINE
Coverage Duration	1YR AT A TIME
Other Criteria	N/A

BOTULINUM A TOXIN

Products Affected

- Botox
- Dysport
- Myobloc
- Xeomin

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	USE FOR COSMETIC PURPOSES (E.G., WRINKLES)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 MONTHS AT A TIME
Other Criteria	CONFIRMED IMPROVEMENT IN SYMPTOMS WITH INITIAL TREATMENT. AT LEAST 3 MONTHS HAVE ELAPSED SINCE THE LAST TREATMENT.

CARBAGLU

Products Affected

- Carbaglu

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YR AT A TIME
Other Criteria	COVERAGE REQUIRES A DIAGNOSIS OF HYPERAMMONEMIA DUE TO THE DEFICIENCY OF THE HEPATIC ENZYME N-ACETYLGLUTAMATE SYNTHASE CONFIRMED BY ENZYME ANALYSIS OR DNA MUTATION ANALYSIS. PATIENTS WHO DO NOT HAVE ENZYME ANALYSIS OR DNA MUTATION ANALYSIS RESULTS CAN BE APPROVED FOR A ONE MONTH TRIAL PENDING RESULTS.

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST
Coverage Duration	1 YR AT A TIME
Other Criteria	COVERAGE REQUIRES A DIAGNOSIS OF CYSTIC FIBROSIS

CERDELGA

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	CYP2D6 PHENOTYPE DETERMINATION TESTING
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	PHYSICIAN WHO SPECIALIZES IN THE TREATMENT OF GAUCHERS DISEASE
Coverage Duration	12 MONTHS AT A TIME
Other Criteria	DIAGNOSIS OF NON NEUROPATHIC (TYPE 1) GAUCHERS DISEASE

CEREZYME

Products Affected

- Cerezyme

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	ENZYME ASSAY DEMONSTRATING DEFICIENCY OF BETA-GLUCOCEREBROSIDASE ENZYME ACTIVITY
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	FOR LONG-TERM ERT IN PEDIATRIC AND ADULT PATIENTS WITH A CONFIRMED DIAGNOSIS OF TYPE 1 GAUCHER DISEASE THAT RESULTS IN ONE OR MORE OF THE FOLLOWING: ANEMIA, THROMBOCYTOPENIA, BONE DISEASE, HEPATOMEGALY, OR SPLENOMEGALY

CESAMET

Products Affected

- Cesamet

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY (CINV): PATIENT IS RECEIVING CANCER CHEMOTHERAPY. FAILURE, CONTRAINDICATION, OR INTOLERANCE TO ONE 5HT-3 RECEPTOR ANTAGONIST (EG, KYTRIL [GRANISETRON], OR ZOFRAN [ONDANSETRON]). FAILURE, CONTRAINDICATION, OR INTOLERANCE TO ONE OF THE FOLLOWING: COMPAZINE (PROCHLORPERAZINE), DECADRON (DEXAMETHASONE), HALDOL (HALOPERIDOL), ZYPREXA (OLANZAPINE).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV: 6 MONTHS.
Other Criteria	SUBJECT TO PART B VS. PART D REVIEW. CINV: APPROVE FOR CONTINUATION OF THERAPY FOR TREATMENT COVERED UNDER PART B WHEN PATIENT IS RECEIVING CANCER CHEMOTHERAPY.

CHANTIX

Products Affected

- Chantix ORAL TABS 0.5MG, 1MG
- Chantix Continuing Month Pak
- Chantix Starting Month Pak

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 WEEKS PER YEAR
Other Criteria	INITIAL AUTHORIZATION WILL BE 12 WEEKS OF THERAPY, FOLLOWED BY AN ADDITIONAL 12 WEEKS, IF THE PATIENT HAS STOPPED SMOKING DURING THE FIRST 12WEEKS OF TX AND HAD NOT SMOKED FOR AT LEAST 7 DAYS AT THE TIME OF THE REQUIRED PRIOR AUTHORIZATION. PATIENTS WILL BE ALLOWED TO HAVE A 2WK QTY OVERRIDE AT POS, IF THEY HAVE NOT HAD THEIR PROVIDER REQUEST A PRIOR AUTHORIZATION FOR THE ADD'L 12WKS OF TX, SO TX WILL NOT BE INTERRUPTED

CHENODOL

Products Affected

- Chenodal

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PREGNANCY (X), LIVER DYSFUNCTION, BILE DUCT ABNORMALITIES, NONVISUALIZING GALLBLADER AFTER 2 SIGNLE DOSES OF DYE, RADIOPAQUE STONES, GALLSTONE COMPLICATIONS REQUIRING SURGERY.
Required Medical Information	ULTRASONOGRAMS, STONE DESCRIPTION, LFTS, REASON WHY PATIENT IS NOT A CANDIDATE FOR SURGERY.
Age Restrictions	N/A
Prescriber Restrictions	GASTROENTEROLOGIST
Coverage Duration	INITIAL=6 MONTHS, RESPONSE =6 MONTHS FOR PARTIAL NO RESPONSE MAX=12 MORE MONTHS
Other Criteria	TRIAL AND FAILURE OF URSODIOL

CHOLBAM

Products Affected

- Cholbam

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF BILE ACID SYNTHESIS DEFECT DUE TO SINGLE ENZYME DEFECT OR DISORDER OF PEROXISOMAL FUNCTION, WITH LIVER DISEASE MANIFESTATIONS,STEATORRHEA,OR COMPLICATIONS DUE TO DECREASED ABSORPTION OF FAT SOLUBLE VITAMINS
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 MONTHS
Other Criteria	N/A

CHORIONIC GONADOTROPINS

Products Affected

- Chorionic Gonadotropin INJ
- Novarel
- Pregnyl W/diluent Benzyl Alcohol/nacl

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	DIAGNOSIS OR USE IN OVULATION INDUCTION
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	PRIOR AUTHORIZATION IS REQUIRED TO ENSURE APPROPRIATE PART D USE.

CIALIS

Products Affected

- Cialis TABS 5MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	ERECTILE DYSFUNCTION OR CONCURRENT USE OF NITRATES
Required Medical Information	DOCUMENTATION OF BENIGN PROSTATIC HYPERPLASIA. PATIENT HAS EXPERIENCED INTOLERANCE TO OR TREATMENT FAILURE WITH AN ALPHA-BLOCKER (E.G.,DOXAZOSIN, PRAZOSIN, TAMSULOSIN) OR A 5-ALPHA REDUCTASE INHIBITOR (E.G., FINASTERIDE)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YR AT A TIME
Other Criteria	N/A

CIMZIA

Products Affected

- Cimzia

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	GASTROENTEROLOGIST, RHEUMATOLOGIST
Coverage Duration	3 MOS FOR INITIAL APPROVAL, 1 YEAR ON REAPPROVAL BASED ON RESPONSE TO TREATMENT
Other Criteria	RA/PSORIATIC ARTH CRITERIA DOC OF INTOLERANCE OR FAILURE TO RESPOND TO A 2MO TRIAL OF A DMARD THERAPY, SUCH AS METHOTREXATE, ARAVA(LEFLUNOMIDE), PLAQUENIL (HYDROXYCHLOROQUINE), OR SULFASALAZINE. FOR CROHNS, DOC THAT PT HAS FAILED TX WITH CORTICOSTEROID OR IMMUNOSUPPRESSANT (AZATHIOPRINE, 6-MP OR METHOTREXATE).ANKYLOSING SPONDYLITIS INDICATION REQUIRING FAILURE OF AT LEAST 1 ANTI-INFLAMMATORY AGENT IN A 2MO PERIOD. DC IF NO RESPONSE AFTER 6-12WKS.

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS (LABS ON TWO SEPARATE DATES) BASED ON EVIDENCE OF A NORMAL C1 LEVEL AND A LOW C4 LEVEL (C4 LESS THAN 14 MG/DL, NORMAL RANGE 14-40 MG/DL, OR C4 BELOW THE LOWER LIMIT OF NORMAL AS DEFINED BY THE LABORATORY PERFORMING THE TEST) PLUS: A LOW C1 INHIBITOR (C1INH) ANTIGENIC LEVEL (C1INH LESS THAN 19 MG/DL NORMAL RANGE 19-37 MG/DL, OR C1INH ANTIGENIC LEVEL BELOW THE LOWER LIMIT OF NORMAL AS DEFINED BY THE LABORATORY PERFORMING THE TEST) OR A NORMAL C1INH ANTIGENIC LEVEL (C1INH GREATER THAN 18 MG/DL) AND A LOW C1INH FUNCTIONAL LEVEL (FUNCTIONAL C1INH LESS THAN 50%, OR BELOW THE LOWER LIMIT OF NORMAL AS DEFINED BY THE LABORATORY PERFORMING THE TEST)
Age Restrictions	N/A
Prescriber Restrictions	ALLERGIST, IMMUNOLOGIST
Coverage Duration	1YR AT A TIME
Other Criteria	MEMBER HAS A HISTORY OF AT LEAST 2 HAE ATTACKS PER MONTH OR A KNOWN HAE-CAUSING C1INH MUTATION. AND MEMBER HAS TRIED AND FAILED OR IS INTOLERANT TO OR HAS A CONTRAINDICATION TO 17 ALPHA-ALKYLATED ANDROGENS (E.G. DANAZOL AND STANOZOLOL) OR ANTI-FIBRINOLYTIC AGENTS (E.G. EPISILON AMINOCAPROIC ACID TRANEXAMIC ACID) FOR HAE PROPHYLAXIS

CRESEMBA

Products Affected

- Cresemba

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	CONCOMITANT USE WITH CYP3A4 INHIBITORS OR INDUCERS
Required Medical Information	DOCUMENTED DIAGNOSIS OF INVASIVE ASPERGILLOS WITH TRIAL FAILURE OR CONTRAINDICATION TO VORICONAZOLE OR DIAGNOSIS OF INVASIVE MUCORMYCOSIS
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	INFECTIOUS DISEASE SPECIALIST
Coverage Duration	3 MONTHS AT A TIME
Other Criteria	N/A

CRINONE

Products Affected

- Crinone

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ALL INDICATIONS: EXCLUDED IF FOR FERTILITY USES.
Required Medical Information	SECONDARY AMENORRHEA: DIAGNOSIS OF SECONDARY AMENORRHEA (THE ABSENCE OF MENSES IN WOMEN WHO HAVE ALREADY STARTED MENSTRUATION WHO ARE NOT PREGNANT, BREASTFEEDING, OR IN MENOPAUSE).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	N/A

CYSTAGON

Products Affected

- Cystagon

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS CONFIRMED BY THE PRESENCE OF INCREASED CYSTINE CONCENTRATION INLEUKOCYTES OR BY DNA TESTING
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	FOR MANAGEMENT OF NEPHROPATHIC CYSTINOSIS IN CHILDREN AND ADULTS

CYSTARAN

Products Affected

- Cystaran

PA Criteria	Criteria Details
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF CORNEAL CYSTEINE CRYSTAL ACCUMULATION CYSTINOSIS
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO CYSTARAN THERAPY

DEFEROXAMINE

Products Affected

- Deferoxamine Mesylate

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	IRON TOXICITY, ACUTE, IRON TOXICITY, CHRONIC, DUE TO TRANSFUSION-DEPENDENT ANEMIAS. ALSO BVD DECISIONS

DESOXYN

Products Affected

- Methamphetamine Hcl

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	ONE OF THE FOLLOWING: A) DIAGNOSIS OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD), OR B) DIAGNOSIS OF ATTENTION DEFICIT DISORDER (ADD)
Age Restrictions	PA APPLIES TO MEMBERS 19 YEARS OF AGE OR OLDER
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	N/A

DUODOTE

Products Affected

- Duodote

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1MO AT A TIME
Other Criteria	TREATMENT OF POISONING BY ORGANOPHOSPHOROUS NERVE AGENTS AS WELL AS ORGANOPHOSPHOROUS INSECTICIDES. ALSO BVD DECISIONS

ELAPRASE

Products Affected

- Elaprase

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	ENZYME ASSAY DEMONSTRATING DEFICIENCY OF IDURONATE 2-SULFATASE ENZYME ACTIVITY OR DNA TESTING
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	FOR PATIENTS WITH HUNTER SYNDROME (MPS II)

ELELYSO

Products Affected

- Elelyso

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTATION OF TYPE 1 GAUCHERS DISEASE
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6MO AT A TIME
Other Criteria	N/A

ELITEK

Products Affected

- Elitek

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PREVIOUS REACTION TO ELITEK, GLUCOSE 6-PHOSPHATE DEFICIENCY (G6PD)
Required Medical Information	DX OF CANCER, ELEVATED URIC ACID LEVELS, TUMOR LYSIS SYNDROME. DOCUMENTATION THAT MEDICATION WAS INITIATED WHILE IN HOSPITAL.
Age Restrictions	N/A
Prescriber Restrictions	ONCOLOGIST
Coverage Duration	1 MONTH
Other Criteria	N/A

EMEND

Products Affected

- Aprepitant
- Emend
- Emend Tripack

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	CHEMOTHERAPY-INDUCED NAUSEA AND VOMITING, DUE TO HIGHLY EMETOGENIC CHEMOTHERAPY, INCLUDING HIGH-DOSE CISPLATIN, PROPHYLAXIS OR EMOTHERAPY-INDUCED NAUSEA AND VOMITING, DUE TO MODERATELY EMETOGENIC CHEMOTHERAPY,PROPHYLAXIS. ALSO BVD DECISIONS

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM MEDICARE PART D
Exclusion Criteria	EPCLUSA WILL NOT BE COVERED FOR PATIENTS THAT ARE REQUESTING EPCLUSA IN COMBINATION WITH ANOTHER HCV DIRECT ACTING ANTIVIRAL AGENT
Required Medical Information	SUB OF MEDICAL RECORDS DOC A DIAGNOSIS OF CHRONIC HEP C VIRUS. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
Age Restrictions	N/A
Prescriber Restrictions	HEPATOLOGIST, GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, HIV SPECIALIST
Coverage Duration	APPROVAL PERIOD WILL BE CONSISTENT WITH CURRENT AASLD/IDSA GUIDELINES
Other Criteria	N/A

EPOETIN

Products Affected

- Epogen INJ 10000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML
- Procrit

PA Criteria	Criteria Details
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	ANEMIA ASSOCIATED WITH ARF, ANEMIA ASSOCIATED WITH CHF, ANEMIA IN CHRONIC DISEASES, INCLUDING: LYMPHOPROLIFERATIVE DISORDERS (I.E., MULTIPLE MYELOMA, NON-HODGKINS LYMPHOMA, AND CHRONIC LYMPHOCYTIC LEUKEMIA), CANCER OR WITH HX OF CANCER WHO IS NOT CURRENTLY UNDERGOING CURRENT CHEMO BUT HAS ANEMIA ASSOCIATED WITH ANY OF THE FOLLOWING: PRIOR CHEMOTHERAPY, PRIOR RADIATION THERAPY, CURRENT TX W RADIATION, MALIGNANCY. ANEMIA IN A WOMAN WITH POSTPARTUM IRON DEFICIENCY ANEMIA, ANEMIA SECONDARY TO AUTOLOGOUS BLOOD DONATION, ATHLETIC PERFORMANCE ENHANCEMENT, CASTLEMAN DISEASE, CHEMO-INDUCED ANEMIA BEYOND 8 WEEKS IN ABSENCE OF RESPONSE, CKD TARGET GREATER THAN 13, GAUCHER DISEASE, NON-CRITICALLY ILL INDIVIDUAL REQUIRING CORRECTION OF ANEMIA, PAROXYSMAL NOCTURNAL HEMOGLOBINURIA,PRURITIS (UREMIC) IN THE ABSENCE OF ANEMIA, SICKLE-CELL ANEMIA
Required Medical Information	ADQUATE IRON STORES SHOWN BY SERUM IRON AND SERUM FERRITIN WITHIN NORMAL RANGE
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 MOS FOR ANEMIA W CKD. 2 MOS FOR OTHER DX.

Other Criteria	FOR THE TREATMENT OF ANEMIA IN THE PRESENCE OF ADEQUATE IRON STORES (I.E. NORMAL TRANSFERRIN OR SERUM FERRITIN LEVEL) FOR ANY OF THE FOLLOWING INDICATIONS: CKD ON OR NOT ON DIALYSIS, WITH A HEMOGLOBIN (HGB) LESS OR EQUAL TO 10 G/DL, CHEMO INDUCED ANEMIA WITH A HGB APPROACHING OR LESS THAN OR EQUAL TO 10 G/DL WHEN ADDITIONAL CHEMOTHERAPY IS ANTICIPATED FOR AT LEAST ANOTHER 2 MONTHS , ELECTIVE SURGERY WITH PREOPERATIVE ANEMIA (HGB GREATER THAN 10 G/ DL AND LESS THAN OR EQUAL TO 13 G/DL) EXCEPT WHEN THE ANEMIA IS SECONDARY TO AUTOLOGOUS BLOOD DONATION. HIV INFECTED INDIVIDUAL RECEIVING ZIDOVUDINE TREATMENT WITH A HGB LESS THAN 13 G/DL IN A MALE AND 12 G/DL IN A FEMALE. ANEMIA WITH A HGB LESS THAN OR EQUAL TO 10 G/DL DUE TO ANY OF THE FOLLOWING: MYELODYSPLASTIC SYNDROME, RIBAVIRIN USE IN HEPATITIS C , INDIVIDUAL WHO WILL NOT OR CANNOT RECEIVE BLOOD PRODUCTS FOR TREATMENT OF ACUTE HEMORRHAGE OR BLOOD LOSS . ALSO BVD DECISIONS

EPOPROSTENOL

Products Affected

- Epoprostenol Sodium
- Veletri

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PATIENTS WITH HYPERSENSITIVITY TO PROSTACYCLIN ANALOGS, HIGH RISK OF HEMORRHAGE (E.G. ACTIVE PEPTIC ULCERS, TRAUMA, INTRACRANIAL HEMORRHAGE), SEVERE CORONARY HEART DISEASE, UNSTABLE ANGINA, MI WITHIN THE LAST 6 MONTHS, DECOMPENSATED CARDIAC FAILURE NOT UNDER CLOSE MEDICAL SUPERVISION, SEVERE ARRHYTHMIAS, CEREBROVASCULAR EVENTS WITHIN THE LAST 3 MONTHS, PULMONARY HYPERTENSION CAUSED BY VENOUS OCCLUSIVE DISEASE, PREGNANT PATIENTS.
Required Medical Information	PREVIOUS MEDICATIONS USED, RESULTS OF ACUTE VASOREACTIVITY TESTING
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST, CARDIOLOGIST
Coverage Duration	1YR AT A TIME
Other Criteria	FOR THE TREATMENT OF PULMONARY ARTERIAL HYPERTENSION IN PATIENTS WITH NYHA CLASS II, III OR IV SYMPTOMS AND FOR PATIENT WHO HAVE TRIED OR FAILED CONVENTIONAL THERAPIES, INCLUDING ORAL ANTICOAGULANTS, DIURETICS, SUPPLEMENTAL OXYGEN, AND/OR DIGOXIN, UNLESS CONTRAINDICATED AND TRIAL AND FAILURE OF ORAL CALCIUM CHANNEL BLOCKERS IF ACUTE VASOREACTIVITY TESTING IS POSITIVE OR UNLESS CONTRAINDICATED (E.G. UNSTABLE PATIENTS OR THOSE WITH SEVERE RIGHT HEART FAILURE). VELETRI REQUIRES A DOCUMENTED TRIAL OF GENERIC EPOPROSTENOL PRIOR TO COVERAGE OF BRAND. ALSO BVD DECISIONS

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF IDIOPATHIC PULM FIBROSIS, DOCUMENTED BASELINE LIVER FUNCTION TESTS
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	ESBRIET WILL HAVE MDL OF 270 CAPS PER 30 DAYS.

EXJADE

Products Affected

- Exjade

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	UNDER 2YO,SEVERE RENAL INSUF,HEPATITIS,IF ON ANY OTHER IRON CHELATION THERAPY CONCOMITANTLY
Required Medical Information	COVERED FOR TRANSFUSIONAL IRON OVERLOAD WHEN THE PATIENT HAS A SERUM FERRITIN LEVEL GREATER THAN 1000 MCG/L AND DISCONTINUATION WHEN LEVELS ARE BELOW 500MCG/L IN TWO CONSECUTIVE MONTHS. COVERED FOR NON-TRANSFUSION DEPENDENT THALASSEMA SYNDROME WITH DOCUMENTATION OF AN LIC OF AT LEAST 5MG FE/G DW AND SERUM FERRITIN GREATER THEN 300 MCG/L AND DISCONTINUATION WHEN LEVELS ARE BELOW 300 MCG/L IN TWO CONSECUTIVE MONTHS. FOR ALL INDICATIONS PATIENT SHOULD HAVE DOCUMENTATION OF AUDITORY AND OPHTHALMIC TESTING PRIOR TO STARTING EXJADE TREATMENT.
Age Restrictions	2YO AND OLDER
Prescriber Restrictions	N/A
Coverage Duration	3 MO AT A TIME
Other Criteria	N/A

EXONDYS 51

Products Affected

- Exondys 51

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM MEDICARE PART D
Exclusion Criteria	EXCLUDED IF MEMBER IS NOT ABLE TO REMAIN AMBULATORY (E.G. ABLE TO WALK WITH ASSISTANCE, NOT WHEEL CHAIR DEPENDENT)
Required Medical Information	DIAGNOSIS OF DUCHENNE MUSCULAR DYSTROPHY WITH CONFIRMED MUTATION OF THE DYSTROPHIN GENE AMENABLE TO EXON 51 SKIPPING
Age Restrictions	N/A
Prescriber Restrictions	SPECIALIST IN THE TREATMENT OF DUCHENNE MUSCULAR DYSTROPHY
Coverage Duration	INITIAL 3 MONTHS. REAPPROVAL 6 MONTHS
Other Criteria	REAPPROVAL WITH DOCUMENTATION OF CLINICAL BENEFIT AND DOCUMENTATION THAT MEMBER IS STILL AMBULATORY

FABRAZYME

Products Affected

- Fabrazyme INJ 35MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	ENZYME ASSAY DEMONSTRATING DEFICIENCY OF ALPHA-GALACTOSIDASE ENZYME ASSAY OR DNA TESTING
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	FOR USE IN PATIENTS WITH FABRY DISEASE

FIRAZYR

Products Affected

- Firazyr

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS WITH LABS ON TWO SEPARATE DATES BASED ON EVIDENCE OF A NORMAL C1 LEVEL IN THE RANGE OF 14 TO 40 MG PER DL AND A LOW C4 LEVEL OF LESS THAN OR EQUAL TO 14 MG/DL AS DEFINED BY THE LABORATORY PERFORMING THE TEST PLUS A LOW C1 INHIBITOR (C1INH) ANTIGENIC LEVEL LESS THAN OR EQUAL TO 19 MG/DL NORMAL RANGE 19 TO 37 MG/DL, OR C1INH ANTIGENIC LEVEL BELOW THE LOWER LIMIT OF NORMAL AS DEFINED BY THE LABORATORY PERFORMING THE TEST, OR A NORMAL C1INH ANTIGENIC LEVEL GREATER THAN OR EQUAL TO 19 MG/DL AND A LOW C1INH FUNCTIONAL LEVEL LESS THAN OR EQUAL TO 50%, OR BELOW THE LOWER LIMIT OF NORMAL AS DEFINED BY THE LABORATORY PERFORMING THE TEST AND MEMBER MUST BE EXPERIENCING AT LEAST ONE SYMPTOM OF THE MODERATE OR SEVERE ATTACK, FOR EXAMPLE AIRWAY SWELLING, SEVERE ABDOMINAL PAIN, FACIAL SWELLING, NAUSEA AND VOMITING, PAINFUL FACIAL DISTORTION
Age Restrictions	GREATER THAN OR EQUAL TO 18 YEARS OF AGE
Prescriber Restrictions	PHYSICIAN SPECIALIZING IN ALLERGY OR IMMUNOLOGY MEDICINE
Coverage Duration	1 YR AT A TIME
Other Criteria	MEMBER MUST HAVE A CONFIRMED DIAGNOSIS OF HEREDITARY ANGIOEDEMA

FORTEO

Products Affected

- Forteo INJ 600MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PATIENTS WHO ARE AT AN INCREASED RISK OF OSTEOSARCOMA, INCLUDING THOSE WITH PAGET'S DZ, UNEXPLAINED ELEVATIONS IN SERUM ALKALINE PHOSPHATASE, OR PRIOR SKELETAL RADIATION, OR IN CHILDREN OR YOUNG ADULTS W. OPEN EPIPHYSES
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YR AT A TIME FOR 2 YEARS MAX
Other Criteria	FOR THE TX OF POSTMENOPAUSAL WOMEN WITH OSTEOPOROSIS OR TO INCREASE BONE MASS IN MEN WITH PRIMARY HYPOGONADAL OSTEOPOROSIS OR FOR THE TX OF MEN AND WOMEN WITH OSTEOPOROSIS ASSOCIATED WITH SUSTAINED SYSTEMIC GLUCOCORTICOID THERAPY (DAILY DOSAGE EQUIVALENT TO 5MG OR GREATER OF PREDNISONE) WHO ARE AT HIGH RISK FOR FRACTURE. HIGH RISK DEFINED AS A HISTORY OF OSTEOPOROTIC FRACTURE, MULTIPLE RISK FACTORS FOR FRACTURE, OR PTS WHO ARE INTOLERANT TO OR HAVE HAD FAILURE TO INCREASE BONE MASS DENSITY AFTER 6 MOS TO 1 YR TX WITH A BISPHOSPHONATE (IN FEMALES)

FOSCARNET

Products Affected

- Foscavir

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	AIDS - CYTOMEGALOVIRAL RETINITIS, HERPES SIMPLEX, MUCOCUTANEOUS, ACYCLOVIR-RESISTANT - PATIENT IMMUNOCOMPROMISED. ALSO BVD DECISIONS

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF SHORT BOWEL SYNDROME WITH DEPENDENCE ON PARENTERAL SUPPORT
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 MO INITIAL WITH DOCUMENTED CLINICAL RESP TO THERAPY FOR RENEWAL
Other Criteria	N/A

GLASSIA

Products Affected

- Glassia

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	HIGH-RISK PHENOTYPE (E.G. PIZZ, PIZNULL, PINULLNULL), PLASMA AAT LEVEL BELOW 11 MICROMOL/L (CORRESPONDING TO 80 MG/DL), FEV1 GREATER OR EQUAL TO 35 AND LESS THAN 80% OF PREDICTED
Age Restrictions	18 OR OLDER
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	ABILITY TO COMPLY WITH THE PROTOCOL FOR ADMINISTRATION, COVERAGE IS LIMITED TO A DOSAGE OF 60 MG/KG WEEKLY OR 250 MG/KG MONTHLY. ALSO BVD DECISIONS

GROWTH HORMONE

Products Affected

- Norditropin Flexpro INJ 10MG/1.5ML, 5MG/1.5ML
- Omnitrope
- Serostim INJ 4MG, 5MG, 6MG
- Somatuline Depot
- Somavert

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	GH STIMULATION TESTS, HT,
Age Restrictions	N/A
Prescriber Restrictions	ENDOCRINOLOGIST, ONCOLOGIST
Coverage Duration	6MO AT A TIME
Other Criteria	N/A

HAEGARDA

Products Affected

- Haegarda

PA Criteria	Criteria Details
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED BY MEDICARE PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF HEREDITARY ANGIOEDEMA (HAE) CONFIRMED BY USING SERUM COMPLEMENT FACTOR 4 (C4), C1 INHIBITOR (C1NH) ANTIGENIC, AND C1NH FUNCTIONAL LEVELS (IF AVAILABLE) TAKEN AT DIFFERENT TIMES (SECOND TEST CONFIRMS DIAGNOSIS)
Age Restrictions	N/A
Prescriber Restrictions	PHYSICIAN SPECIALIZING IN ALLERGY OR IMMUNOLOGY
Coverage Duration	ONE YEAR AT AT TIME
Other Criteria	N/A

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	EGFR LESS THAN 30ML/MIN OR ESRD
Required Medical Information	DIAGNOSIS OF CHRONIC HEPATITIS C VIRUS GENOTYPE 1a, 1b, 4,5 or 6 INCLUDING PATIENTS WITH DECOMPENSATED LIVER DISEASE
Age Restrictions	N/A
Prescriber Restrictions	GASTROENTEROLOGIST INFECTIOUS DISEASE SPECIALIST OR HEPATOLOGIST
Coverage Duration	COVERAGE DURATION WILL FOLLOW RECOMMENDATION SET FORTH BY THE AASLD
Other Criteria	N/A

HEPATITIS B

Products Affected

- Tyzeka

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTATION OF HEPATITIS B AND AN ALT GREATER THAN 2 TIMES UPPER NL
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	N/A

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF TOTAL BLINDNESS IN BOTH EYES. DIAGNOSIS OF NON 24 HOURS SLEEP WAKE DISORDER
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 MO INITIAL AND 12 MONTHS RENEWAL
Other Criteria	N/A

HIZENTRA

Products Affected

- Cuvitru
- Hizentra

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	NOT TO BE GIVEN IN CONDITIONS SUCH AS ITP AND NEUROPATHIES IN WHICH LARGE DOSES ARE USUALLY GIVEN TO BLOCK FC RECEPTOR FUNCTION, COMPLEMENT DEPOSITION OR OTHER IMMUNOMODULATORY EFFECTS. DIAGNOSIS OF PRIMARY IMMUNODEFICIENCY IS THE ONLY COVERED INDICATION FOR SUBCUTANEOUS ROUTE.

HRM - ANTIHISTAMINES

Products Affected

- Diphenhydramine Hcl ELIX
- Hydroxyzine Hcl ORAL TABS
- Promethazine Hcl ORAL TABS

PA Criteria	Criteria Details
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	NAUSEA (INITIAL): DIAGNOSIS OF NAUSEA AND HISTORY OF FAILURE OR INTOLERANCE TO ONDANSETRON OR PROCHLORPERAZINE. HIVES/ITCHING (INITIAL): FAILURE OR INTOLERANCE TO A NON-SEDATING ANTIHISTAMINE (EX. CETIRIZINE).
Age Restrictions	PA APPLIES TO PATIENTS 65 YEARS OR OLDER
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	N/A

IDIOPATHIC PULMONARY FIBROSIS

Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTED BASELINE LIVER FUNCTION TESTS
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST
Coverage Duration	12 MONTHS AT A TIME
Other Criteria	DIAGNOSIS OF IDIOPATHIC PULMONARY FIBROSIS AS DEFINED BY THE AMERICAN THORACIC SOCIETY

ILARIS

Products Affected

- Ilaris

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTATION OF A TUBERCULOSIS SKIN TEST, BASELINE C REACTIVE PROTEIN AND SERUM AMYLOID A LEVELS
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6MO AT A TIME
Other Criteria	MONITOR FOR IMPROVEMENT IN SIGNS AND SYMPTOMS OF CRYOPYRIN ASSOCIATED PERIODIC SYNDROMES IE. FEVER, URTICARIA LIKE RASH, ARTHRALGIA, MYALGIA, FATIGUE, AND CONJUNCTIVITIS

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PTS W.CLOSED EPIPHYSES,PTS W.ACTIVE OR SUSPECTED NEOPLASIA
Required Medical Information	HEIGHT MEASUREMENTS AND SERUM IGF-1 LEVELS THREE OR MORE STD DEVIATIONS BELOW NL(BASED ON LAB REF RANGE FOR AGE AND SEX), AND NL OR ELEVATED GROWTH HORMONE LEVELS
Age Restrictions	2YO OR GREATER
Prescriber Restrictions	ENDOCRINOLOGIST
Coverage Duration	1YR INITIAL,
Other Criteria	DISCONTINUATION OCCURS WHEN LINEAR GROWTH CEASES

INFLECTRA

Products Affected

- Inflectra

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM MEDICARE PART D
Exclusion Criteria	N/A
Required Medical Information	TB SCREENING
Age Restrictions	N/A
Prescriber Restrictions	RHEUMATOLOGIST , GASTROENTEROLOGIST ,DERMATOLOGIST
Coverage Duration	1YR AT A TIME FOR RA,PSORIATIC ARTHRITIS OR ANKYLOSING SPONDYLITIS DX,6MO AT A TIME FOR UC OR CROHNS

Other Criteria	DX OF RA/PSA REQUIRES DOCUMENTATION OF FAILURE TO RESPOND TO A 2MO TRIAL ENBREL OR HUMIRA OR AN INTOL OR CONTRA TO ENBREL OR HUMIRA TX. AND HAVE CONCURRENT TX W MTX. ALL DOSE INCRE AFTER INTIAL TX MUST BE PRIOR AUTH'D. ANK SPOND CRITERIA FAIL OF AT LEAST 2 ANTI-INFLAMMATORY AGENTS IN A 2MO PERIOD. DOC OF FAIL TO RESP TO A 2MO TRIAL ENBREL OR HUMIRA OR AN INTOL OR CONTRAIND TO ENBREL OR HUMIRA TX.DC IF NO RESPONSE AFTER 6-12WKS. DX OF CROHN'S USE FOR MOD TO SEV ACTIVE CD IN PTS WHO HAVE NOT RESP DESPITE COMPLETE & ADEQ TX W A CORTICOST OR IMMUNOSUPP AGT OR AN INTOL OR CONTRA & A 2MO TRIAL & FAIL OF BOTH HUMIRA OR CONTRA OR INTOL TO HUMIRA. DX OF UC, USE FOR MOD TO SEV ACTIVE UC IN PTS WHO HAVE NOT RESP DESPITE COMPL & ADEQ TX W A CORTICO OR AN IMMUNOSUPP AGT OR AN INTOL OR CONTRA & A 2 MO TRIAL AND FAIL OF HUMIRA OR CONTRA OR INTOL TO HUMIRA. FOR PSORIASIS DX, DOC THAT PT HAS CHRONIC MOD OR SEV PLAQUE PSORIASIS INVOLVED IN GRTR THAN 5% OF BSA THAT DID NOT RESP TO 6WKS OF AT LEAST 1 TOP TX AND TRIAL & FAIL AT LEAST ONE OF THE FOLLOWNG SYSTEMIC TX OR IS NOT A CANDID DUE TO A CONTRA:MTX, AZATHIOPRINE, CYCLOSPORINE, ACITRETIN, SULFASALAZINE, 6-THIOGUANINE, HYDROXYUREA, PROPYLTHIOURACIL AND PHOTOTHERAPY (PUVA OR UVB). REQUIRES A TRIAL AND FAIL OF HUMIRA OR ENBREL OR CONTRA TO HUMIRA OR ENBREL. RENEWAL BASED ON IMPROVEMENT OF CLINICAL SIGNS AND SX OF PSORIASIS

INGREZZA

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM MEDICARE PART D
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTATION OF TARDIVE DYSKINESIA
Age Restrictions	N/A
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	12 MONTHS AT A TIME
Other Criteria	QL: 60 TABLETS PER 30 DAYS

ISOTRETINOIN

Products Affected

- Amnesteem
- Claravis
- Myorisan
- Zenatane

PA Criteria	Criteria Details
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	ACNE (INITIAL): DIAGNOSIS OF ACNE. HISTORY OF FAILURE, CONTRAINDICATION OR INTOLERANCE TO AN ADEQUATE TRIAL (AT LEAST 6 WEEKS) ON BOTH OF THE FOLLOWING CONVENTIONAL THERAPY REGIMENS: A) TOPICAL RETINOID OR RETINOID-LIKE AGENT [EG, RETIN-A/RETIN-A MICRO (TRETINOIN)] AND ONE OF THE FOLLOWING: 1) ORAL ANTIBIOTIC [EG, ERY-TAB (ERYTHROMYCIN), MINOCIN (MINOCYCLINE)] OR ADAPALENE.
Age Restrictions	N/A
Prescriber Restrictions	ACNE (INITIAL): PRESCRIBED BY A DERMATOLOGIST
Coverage Duration	ACNE (INITIAL, REAUTH): 5 MONTHS
Other Criteria	ACNE (REAUTH): ONE OF THE FOLLOWING: A) AFTER MORE THAN 2 MONTHS OFF THERAPY, PERSISTENT OR RECURRING SEVERE RECALCITRANT NODULAR ACNE IS STILL PRESENT, OR B) THE TOTAL CUMULATIVE DOSE IS LESS THAN 150 MG/KG (WILL BE APPROVED UP TO A TOTAL OF 150 MG/KG).

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YR AT A TIME
Other Criteria	COVERED FOR THE TREATMENT OF INTERMEDIATE OR HIGH-RISK MYELOFIBROSIS. MYELOFIBROSIS DIAGNOSIS INCLUDES PRIMARY, POSTPOLYCYNTHEMIA, AND POSTESSENTIAL THROMBOCYTHEMIA MYELOFIBROSIS.

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	CONCOMITANT USE WITH MOD OR STRONG CYP3A4 INHIBITORS, HEPATIC IMPAIRMENT, MOD OR SEV (CHILD-PUGH CAT B OR C), LIVER DISEASE, ACTIVE, INCLUDING UNEXPLAINED PERSISTANT ELEVATIONS OF SERUM TRANSAMINASES, PREGNANCY
Required Medical Information	DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA, LIVER FUNCTION TESTS AND NEGATIVE PREGNANCY TEST IN WOMEN WITH REPRODUCTIVE POTENTIAL
Age Restrictions	N/A
Prescriber Restrictions	ENDOCRINOLOGIST OR CARDIOLOGIST
Coverage Duration	6 MO WITH DOCUMENTED CLINICAL RESP TO THERAPY FOR RENEWAL
Other Criteria	N/A

KALBITOR

Products Affected

- Kalbitor

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS (LABS ON TWO SEPARATE DATES) BASED ON EVIDENCE OF A NORMAL C1 LEVEL AND A LOW C4 LEVEL (C4 LESS THAN 14 MG/DL, NORMAL RANGE 14-40 MG/DL, OR C4 BELOW THE LOWER LIMIT OF NORMAL AS DEFINED BY THE LABORATORY PERFORMING THE TEST) PLUS: A LOW C1 INHIBITOR (C1INH) ANTIGENIC LEVEL (C1INH LESS THAN 19 MG/DL NORMAL RANGE 19-37 MG/DL, OR C1INH ANTIGENIC LEVEL BELOW THE LOWER LIMIT OF NORMAL AS DEFINED BY THE LABORATORY PERFORMING THE TEST) OR A NORMAL C1INH ANTIGENIC LEVEL (C1INH GREATER THAN 18 MG/DL) AND A LOW C1INH FUNCTIONAL LEVEL (FUNCTIONAL C1INH LESS THAN 50%, OR BELOW THE LOWER LIMIT OF NORMAL AS DEFINED BY THE LABORATORY PERFORMING THE TEST)
Age Restrictions	N/A
Prescriber Restrictions	ALLERGIST, IMMUNOLOGIST
Coverage Duration	1YR AT A TIME
Other Criteria	CONFIRMED DIAGNOSIS OF HAE AND MEMBER MUST BE EXPERIENCING AT LEAST ONE SYMPTOM OF THE MODERATE OR SEVERE ATTACK (E.G., AIRWAY SWELLING, SEVERE ABDOMINAL PAIN, FACIAL SWELLING, NAUSEA AND VOMITING, PAINFUL FACIAL DISTORTION).

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	diagnosis of CF in pts w/g551d,g1244e,g1349d,g178r,g551s,r117h,s1251n,s1255p,s549n or s549r mutation in the cftr gene
Age Restrictions	2 YEARS OLD OR OLDER FOR ORAL GRANULES, 6 YEARS OLD OR OLDER FOR ORAL TABLETS
Prescriber Restrictions	Pulmonologist
Coverage Duration	12 months at a time
Other Criteria	N/A

KANUMA

Products Affected

- Kanuma

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of Wolman's Disease
Age Restrictions	N/A
Prescriber Restrictions	ENDOCRINOLOGIST, GENETICIST,GASTROENTEROLOGIST,LIPIDOLOGIST OR METABOLIC SPECIALIST
Coverage Duration	Coverage duration is 12 months
Other Criteria	N/A

KEPIVANCE

Products Affected

- Kepivance

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PATIENTS W. NON HEMATOLOGIC MALIGNANCIES
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	ONCOLOGIST
Coverage Duration	3MO AT A TIME
Other Criteria	BVD DECISIONS

KEVEYIS

Products Affected

- Keveyis

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of primary hyperkalemic periodic paralysis or primary hypokalemic periodic paralysis, or related variants of primary paralysis
Age Restrictions	N/A
Prescriber Restrictions	Neurologist or endocrinologist
Coverage Duration	Initial approval 3 months. Reapproval 12 months with doc of beneficial response
Other Criteria	N/A

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D OR DOCUMENTATION OF JUVENILE IDIOPATHIC ARTHRITIS
Exclusion Criteria	HYPERSENSITIVITY TO PROTEINS DERIVED FROM E.COLI
Required Medical Information	DIAGNOSIS OF CHRONIC INFANTILE NEUROLOGICAL, CUTANEOUS AND ARTICULAR SYNDROME OR RHEUMATOID ARTHRITIS
Age Restrictions	N/A
Prescriber Restrictions	RHEUMATOLOGIST, DERMATOLOGIST,NEUROLOGIST OR PEDIATRICIAN
Coverage Duration	4 MO INITIAL, 1 YEAR ON REAPPROVAL BASED ON RESPONSE TO TX
Other Criteria	RA CRITERIA. DOC OF INTOLERANCE OR FAILURE TO RESPOND TO A 2MO TRIAL OF A DMARD THERAPY, SUCH AS METHOTREXATE, ARAVA(LEFLUNOMIDE), PLAQUENIL (HYDROXYCHLOROQUINE), OR SULFASALAZINE AND TRIAL AND FAILURE WITH HUMIRA AND ENBREL. JIA CRITERA: INADEQUATE RESP, INTOLERANCE, OR CONTRAINDICATION TO CORTICOSTEROIDS AND TRIAL AND FAILURE WITH HUMIRA.

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	TYPE 2 DIABETES MELLITUS UNRELATED TO ENDOGENOUS CUSHINGS, PREGNANCY, USE OF SIVASTATIN OR LOVASTATIN AND CYP3A SUBSTRATES W NARROW THERAPEUTIC RANGE, CONCURRENT LONGTERM CORTICOSTEROID USE, WOMEN W HX OF UNEXPLAINED VAGINAL BLEEDING, WOMEN W ENDOMETRIAL HYPERPLASIA W ATYPIA OR ENDOMETRIAL CARCINOMA
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6MO AT A TIME
Other Criteria	COVERED FOR INDICATION OF CONTROLLING HYPERGLYCEMIA SECONDARY TO HYPERCORTISOLISM IN ADULT PATIENTS WITH ENDOGENOUS CUSHINGS SYNDROME WHO HAVE TYPE 2 DIABETES MELLITUS OR GLUCOSE INTOLERANCE AND HAVE FAILED SURGERY OR ARE NOT CANDIDATES FOR SURGERY.

KRYSTEXXA

Products Affected

- Krystexxa

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	ANAPHYLAXIS AND INFUSIONS REACTIONS (BOXED WARNING), CONTRAINDICATED IN PT W/G6PD DEFICIENCY DUE TO RISK OF HEMOLYSIS AND METHEMOGLOBINEMIA,GOUT FLARES DURING INITIATION OF TX
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6MO AT A TIME
Other Criteria	TREATMENT OF CHRONIC GOUT IN ADULT PATIENTS REFRACTORY TO CONVENTIONAL THERAPY AND 3MO TRIAL OF XO INHIBITOR (ALLOPURINOL ,ULORIC). ALSO BVD DECISIONS

KUVAN

Products Affected

- Kuvan

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2MO AT A TIME INITIAL 3 MO THEREAFTER
Other Criteria	PRIOR AUTHORIZATION IS TO MONITOR IF PATIENT IS A RESPONDER OR NONRESPONDER AFTER THERAPY HAS BEEN INITIATED FOR 2MONTHS. IF PHENYLALANINE LEVELS HAVE DECREASED AFTER THE 2 MONTHS, THEN AUTHORIZATION WILL CONTINUE.

KYNAMRO

Products Affected

- Kynamro

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	HEPATIC IMPAIRMENT, MOD OR SEV (CHILD-PUGH CAT B OR C), LIVER DISEASE, ACTIVE, INCLUDING UNEXPLAINED PERSISTANT ELEVATIONS OF SERUM TRANSAMINASES
Required Medical Information	DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA, LIVER FUNCTION TESTS
Age Restrictions	N/A
Prescriber Restrictions	ENDOCRINOLOGIST OR CARDIOLOGIST
Coverage Duration	6 MO WITH DOCUMENTED CLINICAL RESP TO THERAPY FOR RENEWAL
Other Criteria	MAY ALSO COVER HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA WHEN CORONARY ARTERIOSCLEROSIS IS PRESENT AND UNCONTROLLED HYPERCHOLESTEROLEMIA WHEN ALL FORMULARY AGENTS HAVE BEEN TRIED AND FAILED AT MAXIMUM TOLERATED DOSES.

LAZANDA

Products Affected

- Lazanda

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	OPIOD NON-TOLERANT PATIENTS
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	N/A

LEMTRADA

Products Affected

- Lemtrada

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED 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). One of the following: 1) Patient has not been previously treated with alemtuzumab, and patient has history of failure following a trial for at least 4 weeks or history of intolerance or contraindication to 2 of the following: interferon beta-1a (Avonex or Rebif), interferon beta-1b (Betaseron, Extavia), glatiramer acetate (Copaxone or Glatopa), dimethyl fumarate (Tecfidera), teriflunomide (Aubagio), fingolimod (Gilenya), peginterferon beta-1a (Plegridy), natalizumab (Tysabri), or 2) Patient has previously received treatment with alemtuzumab, and at least 12 months have or will have elapsed since the first treatment with alemtuzumab, and patient has not already received the FDA-recommended lifetime limit of two (2) treatment courses of alemtuzumab. Patient is not receiving alemtuzumab in combination with another disease modifying agent (eg, interferon beta preparations, glatiramer acetate, natalizumab, fingolimod, or teriflunomide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MS: 12 MONTHS, MAX 2 YRS OF THERAPY
Other Criteria	N/A

LEUKINE

Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	CONCOMITANT USE WITH CHEMOTHERAPY OR RADIOTHERAPY OR USE WITHIN 24 HOURS
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6MO AT A TIME
Other Criteria	ALLOGENEIC BONE MARROW TRANSPLANTATION, MYELOID RECONSTITUTION IN HLA-MATCHED RELATED DONORS, AUTOLOGOUS BONE MARROW TRANSPLANT, MYELOID RECONSTITUTION FOLLOWING TRANSPLANT IN PATIENTS WITH NON-HODGKIN'S LYMPHOMA, HODGKIN'S DISEASE, AND ACUTE LYMPHOBLASTIC LYMPHOMA, BONE MARROW TRANSPLANT, DELAY OR FAILURE OF MYELOID ENGRAFTMENT, FEBRILE NEUTROPENIA, IN ACUTE MYELOGENOUS LEUKEMIA FOLLOWING INDUCTION CHEMOTHERAPY, PROPHYLAXIS HARVESTING OF PERIPHERAL BLOOD STEM CELLS, PERIPHERAL BLOOD STEM CELL GRAFT, AUTOLOGOUS, MYELOID RECONSTITUTION FOLLOWING TRANSPLANT IN PATIENTS MOBILIZED WITH GRANULOCYTE MACROPHAGE COLONY STIMULATING FACTOR. ALSO BVD DECISIONS

LEUPROLIDE

Products Affected

- Eligard
- Leuprolide Acetate INJ
- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (6-month)
- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	LEUPROLIDE ACETATE INJECTION IS INDICATED IN THE PALLIATIVE TX OF ADVANCED PROSTATE CANCER, TX OF CHILDREN WITH CENTRAL PRECOCIOUS PUBERTY,ENDOMETRIOSIS AND UTERINE LEIOMYOMATA(FIBROIDS). ALSO BVD DECISIONS

LIDOCAINE

Products Affected

- Lidocaine PTCH

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YR AT A TIME
Other Criteria	N/A

LUMIZYME

Products Affected

- Lumizyme

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	ENZYME TESTING THAT DEMONSTRATES REDUCED GAA ENZYME ACTIVITY OR BY DNA TESTING FOR MUTATIONS IN THE GAA GENE
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	N/A

MEGACE

Products Affected

- Megestrol Acetate ORAL SUSP
- Megestrol Acetate ORAL TABS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	EVALUATE USE AS A PART D COVERED DIAGNOSIS

MOZOBIL

Products Affected

- Mozobil

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1MO AT A TIME
Other Criteria	HARVESTING OF PERIP BLOOD STEM CELLS, IN PTS W/NON-HODGKIN'S LYMPH AND MULTI MYEL. ALSO BVD DECISIONS

MYALEPT

Products Affected

- Myalept

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	HIV RELATED LIPODYSTROPHY, PT WITH METABOLIC DISEASE WITHOUT CURRENT EVIDENCE OF GENERALIZED LIPODYSTROPHY.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YT AT A TIME
Other Criteria	DX OF CONGENITAL OR ACQUIRED GENERALIZED LIPODYSTROPHY

MYOZYME

Products Affected

- Myozyme

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	ENZYME TESTING THAT DEMONSTRATES REDUCED GAA ENZYME ACTIVITY OR BY DNA TESTING FOR MUTATIONS IN THE GAA GENE
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	FOR USE IN PATIENTS WITH POMPE DISEASE (GAA DEFICIENCY

NAGLAZYME

Products Affected

- Naglazyme

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	ENZYME ASSAY DEMONSTRATING DEFICIENCY OF N-ACETYLGALACTOSAMINE 4-SULFATASE (ARYLSULFATASE B) ENZYME ACTIVITY OR DNA TESTING
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	FOR PATIENTS WITH MPS VI

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	All FDA Approved Indications, not otherwise excluded from Medicare Part D
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of hypocalcemia due to hypoparathyroidism, AND Documented failure on calcitriol, AND Documented failure on oral phosphate binders (sevelamer, calcium carbonate, calcium acetate, etc.)
Age Restrictions	Age 18 years or older
Prescriber Restrictions	Endocrinologist
Coverage Duration	Approve for 6 months at a time
Other Criteria	N/A

NEUMEGA

Products Affected

- Neumega

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DISCONTINUATION CRITERIA WHEN THERAPY HAS BEEN USED FOR 21 DAYS OR UNTIL POST NADIR PLATELET COUNT IS GRTR THAN OR EQUAL TO 50,000/MCL. AND IF POST NADIR COUNT IS NOT REACHED, THERAPY IS CONTINUED PER MD.
Age Restrictions	N/A
Prescriber Restrictions	ONCOLOGIST - HEMATOLOGIST
Coverage Duration	3MO AT A TIME BASED ON POST NADIR PLATELET COUNTS
Other Criteria	N/A

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of Eosinophilic Phenotype Severe Asthma. Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks.
Age Restrictions	Age 12 years or older
Prescriber Restrictions	Prescribed by an Allergist, Immunologist, or Pulmonologist
Coverage Duration	Coverage duration is 12 months
Other Criteria	Documented concurrent use of an inhaled corticosteroid, AND Documented concurrent use of one of the following: Inhaled Long Acting Beta Agonist (Serevent, Foradil), Long Acting Anti Muscarinic Antagonist (Tudorza, Spiriva), Leukotriene Receptor Antagonist (montelukast, zafirlukast), Theophylline

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM MEDICARE PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PARKINSON'S DISEASE-PSYCHOTIC DISORDER
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	N/A

NUVIGIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	TX OF MULTIPLE SCLEROSIS
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 MOS FOR INITIAL APPROVAL, 1 YEAR ON REAPPROVAL BASED ON RESPONSE TO TREATMENT
Other Criteria	DX OF NARCOLEPSY CONFIRMED BY SLEEP LAB EVALUATION OR DX OF OBSTRUCTIVE SLEEP APNEA OR HYPONEA SYNDROME CONFIRMED BY POLYSOMNOGRAPHY AND HAS SCORE OF 10 OR MORE ON THE EPWORTH SLEEPINESS SCALE

OCALIVA

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF PRIMARY BILIARY CIRRHOSIS, USED IN COMBO WITH URSODEOXYCHOLIC ACID OR AS MONOTHERAPY WHEN URSODEOXYCHOLIC ACID IS NOT TOLERATED
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	N/A

OCTREOTIDE

Products Affected

- Octreotide Acetate
- Sandostatin Lar Depot

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YR AT A TIME
Other Criteria	TX OF ACROMEGALY W INADEQ RESP TO SURG OR RESECTION NOT OPTION OR INADEQ RESP TO RADIATION OR FAILED BROMOCRIPTINE OR ADJUNCTIVE TX W IRRADIATION TO HELP RELIEVE SXS AND POSSIBLY SLOW TUMOR GROWTH, PROPHYL TX PRIOR TO SURG FOR GASTRINOMA, PROPHY TX PRIOR

ONCOLOGY AGENTS

Products Affected

- Afinitor
- Afinitor Disperz
- Alecensa
- Alunbrig
- Bavencio
- Beleodaq
- Bendeka
- Bexarotene
- Blincyto
- Bosulif
- Cabometyx
- Caprelsa
- Cometriq
- Cotellic
- Cyramza
- Darzalex
- Emcyt
- Empliciti
- Erbitux
- Erivedge
- Evomela
- Fareston
- Farydak
- Gazyva
- Gilotrif
- Gleevec ORAL TABS
- Herceptin
- Hexalen
- Ibrance
- Iclusig
- Idhifa
- Imatinib Mesylate
- Imbruvica
- Imfinzi
- Inlyta
- Iressa
- Keytruda
- Kisqali
- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose
- Lartruvo
- Lenvima 10 Mg Daily Dose
- Lenvima 14 Mg Daily Dose
- Lenvima 18 Mg Daily Dose
- Lenvima 20 Mg Daily Dose
- Lenvima 24 Mg Daily Dose
- Lenvima 8 Mg Daily Dose
- Lonsurf
- Lynparza
- Marqibo
- Matulane
- Mekinist
- Melphalan Hydrochloride
- Nerlynx
- Nexavar
- Ninlaro
- Odomzo
- Opdivo
- Perjeta
- Pomalyst
- Portrazza
- Revlimid
- Rituxan
- Rituxan Hycela
- Rubraca
- Rydapt
- Sprycel
- Stivarga
- Sutent
- Sylvant
- Tabloid
- Tafinlar
- Tagrisso
- Tarceva
- Tasigna
- Tecentriq
- Temodar INJ
- Tepadina INJ 100MG
- Treanda
- Trelstar Mixject

- Tretinoin CAPS
- Tykerb
- Vectibix INJ 100MG/5ML, 400MG/20ML
- Velcade
- Venclexta
- Venclexta Starting Pack
- Votrient
- Xalkori
- Xtandi
- Yervoy
- Yondelis
- Zejula
- Zelboraf
- Zoladex
- Zolinza
- Zydelig
- Zykadia
- Zytiga

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D or TX OF CANCER TYPE LISTED IN AN ACCEPTED COMPENDA AHFS-DI, NCCN, THOMSON MICROMEDEX, CLINICAL PHARMACOLOGY, LEXI-DRUGS AND PEER REVIEWED PUBLICATIONS AS OUTLINED IN THE MEDICARE BENEFIT POLICY MANUAL CH. 15 SECTION 50.4.5(C).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	ONCOLOGIST, HEMATOLOGIST
Coverage Duration	6 MO
Other Criteria	TX OF CANCER TYPE LISTED IN AN ACCEPTED COMPENDA AHFS-DI, NCCN, THOMSON MICROMEDEX, CLINICAL PHARMACOLOGY, LEXI-DRUGS AND PEER REVIEWED PUBLICATIONS AS OUTLINED IN THE MEDICARE BENEFIT POLICY MANUAL CH. 15 SECTION 50.4.5(C)

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PATIENTS WITH SEVERE ANEMIA, ON STRONG CYP3A4 INDUCERS (RIFAMPIN) OR CYP3A4 INHIBITORS (KETOCONAZOLE,RITONAVIR), PREGNANT PATIENTS
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST OR CARDIOLOGIST
Coverage Duration	1YR AT A TIME
Other Criteria	DOCUMENTATION OF PREVIOUS MEDICATIONS USED, RESULTS OF ACUTE VASOREACTIVITY TESTING

ORENCIA

Products Affected

- Orencia
- Orencia Clickject

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF JUVENILE IDIOPATHIC ARTHRITIS, RHEUMATOID ARTHRITIS,
Age Restrictions	N/A
Prescriber Restrictions	RHEUMATOLOGIST, DERMATOLOGIST
Coverage Duration	4 MO INITIAL, 1 YEAR ON REAPPROVAL BASED ON RESPONSE TO TX
Other Criteria	RA CRIT. DOC OF INTOLERANCE OR FAILURE TO RESPOND TO A 2MO TRIAL OF A DMARD THERAPY, SUCH AS METHOTREXATE, ARAVA(LEFLUNOMIDE), PLAQUENIL (HYDROXYCHLOROQUINE), OR SULFASALAZINE AND TRIAL AND FAILURE WITH HUMIRA OR ENBREL. JUVENILE IDIOPATHIC ARTHRITIS: DOCUMENTATION OF INTOLERANCE OR FAILURE TO RESPOND TO A MIN OF A 3 MO TRIAL OF METHOTREXATE AND TRIAL AND FAILURE TO HUMIRA . RENEWAL BASED ON IMPROVEMENT OF CLINICAL SIGNS AND SYMPTOMS

ORFADIN

Products Affected

- Orfadin

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	CONFIRMED BY BIOCHEMICAL TESTING(EG, DETECTION OF SUCCINYLACETONEIN URINE) AND APPROPRIATE CLINICALPICTURE OF THE PATIENT OR BY DNATESTING
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	ORFADIN IS INDICATED IN THE TREATMENT OF PATIENTS WITH HEREDITARY TYROSINEMIA TYPE 1 (HT-1)

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of CF and patients who are homozygous for the f508del mutation in the cftr gene
Age Restrictions	12 years and older
Prescriber Restrictions	Pulmonologist
Coverage Duration	12 months
Other Criteria	N/A

OTEZLA

Products Affected

- Otezla

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	RHEUMATOLOGIST OR DERMATOLOGIST
Coverage Duration	INITIAL APPROVAL = 4 MO SECOND APPROVAL 6 MO, REAPPROVAL = 12 MO IF RESPONSE TO INITIAL TREATMENT
Other Criteria	DIAGNOSIS OF PSORIATIC ARTHRITIS, DOC FAILURE INTOLERANCE OR CONTRAINDICATION TO ENBREL AND HUMIRA

OXANDROLONE

Products Affected

- Oxandrolone ORAL TABS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, CARCINOMA OF THE PROSTATE OR THE MALE BREAST, HYPERCALCEMIA, NEPHROSIS, PREGNANCY.
Required Medical Information	STEPS TAKEN TO AVOID WEIGHT LOSS. DOCUMENTATION OF A HX OF A FAILURE TO GAIN WEIGHT. HX OF EXTENSIVE SURGERY, CHRONIC INFECTIONS, SEVERE TRAUMA, OR OTHER PATHOPHYSIOLOGICAL REASONS FOR A FAILURE TO GAIN OR MAINTAIN WEIGHT. HX OF CORTICOSTEROID USE OR DX OF OSTEOPOROSIS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3MOS MAX
Other Criteria	DOCUMENTATION OF A HX OF FAILURE TO GAIN WEIGHT DUE TO A HX OF EXTENSIVE SURGERY, CHRONIC INFECTIONS, SEVERE TRAUMA, OR OTHER PATHOPHYSIOLOGICAL REASONS FOR A FAILURE TO GAIN OR MAINTAIN WEIGHT OR HX OF LONG-TERM CORTICOSTEROID USE OF BONE PAIN ASSOCIATED WITH OSTEOPOROSIS.

PAIN MANAGEMENT

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6MO AT A TIME
Other Criteria	DOCUMENTED TOLERANCE TO CURRENT LONG ACTING OPIOID REGIMEN AND REQUIRES IMMEDIATE-RELEASE BREAKTHROUGH OPIOID. OPIOID TOLERANCE DEFINED AS PT TAKING AT LEAST 60MG MORPHINE/DAY, 50MCG TRANSDERMAL FENTANYL/HR, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID FOR A WEEK OR LONGER.

PH ENDOTHELIN REC ANTAG

Products Affected

- Letairis

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PATIENTS WITH SEVERE HEPATIC DISEASE, SEVERE ANEMIA, ON CYCLOSPORINE A. PREGNANT PATIENTS
Required Medical Information	PREVIOUS MEDICATIONS USED, RESULTS OF ACUTE VASOREACTIVITY TESTING,
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST, CARDIOLOGIST
Coverage Duration	1 YR AT A TIME
Other Criteria	N/A

PH PDE5 INHIBITORS

Products Affected

- Adcirca
- Revatio SUSR
- Sildenafil

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PATIENTS RECEIVING NITRATES IN ANY FORM, EITHER REGULARLY OR INTERMITTENTLY.
Required Medical Information	PREVIOUS MEDICATIONS USED, RESULTS OF ACUTE VASOREACTIVITY TESTING,
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST, CARDIOLOGIST
Coverage Duration	1 YR AT A TIME
Other Criteria	N/A

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM MEDICARE 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 statin therapy, or those with the inability to tolerate statin therapy, 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. Reauth: 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.
Age Restrictions	N/A
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPID SPECIALIST
Coverage Duration	INITIAL 6 MONTHS THEREAFTER 12 MONTHS IF RESPONDING TO MEDICATION

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 or fluvastatin XL 80 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). Initial, reauth: Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.

PROCYSBI

Products Affected

- Procysbi

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	DOCUMENTED ALLERGY TO PENICILLAMINE
Required Medical Information	DOC SHOWING WBC CYSTINE LEVEL LESS THAN 2 NMOL HALF-CYSTINE/MG PROTEIN IN PT WITH INTERABILITY AT HIGHER DOSES. SUBSEQUENT APPROVALS REQ DOC SHOWING WBC CYSTINE LEVEL LESS THAN 1 NMOL HALF-CYSTINE/MG PROTEIN
Age Restrictions	2 YEARS OF AGE AND OLDER
Prescriber Restrictions	N/A
Coverage Duration	6 MO THEN LONGER WITH DOCUMENTATION OF WBC CYSTINE LEVELS
Other Criteria	DOCUMENTATION OF TRIAL AND FAILURE OF MAX REC DOSE OF CYSTEAMINE IR CAPS. ADOLESCENTS WEIGHING MORE THAN 50KG ADULTS 1.95G/M2/DAY OR 90MG/KG/DAY. DOC OF WBC CYSTINE LEVELS GREATER THAN 1NMOL HALF-CYSTINE/MG PROTEIN AND DOC OF PLASMA CYSTINE LEVELS LESS THAN 0.1MG/L. NON-COMPLIANCE MAY BE INDICATED BY PLASMA CYSTINE GREATER THAN 0.1MG/L & WBC CYSTINE LEVELS GREATER THAN 1 NMOL HALF-CYSTINE/MG PROTEIN

PROLASTIN

Products Affected

- Prolastin-c

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	HIGH-RISK PHENOTYPE (E.G. PIZZ, PIZNULL, PINULLNULL), PLASMA AAT LEVEL BELOW 11 MICROMOL/L (CORRESPONDING TO 80 MG/DL), FEV1 GREATER OR EQUAL TO 35 AND LESS THAN 80% OF PREDICTED
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	N/A
Coverage Duration	1 YR AT A TIME
Other Criteria	ABILITY TO COMPLY WITH THE PROTOCOL FOR ADMINISTRATION, COVERAGE IS LIMITED TO A DOSAGE OF 60 MG/KG WEEKLY OR 250 MG/KG MONTHLY. ALSO BVD DECISIONS

PROMACTA AND NPLATE

Products Affected

- Nplate
- Promacta

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	COVERAGE EXCLUDED IF INTENT IS TO SOLELY NORMALIZE PLATELET COUNTS
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6MO AT A TIME
Other Criteria	DOCUMENTATION OF AN INSUFFICIENT RESPONSE OR CONTRAINDICATIONS TO FIRST LINE THERAPIES OF IMMUNE IDIOPATHIC THROMBOCYTOPENIC PURPURA, (EX. CORTICOSTEROIDS OR, IMMUNOGLOBULINS, OR SPLENECTOMY) OR IF CLINICAL CONDITION INCREASES THE RISK FOR BLEEDING. COVERAGE OF NPLATE REQUIRES DOCUMENTATED TRIAL AND FAILURE OF OR A CONTRAINDICATION TO PROMACTA. PROMACTA WILL ALSO BE COVERED FOR THROMBOCYTOPENIA IN PTS W/CHRONIC HEP C

PROVIGIL

Products Affected

- Modafinil

PA Criteria	Criteria Details
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). DEPRESSION (INITIAL): TREATMENT-RESISTANT DEPRESSION DEFINED AS DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER (MDD) OR BIPOLAR DEPRESSION, AND HISTORY OF FAILURE, CONTRAINDICATION, OR INTOLERANCE TO AT LEAST TWO ANTIDEPRESSANTS FROM DIFFERENT CLASSES (EG, SSRIS, SNRIS, BUPROPION). USED AS ADJUNCTIVE THERAPY.

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	OSAHS/DEP(INIT), SWSD (INIT,REAUTH): 3 MO. OSAHS/DEP(REAUTH): 12 MO.
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. DEPRESSION (REAUTH): DOCUMENTATION OF POSITIVE CLINICAL RESPONSE TO MODAFINIL THERAPY. USED AS ADJUNCTIVE THERAPY.

PULMOZYME

Products Affected

- Pulmozyme

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST
Coverage Duration	1 YR AT A TIME
Other Criteria	DX OF CYSTIC FIBROSIS

QUALAQUIN

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6MO AT A TIME
Other Criteria	PRIOR AUTHORIZATION TO ENSURE USE FOR MALARIA

RAVICTI

Products Affected

- Ravicti

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	HYPERSENSITIVITY TO PHENYLBUTYRATE
Required Medical Information	DIAGNOSIS OF CHRONIC DISORDER OF THE UREA CYCLE METABOLISM CONFIRMED BY ENZYMATIC, BIOCHEMICAL OR GENETIC TESTING
Age Restrictions	GREATER THAN 2 MONTHS OF AGE
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	TRIAL AND FAILURE INTOLERANCE OR CONTRAINDICATION TO BUPHENYL

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTATION OF DIABETIC LOWER EXTREMITY
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6MO AT A TIME
Other Criteria	N/A

RELISTOR

Products Affected

- Relistor

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 MO AT A TIME
Other Criteria	REQUIRES TRIAL AND FAILURE OF STANDARD LAXATIVE THERAPY (DOCUSATE, SENNA, POLYETHYLENE GLYCOL (MIRALAX), MAGNESIUM CITRATE, ETC.). CONTINUATION OF THERAPY REQUIRES DOCUMENTATION OF IMPROVEMENT

REMICADE

Products Affected

- Remicade

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	TB SCREENING,
Age Restrictions	N/A
Prescriber Restrictions	RHEUMATOLOGIST , GASTROENTEROLOGIST ,DERMATOLOGIST
Coverage Duration	1YR AT A TIME FOR RA,PSORIATIC ARTHRITIS OR ANKYLOSING SPONDYLITIS DX,6MO AT A TIME FOR UC OR CROHNS

Other Criteria	DX OF RA/PSA REQUIRES DOCUMENTATION OF FAILURE TO RESPOND TO A 2MO TRIAL ENBREL OR HUMIRA OR AN INTOL OR CONTRA TO ENBREL OR HUMIRA TX. AND HAVE CONCURRENT TX W MTX. ALL DOSE INCRE AFTER INTIAL TX MUST BE PRIOR AUTH'D. ANK SPOND CRITERIA FAIL OF AT LEAST 2 ANTI-INFLAMMATORY AGENTS IN A 2MO PERIOD. DOC OF FAIL TO RESP TO A 2MO TRIAL ENBREL OR HUMIRA OR AN INTOL OR CONTRAIND TO ENBREL OR HUMIRA TX.DC IF NO RESPONSE AFTER 6-12WKS. DX OF CROHN'S USE FOR MOD TO SEV ACTIVE CD IN PTS WHO HAVE NOT RESP DESPITE COMPLETE & ADEQ TX W A CORTICOST OR IMMUNOSUPP AGT OR AN INTOL OR CONTRA & A 2MO TRIAL & FAIL OF BOTH HUMIRA OR CONTRA OR INTOL TO HUMIRA. DX OF UC, USE FOR MOD TO SEV ACTIVE UC IN PTS WHO HAVE NOT RESP DESPITE COMPL & ADEQ TX W A CORTICO OR AN IMMUNOSUPP AGT OR AN INTOL OR CONTRA & A 2 MO TRIAL AND FAIL OF HUMIRA OR CONTRA OR INTOL TO HUMIRA. FOR PSORIASIS DX, DOC THAT PT HAS CHRONIC MOD OR SEV PLAQUE PSORIASIS INVOLVED IN GRTR THAN 5% OF BSA THAT DID NOT RESP TO 6WKS OF AT LEAST 1 TOP TX AND TRIAL & FAIL AT LEAST ONE OF THE FOLLOWNG SYSTEMIC TX OR IS NOT A CANDID DUE TO A CONTRA:MTX, AZATHIOPRINE, CYCLOSPORINE, ACITRETIN, SULFASALAZINE, 6-THIOGUANINE, HYDROXYUREA, PROPYLTHIOURACIL AND PHOTOTHERAPY (PUVA OR UVB). REQUIRES A TRIAL AND FAIL OF HUMIRA OR ENBREL OR CONTRA TO HUMIRA OR ENBREL. RENEWAL BASED ON IMPROVEMENT OF CLINICAL SIGNS AND SX OF PSORIASIS

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Covered Uses	All FDA-approved 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 Restrictions	N/A
Prescriber Restrictions	Prescribed by a cardiologist, endocrinologist, or lipid specialist
Coverage Duration	Initial 6 months (HeFH, ASCVD), 12 weeks (HoFH). Renewal 12 months.

Other Criteria	HeFH/ASCVD (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) 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) Patient has a labeled contraindication to all statins as documented in medical records, or (4) Patient has experienced rhabdomyolysis. 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. Patient has a labeled contraindication to all statins as documented in medical records, or 3. Patient has experienced rhabdomyolysis, AND b) patient has been receiving at least 12 consecutive weeks of other LDL-C lowering prescription therapies 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).

RUCONEST

Products Affected

- Ruconest

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PATIENTS WITH LARYNGEAL ATTACK
Required Medical Information	C4 LEVELS C1 INHIBITOR FUNCTION LEVEL AND ANTIGENIC PROTEIN
Age Restrictions	13 YEARS OR OLDER
Prescriber Restrictions	ALLERGIST, IMMUNOLOGIST
Coverage Duration	12 MONTHS AT A TIME
Other Criteria	DIAGNOSIS OF HEREDITARY ANGIOEDEMA

SABRIL

Products Affected

- Sabril

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PHYSICIAN REGISTERED W MANUFACTURER TO PRESCRIBE SABRIL THRU THE SABRIL REMS PROGRAM
Coverage Duration	6MO AT A TIME
Other Criteria	PRIOR AUTHORIZATION IS TO ENSURE FACILITATION OF DRUG THRU THE MANUFACTURER'S SHARE PROGRAM

SAMSCA

Products Affected

- Samsca

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	TO RAISE SERUM NA URGENTLY TO PREVENT OR TO TREAT SERIOUS NEUROLOGICAL SYMPTOMS
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 MOS
Other Criteria	SAMSCA IS IND FOR THE TX OF CLINICALLY SIGNIFICANT HYPERVOLEMIC AND EUVOLEMIC HYPONATREMIA (SERUM SODIUM 125 MEQ/L OR LESS MARKED HYPONATREMIA THAT IS SYMPTOMATIC AND HAS RESISTED CORRECTION WITH FLUID RESTRICTION), INCLUDING PATIENTS WITH HEART FAILURE, CIRRHOSIS, AND SYNDROME OF INAPPROPRIATE ANTIDIURETIC HORMONE (SIADH).1-3. PT REQ INTERVENTION TO RAISE SERUM NA URGENTLY TO PREVENT OR TO TREAT SERIOUS NEUROLOGICAL SYMPTOMS SHOULD NOT BE TREATED WITH SAMSCA.1 IT HAS NOT BEEN ESTABLISHED THAT RAISING SERUM SODIUM WITH SAMSCA PROVIDES A SYMPTOMATIC BENEFIT TO PATIENTS. SHOULD BE INITIATED AND RE-INITIATED IN PATIENTS ONLY IN A HOSPITAL WHERE SERUM SODIUM CAN BE MONITORED CLOSELY.

SIGNIFOR

Products Affected

- Signifor
- Signifor Lar

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF CUSHINGS SYNDROME/DISEASE, BASELINE FASTING PLASMA GLUCOSE AND OR HBA1C
Age Restrictions	N/A
Prescriber Restrictions	ENDOCRINOLOGIST
Coverage Duration	3 MO INITIAL AND 12 MONTHS RENEWAL
Other Criteria	DOCUMENTATION THAT THE PATIENT HAD SURGERY THAT WAS NOT CURATIVE OR IS NOT A CANDIDATE FOR SURGERY. IF MEMBER IS DIABETIC THE ANTIDIABETIC THERAPY MUST BE OPTIMIZED

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	DIAGNOSIS OF LATENT INFECTION DUE TO MYCOBACTERIUM, EXTRAPULMONARY OR DRUG SENSITIVE TB OR NON-TB MYCOBACTERIAL INFECTION
Required Medical Information	MULTI-DRUG RESISTANT TB WITH CONFIRMED SUSCEPTIBILITY DATA THAT INDICATE MEMBER HAS PULMONARY MDR-TB
Age Restrictions	N/A
Prescriber Restrictions	INFECTIOUS DISEASE SPECIALIST
Coverage Duration	188 TABLETS OVER 24 WEEKS
Other Criteria	MUST BE USED IN COMBINATION WITH AT LEAST THREE OTHER DRUGS TO WHICH THE MEMBERS MDR-TB ISOLATE HAS BEEN SHOWN TO BE SUSCEPTIBLE IN VITRO. MDR-TB REFERS TO AN ISOLATE OF M. TB THAT IS RESISTANT TO AT LEAST ISONIAZID AND RIFAMPIN AND POSSIBLY ADDITIONAL AGENTS. TREATMENT FAILURE REFERS TO FAILURE OF CULTURES TO BECOME NEG DURING COURSE OF TX OR REAPPEARANCE OF POS CULT AFTER CULTURES CONVERT TO NEG DURING TREATMENT

SOLIRIS

Products Affected

- Soliris

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTATION OF PT HAVING HAD A MENINGOCOCCAL VACCINATION AT LEAST 2WKS PRIOR TO ADMINISTRATION
Age Restrictions	N/A
Prescriber Restrictions	ONCOLOGIST OR HEMATOLOGIST
Coverage Duration	1MO AT A TIME
Other Criteria	ALSO BVD DETERMINATIONS

SOVALDI

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF CHRONIC HEP C AS A COMPONENT OF A COMBINATION ANTIVIRAL TREATMENT REGIMEN IN PTS W/HEP C GENOTYPE 1a,1b, 2, 3, 4,5 or 6 INCLUDING THOSE WITH HEPATOCELLULAR CARCINOMA MEETING MILAN CRITERIA (AWAITING LIVER TRANSPLANT) AND THOSE WITH HCV/HIV-1 CO-INFECTION
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	COVERAGE DURATION WILL FOLLOW RECOMMENDATION SET FORTH BY THE AASLD
Other Criteria	GENOTYPE 1 MUST HAVE TRIAL AND FAILURE WITH HARVONI OR VIEKIRA PAK PRIOR TO SOVALDI

STRENSIQ

Products Affected

- Strensiq

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of Juvenile Onset Hypophosphatasia or Perinatal or Infant Onset Hypophosphatasia
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBED BY A GENETICIST, ENDROCRINOLOGIST OR METABOLIC SPECIALIST
Coverage Duration	12 months
Other Criteria	N/A

SUCRAID

Products Affected

- Sucraid

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	SUCRASE-ISOMALTASE DEFICIENCY, CONGENITAL

SYMLIN

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	CONFIRMED DX OF GASTROPARESIS. NEED FOR MEDS TO STIMULATE GI MOTILITY. POOR COMPLIANCE WITH CURRENT INSULIN REGIMEN OR SELF-BG MONITORING. HBA1C GREATER THAN 9%. RECURRENT SEVERE HYPOGLYCEMIA REQUIRING ASSISTANCE IN THE LAST 6 MO. PRESENCE OF HYPOGLYCEMIA UNAWARENESS. PED PATIENTS.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	FAILURE TO ACHIEVE ADEQUATE GLYCEMIC CONTROL FOR ADULTS WHO TAKE MEALTIME INSULIN

SYNAGIS

Products Affected

- Synagis INJ 100MG/ML, 50MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	CHILDREN LESS THAN 2YO
Prescriber Restrictions	PEDIATRICIAN OR PEDIATRIC PULMONOLOGIST, CARDIOLOGIST OR NEUROLOGIST
Coverage Duration	RSV SEASON AS DEFINED ANNUALLY BY THE CDC
Other Criteria	INFANTS LESS THAN 12 MO BORN BEFORE 29 WEEKS GESTATION OR THOSE WITH CONG HEART DIS, CLD OR OTHER CHRONIC ILLNESS. 12-24 MO WHO NEEDED SUP O2 FOR 28 DAYS+ AFTER BIRTH AND CONT TO NEED MED INTERVENTION (SUP O2 CHRONIC CORTICOSTEROID OR DIURETIC TX). CHILDREN GREATER THAN 24 MO IF PROFOUNDLY IMMUNOCOMPROMISED DURING RSV SEASON

TAZORAC

Products Affected

- Tazarotene CREA
- Tazorac

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	COVERAGE OF TAZORAC (Tazarotene) BRAND OR GENERIC REQUIRES A DOCUMENTED CONDITION OTHER THAN COSMETIC/PHOTO AGING. TRIAL AND FAILURE OF AT LEAST ONE GENERIC AGENT (E.G., TRETINOIN, ADAPALENE) REQUIRED

TCAS

Products Affected

- Amitriptyline Hcl ORAL TABS
- Chlordiazepoxide/amitriptyline
- Clomipramine Hcl ORAL CAPS
- Doxepin Hcl CONC
- Doxepin Hcl ORAL CAPS
- Imipramine Hcl ORAL TABS
- Imipramine Pamoate
- Perphenazine/amitriptyline

PA Criteria	Criteria Details
Covered Uses	ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YR AT A TIME
Other Criteria	PROVIDER MUST SUBMIT ATTESTATION THAT BENEFIT OUTWEIGHS RISK OF DRUGS FOUND TO BE HIGH RISK MEDICATIONS FOR BENEFICIARIES AGE 65 AND OLDER. PRIOR AUTHORIZATION IS NOT REQUIRED FOR ANYONE UNDER THE AGE OF 65.

TESTOSTERONE REPLACEMENT

Products Affected

- Androgel TRANSDERMAL GEL 20.25MG/1.25GM, 40.5MG/2.5GM
- Androgel Pump GEL 1.62%
- Androxy
- Danazol ORAL CAPS
- Testosterone TRANSDERMAL GEL 10MG/ACT, 25MG/2.5GM, 50MG/5GM
- Testosterone Pump

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D. DANAZOL WILL BE COVERED FOR THE FOLLOWING INDICATIONS: ENDOMETRIOSIS, FIBROCYSTIC BREAST DISEASE, HEREDITARY ANGIOEDEMA AND METASTATIC BREAST CANCER.
Exclusion Criteria	N/A
Required Medical Information	DOCUMENTATION OF MALE WITH HYPOGONADISM WITH TOTAL SERUM TESTOSTERONE LESS THAN 300NG/DL W/IN 90D OR DOCUMENTATION OF MALE WITH DELAYED PUBERTY NOT SECONDARY TO PATHOLOGICAL DISORDER OR DOCUMENTATION OF FEMALE WITH METASTATIC BREAST CANCER
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	DANAZOL WILL ALSO BE COVERED FOR THE FOLLOWING INDICATIONS: ENDOMETRIOSIS, FIBROCYSTIC BREAST DISEASE AND HEREDITARY ANGIOEDEMA.

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	PREGNANCY
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	ONCOLOGIST
Coverage Duration	6MOS
Other Criteria	ERYTHEMA NODOSUM LEPROSUM, ERYTHEMA NODOSUM LEPROSUM, PROPH, MULTIPLE MYELOMA, NEWLY DIAGNOSED, IN COMBINATION WITH DEXAMETHASONE

TOBRAMYCIN

Products Affected

- Kitabis Pak
- Tobi Podhaler
- Tobramycin NEBU
- Tobramycin Inhalation Solution Pak

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST
Coverage Duration	1YR AT A TIME
Other Criteria	DIAGNOSIS OF CYSTIC FIBROSIS

TREPROSTINIL

Products Affected

- Orenitram
- Remodulin
- Tyvaso
- Tyvaso Refill
- Tyvaso Starter

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	PREVIOUS MEDICATIONS USED, RESULTS OF ACUTE VASOREACTIVITY TESTING,
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST, CARDIOLOGIST
Coverage Duration	1 YR AT A TIME
Other Criteria	THE DRUG IS PRESCRIBED BY A PHYSICIAN EXPERIENCED IN THE MANAGEMENT OF PULMONARY VASCULAR DISEASE FOR THE TREATMENT OF PULMONARY ARTERIAL HYPERTENSION IN PATIENTS WITH NYHA CLASS II, III OR IV SYMPTOMS

TRETINOIN/AZELAIC ACID

Products Affected

- Avita
- Azelex
- Finacea
- Finacea Plus
- Tretinoin EXTERNAL CREA
- Tretinoin EXTERNAL GEL
- Tretinoin Microsphere

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	COSMETIC PURPOSES (E.G., WRINKLES, PHOTOAGING)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	N/A

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	TYSABRI COVERAGE FOR MODERATE TO SEVERE CROHN'S WITH INADEQUATE RESPONSE OR UNABLE TO TOLERATE TREATMENT WITH HUMIRA. TYSABRI WILL ALSO BE COVERED FOR RELASPSING FORMS OF MS. ALSO BVD DECISIONS

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of pulmonary arterial hypertension
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	Documented failure, intolerance or contraindication to sildenafil

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	ONCOLOGIST
Coverage Duration	6MO AT A TIME
Other Criteria	INDICATED FOR THE TOPICAL TREATMENT OF STAGE 1A AND 1B MYCOSIS FUNGOIDES-TYPE CUTANEOUS T-CELL LYMPHOMA IN PATIENTS WHO HAVE RECEIVED PRIOR SKIN-DIRECTED THERAPY

VENTAVIS

Products Affected

- Ventavis

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	PREVIOUS MEDICATIONS USED, RESULTS OF ACUTE VASOREACTIVITY TESTING,
Age Restrictions	N/A
Prescriber Restrictions	PULMONOLOGIST, CARDIOLOGIST
Coverage Duration	1YR AT A TIME
Other Criteria	FOR THE TREATMENT OF PULMONARY ARTERIAL HYPERTENSION IN PATIENTS WITH NYHA CLASS II, III OR IV SYMPTOMS AND FOR PATIENT WHO HAVE TRIED OR FAILED CONVENTIONAL THERAPIES, AND TRIAL AND FAILURE OF ORAL CALCIUM CHANNEL BLOCKERS IF ACUTE VASOREACTIVITY TESTING IS POSITIVE OR UNLESS CONTRAINDICATED (E.G. UNSTABLE PATIENTS OR THOSE WITH SEVERE RIGHT HEART FAILURE).

VFEND AND NOXAFIL

Products Affected

- Noxafil
- Voriconazole INJ
- Voriconazole ORAL TABS
- Voriconazole SUSR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	IMMUNOLOGIST, INFECTIOUS DZ SPECIALIST, ONCOLOGIST
Coverage Duration	3MO AT A TIME
Other Criteria	N/A

VIMIZIM

Products Affected

- Vimizim

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	5 YEARS OF AGE OR OLDER
Prescriber Restrictions	GENETICIST
Coverage Duration	6 MONTHS
Other Criteria	VIMIZIM IS A HYDROLYTIC LYSOSOMAL GLYCOSAMINOGLYCAN (GAG)-SPECIFIC ENZYME INDICATED FOR PATIENTS WITH MUCOPOLYSACCHARIDOSIS TYPE IVA (MPS IVA MORQUIO A SYNDROME)

VIRAZOLE

Products Affected

- Ribavirin SOLR
- Virazole

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	HYPERSENSITIVITY TO RIBAVIRIN OR ANY COMPONENT OF THE PRODUCT, PREGNANT WOMEN OR WOMEN WHO MAY BECOME PREGNANT DURING TREATMENT.
Required Medical Information	CONFIRMED DX OF RSV INFECTION.
Age Restrictions	N/A
Prescriber Restrictions	IMMUNOLOGIST/INFECTIOUS DISEASE SPECIALIST, OR PULMONOLOGIST
Coverage Duration	1 MONTH
Other Criteria	HOSPITALIZATION DUE TO RSV INFECTION. ALSO BVD DECISIONS

VORAXAZE

Products Affected

- Voraxaze

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1MO AT A TIME
Other Criteria	METHOTREXATE TOXICITY, CONCENTRATIONS GREATER THAN 1 MCMOL/L - RENAL IMPAIRMENT. ALSO BVD DECISIONS

VPRIV

Products Affected

- Vpriv

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	ENZYME ASSAY DEMONSTRATING DEFICIENCY OF BETA-GLUCOCEREBROSIDASE ENZYME ACTIVITY
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	FOR LONG-TERM ERT FOR PEDIATRIC AND ADULT PATIENTS WITH TYPE 1 GAUCHER DISEASE

XENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	1YR AT A TIME
Other Criteria	CHOREA ASSOCIATED WITH HUNTINGTON DISEASE

XIAFLEX

Products Affected

- Xiaflex

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	TREATMENT OF ADULT PATIENTS WITH DUPUYTREN'S CONTRACTURE WITH A PALPABLE CORD

XIFAXAN

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	ALLERGY TO RIFAMYCIN AGENTS
Required Medical Information	DIAGNOSIS OF TRAVELER'S DIARRHEA CAUSED BY NON-INVASIVE STRAINS OF E. COLI AND PATIENT DOES NOT HAVE FEVER OR BLOOD IN THE STOOL AND TRIED EITHER A FLUROQUINOLONE OR AZITHROMYCIN OR DIAGNOSIS OF HEPATIC ENCEPHALOPATHY AND TRIED LACTULOSE THERAPY OR IBS-D WITHOUT CONSTIPATION AND TRIED LOPERAMIDE
Age Restrictions	TRAVELERS DIARRHEA AGE 12 OR OLDER. HEPATIC ENCEPHALOPATHY AND IBS-D WITHOUT CONSTIPATION AGE 18 OR OLDER
Prescriber Restrictions	N/A
Coverage Duration	TRAVELERS DIARRHEA 3 DAYS. HEPATIC ENCEPHALOPATHY 6 MONTHS. IBS-D WITHOUT CONSTIPATION 14 DAYS
Other Criteria	N/A

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	ASTHMA CRITERIA: DX SEV PERSISTENT ASTHMA, DOC REACTIVITY TO AT LEAST 1 PERENNIAL AEROALLERGEN,PRETREATMENT IGE GREATER THAN 30IU/ML, ASTHMA SX INADEQUATELY CONT W/MAX TOL DOSE OF INHALED CORTICOSTEROID AND LABA. CIU CRITERIA: DOC ITCHY HIVES FOR AT LEAST 6 WKS AND ONE OF THE FOLLOWING UNLESS OTHERWISE CONTRAINDICATED: DOC FAIL ON AT LEAST 2 DIFF H1 ANTIHISTAMINES AT MAX TOL DOSE OR DOC FAIL OF ONE H1 ANTIHIST AT MAX TOL DOSE AND INADEQUATE RESPONSE TO MONTELUKAST OR DOC FAIL OF ONE H1 ANTIHIST AT MAX TOL DOSE AND USED IN COMB W H2 ANTAG AT MAX TOL DOSE
Age Restrictions	ASTHMA:GREATER THAN OR EQUAL TO 6YO. CIU: GREATER THAN OR EQUAL TO 12YO
Prescriber Restrictions	PHYSICIAN SPECIALIZING IN ALLERGY, PULMONARY MEDICINE, DERMATOLOGY, OR IMMUNOLOGY.
Coverage Duration	6MO AT A TIME
Other Criteria	DOSE DOES NOT EXCEED FDA LABEL MAX FOR ASTHMA OR CIU

XURIDEN

Products Affected

- Xuriden

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF OROTIC ACIDURIA
Age Restrictions	N/A
Prescriber Restrictions	GENETICIST, UROLOGIST OR NEPHROLOGIST
Coverage Duration	12 MONTHS
Other Criteria	N/A

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	MEMBER HAS A DOCUMENTED DIAGNOSIS OF NARCOLEPSY CONFIRMED BY SLEEP LAB EVALUATION OR MEMBER HAS EPISODES OF CATAPLEXY INCLUDING HYPNAGOGIC HALLUCINATIONS AND/OR SLEEP PARALYSIS OR MEMBER HAS EXCESSIVE DAYTIME SLEEPINESS WITH SYMPTOMS THAT LIMIT THE ABILITY TO PERFORM NORMAL DAILY ACTIVITIES

ZAVESCA

Products Affected

- Zavesca

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	ENZYME ASSAY DEMONSTRATING DEFICIENCY OF BETA-GLUCOCEREBROSIDASE ENZYME ACTIVITY
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	FOR TREATMENT OF ADULT PATIENTS WITH MILD TO MODERATE TYPE 1 GAUCHER DISEASE FOR WHOM ERT IS NOT A THERAPEUTIC OPTION (E.G., DUE TO CONSTRAINTS SUCH AS ALLERGY, HYPERSENSITIVITY, OR POOR VENOUS ACCESS)

ZEMAIRA

Products Affected

- Zemaira

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D
Exclusion Criteria	N/A
Required Medical Information	HIGH-RISK PHENOTYPE (E.G. PIZZ, PIZNULL, PINULLNULL), PLASMA AAT LEVEL BELOW 11 MICROMOL/L (CORRESPONDING TO 80 MG/DL), FEV1 GREATER OR EQUAL TO 35 AND LESS THAN 80% OF PREDICTED
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	N/A
Coverage Duration	1YR AT A TIME
Other Criteria	ABILITY TO COMPLY WITH THE PROTOCOL FOR ADMINISTRATION, COVERAGE IS LIMITED TO A DOSAGE OF 60 MG/KG WEEKLY OR 250 MG/KG MONTHLY. ALSO BVD DECISIONS

ZEPATIER

Products Affected

- Zepatier

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	N/A
Required Medical Information	ALL OF THE FOLLOWING: A) CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDELINE AND B) PATIENT IS NOT RECEIVING ZEPATIER IN COMBINATION WITH ANOTHER HCV DIRECT ACTING ANTIVIRAL AGENT AND C) PATIENT DOES NOT HAVE MODERATE TO SEVERE HEPATIC IMPAIRMENT (EG, CHILD-PUGH CLASS B OR C) AND D) FOR GENOTYPE 1A, PATIENT AS BEEN TESTED FOR THE PRESENCE OF NS5A RESISTANCE-ASSOCIATED POLYMORPHISMS (IE,POLYMORPHISMS AT AMINO ACID POSITIONS 28,30,31, OR 93).
Age Restrictions	N/A
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST OR HEPATOLOGIST
Coverage Duration	COVERAGE DURATION WILL FOLLOW RECOMMENDATION SET FORTH BY THE AASLD
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adriamycin INJ 2MG/ML
- Adrucil INJ 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Albuterol Sulfate INHALATION NEBU
- Aminosyn INJ 148MEQ/L; 1280MG/100ML; 980MG/100ML; 1280MG/100ML; 300MG/100ML; 720MG/100ML; 940MG/100ML; 720MG/100ML; 400MG/100ML; 440MG/100ML; 5.4MEQ/L; 860MG/100ML; 420MG/100ML; 520MG/100ML; 160MG/100ML; 44MG/100ML; 800MG/100ML, 90MEQ/L; 1100MG/100ML; 850MG/100ML; 35MEQ/L; 1100MG/100ML; 260MG/100ML; 620MG/100ML; 810MG/100ML; 624MG/100ML; 340MG/100ML; 380MG/100ML; 5.4MEQ/L; 750MG/100ML; 370MG/100ML; 460MG/100ML; 150MG/100ML; 44MG/100ML; 680MG/100ML
- Aminosyn 7%/electrolytes
- Aminosyn 8.5%/electrolytes
- Aminosyn II INJ 50.3MEQ/L; 695MG/100ML; 713MG/100ML; 490MG/100ML; 517MG/100ML; 350MG/100ML; 210MG/100ML; 462MG/100ML; 700MG/100ML; 735MG/100ML; 120MG/100ML; 209MG/100ML; 505MG/100ML; 371MG/100ML; 31.3MEQ/L; 280MG/100ML; 140MG/100ML; 189MG/100ML; 350MG/100ML, 61.1MEQ/L; 844MG/100ML; 865MG/100ML; 595MG/100ML; 627MG/100ML; 425MG/100ML; 255MG/100ML; 561MG/100ML; 850MG/100ML; 893MG/100ML; 146MG/100ML; 253MG/100ML; 614MG/100ML; 450MG/100ML; 33.3MEQ/L; 340MG/100ML; 170MG/100ML; 230MG/100ML; 425MG/100ML, 71.8MEQ/L; 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 45.3MEQ/L; 400MG/100ML; 200MG/100ML; 270MG/100ML; 500MG/100ML
- Aminosyn II 8.5%/electrolytes
- Aminosyn M INJ 65MEQ/L; 448MG/100ML; 343MG/100ML; 40MEQ/L; 448MG/100ML; 105MG/100ML; 252MG/100ML; 329MG/100ML; 252MG/100ML; 3MEQ/L; 140MG/100ML; 154MG/100ML; 3.5MMOLE/L; 13MEQ/L; 300MG/100ML; 147MG/100ML; 40MEQ/L; 182MG/100ML; 56MG/100ML; 31MG/100ML; 280MG/100ML
- Aminosyn-hbc

- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 3.4MEQ/L; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML
- Aminosyn-pf 7%
- Aminosyn-rf
- Amphotericin B INJ
- Astagraf XL
- Azasan
- Azathioprine INJ
- Azathioprine TABS
- Bivigam
- Bleo 15k
- Bleomycin Sulfate INJ
- Brovana
- Budesonide INHALATION SUSP
- Cellcept Intravenous
- Cladribine
- Clinimix 2.75%/dextrose 5%
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 20%
- Clinimix 4.25%/dextrose 25%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 5%/dextrose 25%
- Clinimix E 2.75%/dextrose 10%
- Clinimix E 2.75%/dextrose 5%
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 25%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinimix E 5%/dextrose 25%
- Clinisol Sf 15%
- Cromolyn Sodium NEBU
- Cyclophosphamide ORAL CAPS
- Cyclosporine INJ
- Cyclosporine ORAL CAPS
- Cyclosporine Modified
- Cytarabine Aqueous
- Depocyt
- Dobutamine Hcl INJ 250MG/20ML
- Dobutamine Hcl/d5w INJ 5%; 1MG/ML
- Dobutamine Hydrochloride/dextrose
- Dobutamine/dextrose 5% INJ 5%; 2MG/ML, 5%; 4MG/ML
- Dopamine Hcl
- Dopamine Hydrochloride/dextrose
- Dopamine/d5w INJ 5%; 0.8MG/ML, 5%; 1.6MG/ML, 5%; 3.2MG/ML
- Doxorubicin Hcl INJ 10MG, 2MG/ML, 50MG
- Doxorubicin Hcl Liposome
- Engerix-b
- Flebogamma Dif
- Floxuridine INJ
- Fluorouracil INJ 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Freamine Hbc 6.9%
- Freamine III INJ 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML
- Gablofen
- Gamastan S/d
- Gammagard Liquid
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked
- Gammaplex
- Gamunex-c
- Ganciclovir INJ 500MG
- Gengraf

- Granisetron Hcl TABS
- Hecoria
- Hepatamine
- Hyqvia
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol NEBU
- Levalbuterol Hcl INHALATION NEBU
- Lioresal Intrathecal
- Lipodox
- Lipodox 50
- Liposyn III INJ 2.5%; 30%
- Milrinone In Dextrose INJ 5%; 20MG/100ML, 5%; 40MG/200ML
- Mycophenolate Mofetil
- Mycophenolic Acid Dr
- Nebupent
- Nephramine
- Nulojix
- Nutrilipid
- Octagam
- Ondansetron Hcl ORAL SOLN
- Ondansetron Hcl ORAL TABS
- Ondansetron Odt
- Plenamine
- Premasol
- Privigen INJ 10GM/100ML, 20GM/200ML, 5GM/50ML
- Procalamine
- Prosol
- Rapamune SOLN
- Recombivax Hb
- Simulect INJ 20MG
- Sirolimus ORAL TABS
- Tacrolimus ORAL CAPS
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trophamine
- Vinblastine Sulfate INJ 1MG/ML
- Vincasar Pfs
- Vincristine Sulfate INJ
- Zaltrap
- Zortress

Details

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

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