# ACTEMRA

## Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | New starts rheumatoid arthritis (RA): patient has moderate to severe disease and had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, or Xeljanz. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Renewals: patient has had a positive clinical response to Actemra. |

# ACTHAR

## Products Affected

- ACTHAR H.P.

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Receipt of live or live attenuated vaccines within 6 weeks of H.P. Acthar Gel, suspected congenital infection (infants), scleroderma, osteoporosis, systemic fungal infection, peptic ulcer disease, ocular herpes simplex, congestive heart failure, recent surgery, uncontrolled hypertension, known hypersensitivity to porcine proteins, primary adrenocortical insufficiency or hyperfunction. |
| **Required Medical Information** | For the following diagnoses, patient must have an inadequate response to a trial of parenteral corticosteroids: 1) For rheumatic diseases (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis): H.P. Acthar gel must be used as adjunctive treatment, 2) For nephrotic syndrome: H.P. Acthar gel must be requested for induction of diuresis or for remission of proteinuria, 3) For multiple sclerosis (MS): H.P. Acthar gel is being used for MS exacerbation, 4) Collagen diseases (e.g., systemic lupus erythematosus, dermatomyositis, or polymyositis), 5) Dermatologic disorders (e.g., severe erythema multiforme, Stevens-Johnson syndrome), 6) Ophthalmic disorders, acute or chronic (e.g., iritis, keratitis, optic neuritis), 7) Symptomatic sarcoidosis, 8) Serum sickness. |
| **Age Restrictions** | For infantile spasms: patient is 2 years of age or younger. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | IS: 12 months. Collagen and ophthalmic diseases, nephrotic syndrome: 6 months. Others: 1 month |
| **Other Criteria** | N/A |

# ADEMPAS

## Products Affected

- ADEMPAS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of pulmonary arterial hypertension (WHO group I) and diagnosis was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) OR Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) and patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.) |

# AFINITOR

## Products Affected

- AFINITOR
- AFINITOR DISPERZ

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with Sutent or Nexavar OR Diagnosis of progressive pancreatic neuroendocrine tumors (pNET) that are unresectable OR progressive, well-differentiated, nonfunctional GI or lung endocrine tumors in patients with unresectable, locally advanced or metastatic disease OR Diagnosis of renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery OR Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin OR Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection OR diagnosis of tuberous sclerosis complex (TSC)-associated partial-onset seizures. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# AIMOVIG

## Products Affected

- AIMOVIG AUTOINJECTOR (2 PACK)

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of either episodic migraines or chronic migraines. For episodic migraine, patient must have both of the following: less than 15 headache days per month and 4-14 migraine days per month. For chronic migraine, patient must have both of the following: at least 15 headache days per month and at least 8 migraine days per month. Patient has had a trial and failure or contraindication to at least 2 different preventative migraine medications. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a neurologist or headache specialist |
| **Coverage Duration** | Initial: 3 months. Renewal: plan year. |
| **Other Criteria** | For renewal, patient must have a positive clinical response. |

# ALECENSA

## Products Affected

- ALECENSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of metastatic non-small cell lung cancer (NSCLC) with anaplastic lymphoma kinase (ALK) positive disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ALUNBRIG

## Products Affected

- ALUNBRIG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer has anaplastic lymphoma kinase (ALK)-positive disease. Patient had an inadequate response, progressed on, or had an intolerance or contraindication to Xalkori. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# AMPYRA

## Products Affected

- AMPYRA
- DALFAMPRIDINE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Moderate to severe renal impairment (CrCL less than or equal to 50 mL/min) and/or history of seizures. |
| **Required Medical Information** | Patient must have the ability to walk 25 feet (with or without assistance) prior to starting Ampyra. Patient has a diagnosis of multiple sclerosis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | To continue therapy, the patient must experience improvement in walking speed or other objective measure of walking ability since starting Ampyra. Ampyra at doses exceeding 10mg twice daily are not covered. |

# AUBAGIO

## Products Affected

- AUBAGIO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Severe hepatic impairment. Pregnancy. Concomitant use with leflunomide. |
| **Required Medical Information** | Patient has a diagnosis of a relapsing form of multiple sclerosis. Serum transaminase and bilirubin levels must be drawn within 6 months prior to initiation of therapy with Aubagio. For female patients of childbearing potential: Pregnancy was excluded prior to initiation of therapy and patient will use reliable contraception during treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# AURYXIA

## Products Affected

- AURYXIA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Auryxia will not be approved for a diagnosis of iron deficiency anemia. |
| **Required Medical Information** | Patient has a diagnosis of hyperphosphatemia. Patient has chronic kidney disease and is on dialysis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# AUSTEDO

## Products Affected

- AUSTEDO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Actively suicidal or has untreated or inadequately treated depression. Impaired hepatic function. Concomitant monoamine oxidase inhibitor (MAOI) or use within 14 days of stopping MAOI. Concomitant reserpine or use within 20 days of stopping reserpine. Concomitant tetrabenazine (Xenazine). |
| **Required Medical Information** | Patient has a diagnosis of chorea associated with Huntington's disease OR has a diagnosis of tardive dyskinesia clinically diagnosed with all of the following: involuntary athetoid or choreiform movements, history of treatment with dopamine receptor blocking agent. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# BENLYSTA

## Products Affected

- BENLYSTA SUBCUTANEOUS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Severe active lupus nephritis, severe active CNS lupus, or use of Benlysta in combination with other biologics, including B-cell targeted therapies or intravenous (IV) cyclophosphamide. |
| **Required Medical Information** | Patient has active, autoantibody-positive systemic lupus erythematosus (SLE) and is receiving standard therapy (corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) or is not on standard therapy due to past trial and inadequate response or intolerance. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# BEXAROTENE

## Products Affected

- BEXAROTENE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of cutaneous T-cell lymphoma and is refractory to at least 1 prior systemic therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# BOSULIF

## Products Affected

- BOSULIF

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of chronic (newly diagnosed or previously treated), accelerated, or blast phase Philadelphia chromosome-positive chronic myelogenous leukemia (CML). For a diagnosis of accelerated phase or blast phase, patient had resistance or intolerance to prior treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# BPH VS ED

## Products Affected

- CIALIS ORAL TABLET 2.5 MG, 5 MG
- *tadalafil oral tablet 2.5 mg, 5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Not covered for the treatment of Erectile Dysfunction. Maximum dose: 5mg daily |
| **Required Medical Information** | Patient must have a diagnosis of BPH. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# BRAFTOVI

## Products Affected

- BRAFTOVI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation. Encorafenib (Braftovi) will be used in combination with binimetinib (Mektovi). Patient was not previously treated with a BRAF inhibitor or MEK inhibitor. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# CABOMETYX

## Products Affected

- CABOMETYX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced renal cell carcinoma. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# CALQUENCE

## Products Affected

- CALQUENCE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has mantle cell lymphoma. Patient has had at least 1 prior treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# CAPRELSA

## Products Affected

- CAPRELSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Patient has congenital long QT syndrome. |
| **Required Medical Information** | Patient has a diagnosis of symptomatic or progressive medullary thyroid cancer. Patient has unresectable locally advanced or metastatic disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# 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** | Patient has a diagnosis of a bile acid synthesis disorder due to single enzyme defects (SEDs) OR Cholbam is being used as an adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients with manifestations of liver disease, steatorrhea or complications from decreased fat soluble vitamin absorption. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by a hepatologist or gastroenterologist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# CIMZIA

## Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | New starts: Patient has a diagnosis of moderate to severe rheumatoid arthritis and has had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, or Xeljanz. Patient has a diagnosis of moderate to severe Crohn's disease and has had a failure, contraindication, or intolerance to Humira and one of the following: 6-mercaptopurine, azathioprine, corticosteroid, methotrexate. Patient has a diagnosis of active psoriatic arthritis and has had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, Otezla, Cosentyx, Stelara. Patient has a diagnosis of active ankylosing spondylitis and has had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, Cosentyx. Patient has a diagnosis of moderate to severe plaque psoriasis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Renewals: patient has had a positive clinical response to Cimzia. |

# 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** | Patient has a diagnosis of hereditary angioedema. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with an allergist or immunologist or another physician that specializes in the treatment of hereditary angioedema |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# COMETRIQ

## Products Affected

- COMETRIQ

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of progressive, metastatic, medullary thyroid cancer. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# COPIKTRA

## Products Affected

- COPIKTRA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of chronic lymphocytic leukemia, small lymphocytic lymphoma, or follicular lymphoma. Patient has had at least two prior therapies. Prophylaxis for Pneumocystis jirovecii (PJP) will be provided during treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# COSENTYX

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | New starts: Patient has a diagnosis of moderate to severe plaque psoriasis and has had a failure, intolerance, or contraindication to systemic treatment such as methotrexate, acitretin, cyclosporine. Patient has a diagnosis of active psoriatic arthritis and has had a failure, contraindication, or intolerance to a DMARD such as: methotrexate, sulfasalazine, leflunomide. Patient has a diagnosis of active ankylosing spondylitis and a failure, contraindication, or intolerance to at least two different NSAIDs. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Renewals: patient has had a positive clinical response to Cosentyx. |

# COTELLIC

## Products Affected

- COTELLIC

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation. Cobimetinib will be used in combination with vemurafenib (Zelboraf). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# DAURISMO

## Products Affected

- DAURISMO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of acute myeloid leukemia (AML) and is newly diagnosed. Daurismo (glasdegib) will be used in combination with low-dose cytarabine. Patient is 75 years old or older OR has comorbidities that precludes the use of intensive induction chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# DEFERASIROX

## Products Affected

- EXJADE
- JADENU
- JADENU SPRINKLE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Patients with a creatinine clearance (CrCL) less than 40mL/min. Patient's with a platelet count less than 50 million/L. |
| **Required Medical Information** | (1) For chronic iron overload due to blood transfusions, Diagnosis of chronic iron overload due to blood transfusions and current serum ferritin level greater than 1000 mcg/L. (2) For iron overload in patients with NON-transfusion-dependent thalassemia (NTDT), a) Diagnosis of a NON-transfusion thalassemia syndrome and chronic iron overload, b)For initiation: i) pretreatment LIC of at least 5 mg per gram of dry weight and ii) pretreatment serum ferritin levels greater than 300 mcg/L and iii) For patients currently on deferasirox therapy: current LIC is greater than 3 mg per gram of dry weight or deferasirox will be withheld until the LIC reaches above 5 mg per gram of dry weight. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# DICLOFENAC

## Products Affected

- DICLOFENAC SODIUM TOPICAL GEL
  3 %

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient must have a diagnosis of actinic keratosis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# DUPIXENT

## Products Affected

- DUPIXENT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of moderate-to-severe atopic dermatitis. Patient has tried and failed or has contraindications to at least two topical prescription therapies from the following classes: medium to high potency corticosteroid or calcineurin inhibitor. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ENBREL

## Products Affected

- ENBREL
- ENBREL SURECLICK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | New starts: Patient has a diagnosis of moderate to severely active rheumatoid arthritis and has had a failure, contraindication, or intolerance to one DMARD such as: methotrexate, leflunomide, sulfasalazine. Patient has a diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis and has had a failure, contraindication, or intolerance to methotrexate or leflunomide. Patient has a diagnosis of active psoriatic arthritis and has had a failure, contraindication, or intolerance to a DMARD such as: methotrexate, sulfasalazine, leflunomide. Patient has a diagnosis of moderate to severe plaque psoriasis and has had a failure, intolerance, or contraindication to systemic treatment such as methotrexate, acitretin, cyclosporine. Patient has a diagnosis of active ankylosing spondylitis and has had a failure, contraindication, or intolerance to at least two NSAIDs. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Renewals: patient has had a positive clinical response to Enbrel. |

# EPCLUSA

## Products Affected

- EPCLUSA
- SOFOSBUVIR-VELPATASVIR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Information required for review: genotype, prior treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 12 weeks |
| **Other Criteria** | N/A |

# EPIDIOLEX

## Products Affected

- EPIDIOLEX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of seizures associated with Lennox-Gastaut syndrome or Dravet syndrome. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a neurologist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ERIVEDGE

## Products Affected

- ERIVEDGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic basal cell carcinoma OR has a diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ERLEADA

## Products Affected

- ERLEADA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has non-metastatic, castration-resistant prostate cancer. Patient will also be on concurrent gonadotropin-releasing hormone (GnRH) analog or had a bilateral orchiectomy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# 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** | The patient has a diagnosis of idiopathic pulmonary fibrosis. Liver function tests were performed prior to starting therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a pulmonologist |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewal, the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage. |

# FARYDAK

## Products Affected

- FARYDAK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | History of recent myocardial infarction or unstable angina, QTcF greater than 450 msec or significant baseline ST-segment or T-wave abnormalities. |
| **Required Medical Information** | Patient must have multiple myeloma and received at least 2 prior regimens, including bortezomib and an immunomodulatory agent. Must be used in combination with bortezomib and dexamethasone. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewals: Patient must have clinical benefit. Patient must not have experienced unresolved severe or medically significant toxicity. Total treatment duration will not exceed 16 cycles (48 weeks). |

# FASENRA

## Products Affected

- FASENRA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has severe asthma with an eosinophilic phenotype. Patient is maintained with high dose inhaled corticosteroid or with medium to high dosed inhaled corticosteroid with a long-acting beta agonist (LABA). Patient has had at least two exacerbations in the past year or at least one exacerbation in the prior year while on daily oral corticosteroid treatment. |
| **Age Restrictions** | 12 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# FERRIPROX

## Products Affected

- FERRIPROX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of transfusion-related iron overload due to thalassemia syndromes. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# 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** | Patient has a diagnosis of hereditary angioedema. Firazyr will be used for acute attacks of angioedema. Patient has been advised to seek immediate medical attention in addition to treatment with Firazyr. Patient has been counseled to use no more than 3 doses in a 24 hour period. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# FLECTOR

## Products Affected

- FLECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Application to non-intact skin from any etiology. |
| **Required Medical Information** | Patient has acute pain due to minor strains, sprains, or contusions. Patient has been counseled to not wear the patch while bathing or showering. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# GILENYA

## Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Recent occurrence (within the last 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, class III or IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500ms. Treatment with Class Ia or Class III anti-arrhythmic drugs. |
| **Required Medical Information** | Patient has a diagnosis of a relapsing form of multiple sclerosis. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# GILOTRIF

## Products Affected

- GILOTRIF

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of previously untreated metastatic non-small cell lung cancer (NSCLC) with tumors expressing non-resistant epidermal growth factor receptor mutations. OR Patient has a diagnosis of metastatic squamous NSCLC and has been previously treated with platinum-based chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# GROWTH HORMONE

## Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE
- NORDITROPIN FLEXPRO
- NUTROPIN AQ NUSPIN
- OMNITROPE
- SAIZEN
- SAIZEN SAIZENPREP
- SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG
- ZOMACTON
- ZORBTIVE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D including adult or childhood onset growth hormone deficiency (GHD), Turner syndrome (TS), Noonan syndrome (NS), small for gestational age (SGA), Prader-Willi syndrome (PWS), short stature homeobox-containing gene deficiency (SHOXD), chronic renal insufficiency (CRI). |
| **Exclusion Criteria** | Closed epiphyses in pediatric patients. Acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma or acute respiratory failure. Active malignancy. Active proliferative or severe non-proliferative diabetic retinopathy. For Prader-Willi Syndrome only: severe obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment. |
| **Required Medical Information** | For CRI: patient is not post-kidney transplant. For TS: diagnosis confirmed by karyotyping. For PWS: diagnosis confirmed by genetic testing. For pediatric GHD, CRI, SHOXD, and NS, patient must meet one of the following: 1) height more than 3 SDS below mean for age and gender 2) Height more than 2 SDS below mean with growth velocity more than 1 SDS below mean, or 3) Growth velocity over 1 year 2 SDS below mean. For adult GHD: must meet one of the following: 1) Failed 2 standard GH stimulation tests 2) Panhypopituitarism or 3 or more pituitary hormone deficiencies 3) Childhood-onset GHD with known mutations, embryopathic lesions, or irreversible structural lesions/damage 4) Low pre-treatment IGF-1 and failed 1 stimulation test prior to starting treatment |
| **Age Restrictions** | For SGA: patient is more than 2 years old. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | For renewal of pediatric indications: final adult height has not been reached. For renewal of adult indications, patient has experienced an improvement or normalization of IGF-1 levels (not applicable to patients with panhypopituitarism) |

# HARVONI

## Products Affected

- HARVONI
- LEDIPASVIR-SOFOSBUVIR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Information required for review: genotype, prior treatments, cirrhosis status, desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines as of the date of the request. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 12 or 24 weeks. 8 weeks per prescriber discretion |
| **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** | Patient has a diagnosis of non-24-hour sleep-wake disorder. Patient is totally blind in both eyes and unable to perceive light. For renewals: patient must experience an increase in total nighttime sleep or decreased daytime nap duration. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Initial: 3 months, Renewal: plan year |
| **Other Criteria** | N/A |

# HRM-ANTIDIABETICS

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient tried and failed to at least one of the following: glipizide, glipizide/metformin, glimepiride or has contraindications to all alternatives. |
| **Age Restrictions** | Applies to patients 65 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Patient will be monitored for hypoglycemia. Conservative dosing will be used to minimize hypoglycemic events. |

# HRM-DIGOXIN

## Products Affected

- *digitek oral tablet 250 mcg*
- *digox oral tablet 250 mcg*
- *digoxin oral tablet 250 mcg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has tried a lower dose (less than or equal to 0.125mg daily) or has contraindications to a lower dose. |
| **Age Restrictions** | Applies to patients 65 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | The patient has been counseled on and does not have signs and symptoms of toxicity. |

# HRM-HYPNOTICS

## Products Affected

- *eszopiclone*
- *zaleplon*
- *zolpidem oral*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has tried and failed one of the following non-HRM formulary drugs: low-dose trazodone, Rozerem, Silenor OR a non-HRM formulary drug is not an acceptable alternative. Prescriber must acknowledge that the benefits of the HRM outweigh the potential risks. The prescriber attests that the lowest effective dose will be used to minimize side effects. |
| **Age Restrictions** | Applies to patients 65 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# HRM-MUSCLE RELAXANTS

## Products Affected

- *cyclobenzaprine oral tablet*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The prescriber must attest that the medication benefits outweigh the potential risks. |
| **Age Restrictions** | Applies to patients 65 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# HRM-NITROFURANTOIN

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The prescriber has considered the risk for pulmonary and hepatic toxicity and acknowledges that the benefits outweigh the risks. The patient has tried and failed at least one of the following for UTI prophylaxis: trimethoprim, trimethoprim/sulfamethoxazole, ciprofloxacin or has contraindications to all alternatives. |
| **Age Restrictions** | Applies to patients 65 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Applies to patients that have greater than 90 days of therapy per year. |

# HUMIRA

## Products Affected

- HUMIRA
- HUMIRA PEDIATRIC CROHNS START
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | New starts: Patient has a diagnosis of moderate to severely active rheumatoid arthritis and has had a failure, contraindication, or intolerance to one DMARD such as: methotrexate, leflunomide, sulfasalazine. Patient has a diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis and has had a failure, contraindication, or intolerance to methotrexate or leflunomide. Patient has a diagnosis of active psoriatic arthritis and has had a failure, contraindication, or intolerance to a DMARD such as: methotrexate, sulfasalazine, leflunomide. Patient has a diagnosis of moderate to severe plaque psoriasis and has had a failure, contraindication, or intolerance to a DMARD such as: methotrexate, sulfasalazine, leflunomide. Patient has a diagnosis of active ankylosing spondylitis and has had a failure, contraindication, or intolerance to at least two NSAIDs. Patient has a diagnosis of moderate to severe Crohn's Disease and has had a failure, contraindication, or intolerance to 1 of the following: methotrexate, azathioprine, corticosteroid, 6-mercaptopurine, Remicade. Patient has a diagnosis of moderate to severe ulcerative colitis and has a failure, contraindication, or intolerance to 1 of the following: aminosalicylate, corticosteroid, azathioprine, 6-mercaptopurine. Patient has a diagnosis of moderate to severe hidradenitis suppurativa. Patient has a diagnosis of non-infectious uveitis that is intermediate, posterior, or panuveitis. |
| **Age Restrictions** | N/A |

| PA Criteria | Criteria Details |
|---|---|
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Renewals: patient has had a positive clinical response to Humira. |

# IBRANCE

## Products Affected

- IBRANCE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer. Ibrance will be used with aromatase inhibitor as initial endocrine based therapy in postmenopausal women OR with fulvestrant in women with disease progression following endocrine therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ICLUSIG

## Products Affected

- ICLUSIG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Patient must not have newly diagnosed chronic phase CML. |
| **Required Medical Information** | Patient has chronic myeloid leukemia (CML) and is T315I-positive, OR patient has T315I-positive Philadelphia chromosome positive acute lymphoblastic leukemia (ALL), OR patient has CML or Philadelphia chromosome positive ALL for whom no other tyrosine kinase inhibitor is indicated. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# IDHIFA

## Products Affected

- IDHIFA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML). Patient has an isocitrate dehydrogenase-2 (IDH2) mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# IMATINIB

## Products Affected

- *imatinib*

| 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 one of the following in an adult: A) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B) Ph+ acute lymphoblastic leukemia (ALL), C) Myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, D) Aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown, E) Hypereosinophilic syndrome or chronic eosinophilic leukemia, F) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, G) Gastrointestinal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy. Diagnosis of one of the following in a pediatric patient: A) Ph+ CML that is newly diagnosed in the chronic phase B) newly diagnosed Ph+ ALL. |
| **Age Restrictions** | 18 years of age or younger - newly diagnosed CML in the chronic phase or newly diagnosed Ph+ ALL. 18 years of age or older for other indications. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# IMBRUVICA

## Products Affected

- IMBRUVICA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of mantle cell lymphoma (MCL) and patient has received at least one prior therapy. Diagnosis of chronic lymphocytic leukemia (CLL). Diagnosis of CLL with 17p deletion. Diagnosis of Waldenstrom's macroglobulinemia (WM). Diagnosis of marginal zone lymphoma in patients that have received at least one prior anti-CD20-based therapy such as rituximab. Diagnosis of chronic graft-versus-host disease after failure of one or more lines of systemic therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# INGREZZA

## Products Affected

- INGREZZA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Concomitant monoamine oxidase inhibitor (MAOI) or tetrabenazine. |
| **Required Medical Information** | Patient has been clinically diagnosed with moderate to severe tardive dyskinesia including all of the following: involuntary athetoid or choreiform movements, history of treatment with dopamine receptor blocking agent. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Ingrezza is prescribed by or in consultation with a neurologist or psychiatrist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewal, patient must have improvement in symptoms. |

# INLYTA

## Products Affected

- INLYTA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced renal cell carcinoma (RCC). Patient has failed one prior systemic therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# INVEGA TRINZA

## Products Affected

- INVEGA TRINZA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient must have a diagnosis of schizophrenia. Patient must have been adequately treated with Invega Sustenna for at least 4 months. Invega Trinza will only be given once every 3 months. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# IRESSA

## Products Affected

- IRESSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has metastatic non-small cell lung cancer. The tumors have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations. Patient is using Iressa first line. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# IVIG

## Products Affected

- BIVIGAM
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- GAMMAGARD LIQUID
- GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- GAMMAPLEX
- GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- PRIVIGEN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | History of hypersensitivity to immune globulin or any component of the preparation. |
| **Required Medical Information** | For a diagnosis of ITP: patient must have a trial of corticosteroids unless platelet count is less than 20,000 cells/mm3 and bleeding has occurred. For a diagnosis of hypogammaglobulinemia associated with B-cell chronic lymphocytic leukemia: IgG level is less than 500 mg/dL or patient has a history of infection. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |

# 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** | Patient has a diagnosis of intermediate or high-risk myelofibrosis (including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis). OR Patient has a diagnosis of polycythemia vera and has had an inadequate response to or was intolerant of hydroxyurea. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# JUXTAPID

## Products Affected

- JUXTAPID

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | For initiation of treatment, moderate or severe hepatic impairment (eg, Child-Pugh B or C). For renewal, ALT or AST equal to or greater than 5 times the upper limit normal (ULN), or equal to greater than 3x ULN with signs or symptoms of liver toxicity or injury, increases in bilirubin greater than 2x ULN or active liver disease. |
| **Required Medical Information** | For initiation of therapy, 1. Patient has a diagnosis of homozygous familial hypercholesterolemia confirmed by one of the following: A. documented mutations in both alleles at LDL receptor, ApoB, PCSK9, or ARH adapter protein gene locus, B. documented skin fibroblast LDL receptor activity less than 20% of normal, OR C. the following criteria are met: a) untreated LDL-C greater than 500 mg/dL or unknown AND b) triglyceride level less than 350 mg/dL AND c) tendon or cutaneous xanthomas at age 10 or younger OR d) both parents with a history of LDL-C greater than 190 mg/dL, AND 2. Patient has tried and had an inadequate response to the maximum tolerated dose of a high potency statin and a PCSK9 inhibitor unless contraindicated. For renewal of therapy, 1. Patient meets all initial criteria AND 2. Current LDL-C is improved from the levels immediately prior to initiation of treatment with Juxtapid. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# 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** | Statement from physician or lab results showing patient has cystic fibrosis with a CFTR gene mutation responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. Patient is not homozygous for the F508del mutation in the CFTR gene. |
| **Age Restrictions** | Patient is at least 2 years old for granules and 6 years old for tablets. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# KEVZARA

## Products Affected

- KEVZARA SUBCUTANEOUS SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Patient has an ANC less than 2,000/mm3, platelet count less than 150,000/mm3, or ALT and AST are more than 1.5 times the upper limit of normal. |
| **Required Medical Information** | Patient has a diagnosis of moderately to severely active rheumatoid arthritis. Patient has had an inadequate response, contraindication, or intolerance to at least 2 of the following: Humira, Enbrel, Xeljanz. |
| **Age Restrictions** | Patient is 18 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# KISQALI

## Products Affected

- KISQALI
- KISQALI FEMARA CO-PACK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of hormone receptor positive, human epidermal growth factor receptor 2 negative advanced or metastatic breast cancer. Patient will use as initial endocrine-based therapy in combination with an aromatase inhibitor OR patient is postmenopausal and will use in combination with fulvestrant. Concomitant use with fulvestrant does not apply to Kisqali Femara Co-Pack requests. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# KORLYM

## Products Affected

- KORLYM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Not covered if patient is pregnant. Maximum dose: 1200mg daily, not to exceed 20mg/kg/day. Patient requires concomitant treatment with long-term corticosteroids (e.g., immunosuppression for organ transplant). History of unexplained vaginal bleeding. Endometrial hyperplasia with atypia or endometrial carcinoma. Concomitantly taking simvastatin, lovastatin, or a CYP3A substrate with a narrow therapeutic range (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus) |
| **Required Medical Information** | Patient has a diagnosis of endogenous Cushing's syndrome and has type 2 diabetes mellitus or glucose intolerance. Patient has failed surgery or is not a candidate for surgery. Statement from physician verifying that non-hormonal contraception will be used during treatment and for one month after discontinuation of therapy unless the patient has had surgical sterilization. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribing physician must be an endocrinologist |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# KUVAN

## Products Affected

- KUVAN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has hyperphenylalaninemia due to Phenylketonuria (PKU). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# KYNAMRO

## Products Affected

- KYNAMRO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | For initiation of treatment, moderate or severe hepatic impairment (eg, Child-Pugh B or C). For renewal, ALT or AST equal to or greater than 5 times the upper limit normal (ULN), or equal to greater than 3x ULN with signs or symptoms of liver toxicity or injury, increases in bilirubin greater than 2x ULN or active liver disease. |
| **Required Medical Information** | For initiation of therapy, all of the following requirements are met : 1)Patient has a diagnosis of homozygous familial hypercholesterolemia confirmed by one of the following: a) documented mutations in both alleles at LDL receptor, ApoB, PCSK9, or ARH adapter protein gene locus, b) documented skin fibroblast LDL receptor activity less than 20% of normal, OR c) the following criteria are met: i) untreated LDL-C greater than 500 mg/dL or unknown AND ii) triglyceride level less than 350 mg/dL AND iii) tendon or cutaneous xanthomas at age 10 or younger or both parents with a history of LDL-C greater than 190 mg/dL, AND 2) Patient has tried and had an inadequate response to the maximum tolerated dose of a high potency statin and a PCSK9 inhibitor unless contraindicated. For renewal of therapy, Patient meets all criteria for initiation of therapy AND current LDL-C is improved from levels immediately prior to initiation of treatment with Kynamro. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# LENVIMA

## Products Affected

- LENVIMA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer. OR Patient has a diagnosis of advanced renal cell carcinoma (RCC) and has failed one prior anti-angiogenic therapy. Lenvima will be used in combination with everolimus when used for RCC. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# LETAIRIS

## Products Affected

- LETAIRIS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Pregnancy |
| **Required Medical Information** | Patient has a diagnosis of pulmonary arterial hypertension (WHO Group I). For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, AND 2) Patient will use reliable contraception during treatment and for one month after stopping treatment |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# LIDODERM

## Products Affected

- LIDOCAINE TOPICAL ADHESIVE PATCH,MEDICATED

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D including diabetic neuropathy and cancer-related neuropathic pain. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has a diagnosis of post-herpetic neuralgia, diabetic neuropathy, or cancer-related neuropathic pain. The patch will only be applied to intact skin |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# LONSURF

## Products Affected

- LONSURF

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic colorectal cancer. Patient has been previously treated with a fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy (such as FOLFOX, FOLFIRI, FOLFOXIRI) AND an anti-VEGF biological therapy (such as Avastin). If patient is RAS wild-type, patient has been previously treated with an anti-EGFR therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# LORBRENA

## Products Affected

- LORBRENA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of anaplastic lymphoma kinase (ALK) positive metastatic non-small cell lung cancer (NSCLC). Patient has progressed on one of the following: crizotinib and at least one other ALK inhibitor for metastatic disease, or alectinib as the first ALK inhibitor therapy for metastatic disease, or certinib as the first ALK inhibitor therapy for metastatic disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# LYNPARZA

## Products Affected

- LYNPARZA ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of one of the following: recurrent ovarian cancer (epithelial, fallopian tube, or primary peritoneal) after platinum-based chemotherapy, OR advanced ovarian cancer with deleterious or suspected deleterious germline BRCA-mutations and has been treated with 3 or more prior lines of chemotherapy, OR metastatic HER-2 negative breast cancer with deleterious or suspected deleterious germline BRCA-mutations and has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# MAVYRET

## Products Affected

- MAVYRET

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Patient does not have moderate to severe hepatic impairment (Child-Pugh B or C). |
| **Required Medical Information** | Information required for review: genotype, prior HCV treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 8, 12, or 16 weeks |
| **Other Criteria** | N/A |

# MEKINIST

## Products Affected

- MEKINIST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has unresectable or metastatic melanoma with BRAF V600E or V600K mutations and Mekinist will be used as a single agent or with dabrafenib (Tafinlar) and patient has not received prior BRAF-inhibitor therapy (Zelboraf, Tafinlar). OR patient has a diagnosis of BRAF V600E mutation positive metastatic non-small cell lung cancer and will use in combination with dabrafenib (Tafinlar). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# MEKTOVI

## Products Affected

- MEKTOVI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation. Binimetinib (Mektovi) will be used in combination with encorafenib (Braftovi). Patient was not previously treated with a BRAF inhibitor or MEK inhibitor. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# NERLYNX

## Products Affected

- NERLYNX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of early stage HER2-overexpressed breast cancer. Patient has been on trastuzumab based therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# NEXAVAR

## Products Affected

- NEXAVAR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of one of the following: unresectable hepatocellular carcinoma, advanced renal cell carcinoma, or locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# NINLARO

## Products Affected

- NINLARO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of multiple myeloma. Ixazomib will be used in combination with lenalidomide and dexamethasone. Patient has received at least one prior therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# NORTHERA

## Products Affected

- NORTHERA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient must have a diagnosis of neurogenic orthostatic hypotension caused by primary autonomic failure (due to Parkinson disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, and nondiabetic autonomic neuropathy. Patient must also have tried midodrine. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a cardiologist or a neurologist. |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# NUEDEXTA

## Products Affected

- NUEDEXTA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Patient is currently using quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong the QT interval and are metabolized by CYP2D6 (examples: thioridazine and pimozide). Patient has a prolonged QT interval or congenital long QT syndrome (LQTS), or heart failure or a history suggestive of torsades de pointes (TdP). Patient has complete atrioventricular (AV) block without an implanted pacemaker or is at high risk of complete AV block. |
| **Required Medical Information** | Diagnosis of pseudobulbar affect (PBA). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **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** | N/A |
| **Required Medical Information** | Diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder. |
| **Age Restrictions** | 17 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ODOMZO

## Products Affected

- ODOMZO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of locally advanced basal cell carcinoma (BCC). BCC has either recurred following surgery or radiation therapy or patient was not a candidate for surgery or radiation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# OFEV

## Products Affected

- OFEV

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | The patient has a diagnosis of idiopathic pulmonary fibrosis. Liver function tests were performed prior to starting therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | Prescribed by or in consultation with a pulmonologist |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewal, the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage. |

# OPSUMIT

## Products Affected

- OPSUMIT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has pulmonary arterial hypertension (PAH), World Health Organization Group I disease. PAH was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). Liver function tests were performed prior to starting therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# 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** | New starts: Patient has a diagnosis of moderate to severe rheumatoid arthritis and has had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, Xeljanz. Patient has a diagnosis of moderate to severe juvenile idiopathic arthritis and has had a failure, contraindication, or intolerance to both Enbrel and Humira. Patient has a diagnosis of active psoriatic arthritis and has had a failure, contraindication, or intolerance to two of the following: Enbrel, Humira, Otezla, Cosentyx, Stelara. |
| **Age Restrictions** | Juvenile idiopathic arthritis: IV: 6 years and older . SC: 2 years and older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Renewals: patient has had a positive clinical response to Orencia. |

# ORENITRAM

## Products Affected

- ORENITRAM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Patient has a diagnosis of severe hepatic impairment (Child Pugh Class C). |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ORKAMBI

## Products Affected

- ORKAMBI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has cystic fibrosis and is homozygous for the F508del mutation in the CFTR gene. Patient had baseline ALT, AST, and bilirubin assessed. |
| **Age Restrictions** | 2 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# OTEZLA

## Products Affected

- OTEZLA
- OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of active psoriatic arthritis OR moderate to severe plaque psoriasis and is a candidate for phototherapy or systemic therapy. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewals, patient has stable disease or has improved while on therapy. |

# POMALYST

## Products Affected

- POMALYST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For multiple myeloma: 1) Patient received prior therapy with Velcade (bortezomib) AND Revlimid (lenalidomide), 2) disease has progressed during or within 60 days of completion of last therapy 3) Will be used in combination with dexamethasone. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# PRALUENT

## Products Affected

- PRALUENT PEN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease (ASCVD, defined as having at least one of the following: ACS, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin) and requires additional lowering of LDL cholesterol. Patient is on maximally tolerated statin therapy or has zero tolerance to statin therapy. Patient will be started on the 75mg dose. For a diagnosis of clinical atherosclerotic cardiovascular disease: patient has tried at least two statins (rosuvastatin, atorvastatin, simvastatin, pravastatin, lovastatin, or fluvastatin) |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# PROMACTA

## Products Affected

- PROMACTA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Use in the management of thrombocytopenia in myelodysplastic syndrome (MDS). |
| **Required Medical Information** | Patient has a diagnosis of chronic immune thrombocytopenic purpura (ITP) and meets both of the following: baseline platelet count less than 50,000/mcL, had an insufficient response to either corticosteroids, immunoglobulins, or splenectomy. Patient has a diagnosis of severe aplastic anemia with a platelet count less than 30,000/mcL. Patient has a diagnosis of thrombocytopenia in a patient with chronic hepatitis C. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# PROVIGIL

## Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

| 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 excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder. |
| **Age Restrictions** | 17 years of age or older. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# QUININE

## Products Affected

- *quinine sulfate*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D, babesiosis, uncomplicated Plasmodium vivax malaria. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of uncomplicated Plasmodium falciparum malaria, uncomplicated Plasmodium vivax malaria, or babesiosis. Patient is not prescribed quinine for the treatment or prevention of leg cramps. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# 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** | Patient has diabetes. Patient has neuropathic ulcers on the lower extremity that extend into the subcutaneous tissue or beyond and have an adequate blood supply (i.e. is not an ischemic ulcer). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 20 weeks |
| **Other Criteria** | N/A |

# RELISTOR

## Products Affected

- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Patient with known or suspected mechanical GI obstruction and at increased risk of recurrent obstruction. |
| **Required Medical Information** | Patient has a diagnosis of opioid induced constipation with either chronic non cancer pain or advanced illness or pain caused by cancer who are receiving palliative care, when response to laxative therapy has not been sufficient. Patient has had an inadequate response to Amitiza or Movantik. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# REPATHA

## Products Affected

- REPATHA
- REPATHA PUSHTRONEX
- 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** | Patient has a diagnosis of heterozygous or homozygous familial hypercholesterolemia (HeFH or HoFH) or clinical atherosclerotic cardiovascular disease (ASCVD, defined as having at least one of the following: ACS, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin) and requires additional lowering of LDL cholesterol. Patient is on maximally tolerated statin therapy or has zero tolerance to statin therapy. For a diagnosis of clinical atherosclerotic cardiovascular disease: patient has tried at least two statins (rosuvastatin, atorvastatin, simvastatin, pravastatin, lovastatin, or fluvastatin) |
| **Age Restrictions** | 13 years of age or older for HoFH, 18 years of age or older for other indications |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# RESPIRATORY PDE-5 INHIBITOR

## Products Affected

- ADCIRCA
- ALYQ
- REVATIO ORAL SUSPENSION FOR RECONSTITUTION
- SILDENAFIL (PULMONARY ARTERIAL HYPERTENSION) ORAL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Receiving nitrate therapy (includes intermittent use) |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has (WHO Group I) PAH. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# REVLIMID

## Products Affected

- REVLIMID

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of multiple myeloma and medication will be used in combination with dexamethasone or as maintenance therapy after autologous hematopoietic stem cell transplant. OR Diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5 q cytogenetic abnormality with or without additional cytogenetic abnormalities. OR Diagnosis of mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib. AND Patient is not using the medication for the treatment of chronic lymphocytic leukemia. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# RUBRACA

## Products Affected

- RUBRACA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer with deleterious BRCA mutation and has been treated with 2 or more chemotherapies OR rucaparib will be used for the maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer after a complete or partial response to platinum-based chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# RYDAPT

## Products Affected

- RYDAPT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of new onset acute myeloid leukemia (AML) that is FLT3 mutation positive, aggressive systemic mastocytosis, systemic mastocytosis with associated hematological neoplasm, mast cell leukemia. For patients with AML, midostaurin will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy. Midostaurin will not be used as a single-agent induction for AML. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# SOMATULINE

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of either Acromegaly or gastroenteropancreatic neuroendocrine tumors (GEP-NETs), or carcinoid syndrome. For acromegaly, patient has had an inadequate or partial response to surgery and/or radiotherapy or patient was not a candidate for surgery or radiotherapy. For GEP-NETs, tumors are unresectable, well- or moderately-differentiated, locally advanced or metastatic. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# SPRYCEL

## Products Affected

- SPRYCEL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. Gastrointestinal stromal tumor (GIST). |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Newly diagnosed adults with Philadelphia chromosome-positive chronic myelogenous leukemia (CML) in chronic phase. Adults with chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome-positive CML with resistance or intolerance to prior therapy including imatinib. Adults with diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (ALL) with resistance or intolerance to prior therapy. Pediatric patients with a diagnosis of Philadelphia chromosome-positive CML in chronic phase. For patients with GIST, patient must have progressed on imatinib or sunitinib. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# STELARA

## Products Affected

- STELARA SUBCUTANEOUS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of moderate to severe plaque psoriasis (affects more than 5% of body surface area or affects crucial areas such as hands, feet, or genitals), active psoriatic arthritis, or moderate to severe Crohn's disease. For Crohn's disease: patient has failed or was intolerant to at least 1 TNF blocker, immunomodulator, or corticosteroid. Patient was negative for latent TB infection. |
| **Age Restrictions** | For psoriasis only, patient must be 12 years or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewals: patient has had stable disease or improved on therapy. |

# STIVARGA

## Products Affected

- STIVARGA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of: A) metastatic colorectal cancer AND patient has previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan -based therapy, an anti-vascular endothelial growth factor (VEGF) therapy, and, if KRAS wild type, an anti-epidermal growth factor receptor (EGFR) therapy or B) gastrointestinal stromal tumors that is locally advanced, unresectable or metastatic AND patient has tried and had an inadequate response, contraindication or intolerance to imatinib and sunitinib or C) hepatocellular carcinoma and has been previously treated with sorafenib. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# SUTENT

## Products Affected

- SUTENT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of advanced/metastatic renal cell carcinoma or as an adjuvant treatment after nephrectomy. Diagnosis of gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to imatinib. Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) in a patient with unresectable locally advanced or metastatic disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# SYMDEKO

## Products Affected

- SYMDEKO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has cystic fibrosis and is homozygous for the F508del mutation or has at least 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence. Patient had baseline ALT and AST assessed. |
| **Age Restrictions** | 12 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# SYMLIN

## Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of type 1 or type 2 diabetes mellitus. Patient is currently receiving optimal mealtime insulin therapy. Patient has had an inadequate treatment response to insulin. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TAFINLAR

## Products Affected

- TAFINLAR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation and will be used in combination with trametinib OR a diagnosis of unresectable or metastatic melanoma AND will be used as monotherapy in patients with the BRAF V600E mutation OR dabrafenib will be used in combination with trametinib in patients with BRAF V600E or V600K mutations. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TAGRISSO

## Products Affected

- TAGRISSO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) T790M mutation-positive disease. Patient must have progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy OR patient has a diagnosis of metastatic NSCLC with EGFR exon 19 deletions or exon 21 L858R mutations and Tagrisso will be used first line. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TALZENNA

## Products Affected

- TALZENNA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of locally advanced or metastatic breast cancer. Patient has deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA)-mutated human epidermal growth factor receptor 2 (HER2) negative disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TARCEVA

## Products Affected

- TARCEVA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For pancreatic cancer: Used first-line in locally advanced, unresectable, or metastatic cancer in combination with gemcitabine. For metastatic non-small cell lung cancer: not used in combination with platinum-based chemotherapy, tumors have EGFR exon 19 deletions or exon 21 substitution mutations. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TARGRETIN

## Products Affected

- TARGRETIN TOPICAL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For gel: patient has a diagnosis of stage 1A or 1B cutaneous T-cell lymphoma that is refractory or persistent after treatment with other therapies or has not tolerated other therapies. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TASIGNA

## Products Affected

- TASIGNA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Uncorrected hypokalemia or hypomagnesemia, long QT syndrome. Use of concomitant drugs known to prolong the QT interval or strong CYP3A4 inhibitors. |
| **Required Medical Information** | Patient (age 1 or older) has a diagnosis of newly diagnosed Philadelphia chromosome positive CML in chronic phase OR adult patient with a diagnosis of chronic phase or accelerated phase Philadelphia chromosome positive CML in patients that are resistant or intolerant to imatinib OR pediatric patient with a diagnosis of chronic phase Philadelphia chromosome positive CML in patients that are resistant or intolerant to prior tyrosine-kinase inhibitor therapy. |
| **Age Restrictions** | Age 1 and older for pediatric indications |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TAVALISSE

## Products Affected

- TAVALISSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of chronic immune thrombocytopenia (ITP).<br>Patient had an insufficient response to a previous treatment. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TECFIDERA

## Products Affected

- TECFIDERA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of a relapsing form of multiple sclerosis. Patient must have a complete blood count within the past 6 months before initiation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | To continue therapy, the patient must demonstrate stabilization or improvement while on Tecfidera. |

# THALOMID

## Products Affected

- THALOMID

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of: A) multiple myeloma that is newly diagnosed and is receiving concurrent dexamethasone B) acute treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum C) Maintenance therapy for prevention and suppression of the cutaneous manifestations of erythema nodosum leprosum recurrence. Thalidomide will not be used as monotherapy for erythema nodosum leprosum treatment if the member has moderate to severe neuritis |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TIBSOVO

## Products Affected

- TIBSOVO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML). Patient has a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TRACLEER

## Products Affected

- TRACLEER

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Pregnancy. Concomitant use with cyclosporine or glyburide. For initial therapy: alanine aminotransferase (ALT)/aspartate aminotransferase (AST) level greater than 3 times the upper limit of normal (ULN). |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension (WHO Group I) that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). NYHA Functional Class II to IV symptoms. For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, and 2) Patient will use reliable contraception during treatment and for one month after stopping treatment |
| **Age Restrictions** | Age 3 and older |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TRANSMUCOSAL FENTANYL PRODUCTS

## Products Affected

- FENTANYL CITRATE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has active cancer and TIRF will be used for breakthrough cancer pain. Patient has tried and failed or has contraindications to at least 2 of the following short acting narcotics: oxycodone, morphine sulphate, hydromorphone. Long-Acting opioid is being prescribed The patient is opioid tolerant (Patients are considered opioid tolerant if they have been taking at least 60 mg of oral morphine per day, 25 mcg of transdermal fentanyl/hr, 30 mg of oral oxycodone daily, 8 mg of oral hydromorphone daily, 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer.). |
| **Age Restrictions** | 16 years of age or older (fentanyl oral lozenge), 18 years of age or older all others. |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# TYKERB

## Products Affected

- TYKERB

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced or metastatic breast cancer with overexpression of HER2 AND Tykerb will be used with capecitabine AND patient has received prior therapy with an anthracycline, a taxane, and trastuzumab. OR Patient is postmenopausal with a diagnosis of hormone receptor positive metastatic breast cancer with overexpression of HER2 AND Tykerb will be used with letrozole. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# 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** | Diagnosis of pulmonary arterial hypertension (WHO Group I) that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# VENCLEXTA

## Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Must not be on a strong CYP3A inhibitor (such as ketoconazole, conivaptan, clarithromycin, indinavir, itraconazole, lopinavir, ritonavir, telaprevir, posaconazole, or voriconazole) at Venclexta initiation and during Venclexta ramp-up phase. |
| **Required Medical Information** | Patient has a diagnosis of chronic lymphocytic leukemia (CLL) with 17p deletion. Patient has received at least one prior therapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# VERZENIO

## Products Affected

- VERZENIO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has advanced or metastatic hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER2) negative breast cancer. Patient will use in combination with an aromatase inhibitor as initial treatment in a post menopausal woman OR will be used in combination with fulvestrant in patients that had disease progression following endocrine therapy OR patient has metastatic disease and it will be used as monotherapy for patients that had disease progression following endocrine therapy and prior chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# VIBERZI

## Products Affected

- VIBERZI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of irritable bowel syndrome with diarrhea. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# VITRAKVI

## Products Affected

- VITRAKVI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has solid tumors that have all of the following characteristics: a confirmed neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, metastatic disease or where surgical resection is likely to result in severe morbidity, AND there are no satisfactory alternative treatments or disease has progressed following treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# VIZIMPRO

## Products Affected

- VIZIMPRO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations. Vizimpro will be used as a first-line treatment. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# VOSEVI

## Products Affected

- VOSEVI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Information required for review: genotype, prior HCV treatments, cirrhosis status (including Child-Pugh class), desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines with the highest evidence rating in that category as of the date of the request. In cases where the request is for a lower evidence rated treatment, an explanation will be required as to why the higher rated regimen is not preferred. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 12 weeks |
| **Other Criteria** | N/A |

# VOTRIENT

## Products Affected

- VOTRIENT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of advanced renal cell carcinoma or advanced soft tissue sarcoma. Patients with a diagnosis of soft tissue sarcoma must have received prior chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# XALKORI

## Products Affected

- XALKORI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC). The tumor is ROS1- or ALK-positive. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# XELJANZ

## Products Affected

- XELJANZ
- XELJANZ XR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of moderate to severe rheumatoid arthritis, ulcerative colitis OR active psoriatic arthritis. For a diagnosis of rheumatoid arthritis or psoriatic arthritis: patient has had a failure, contraindication, or intolerance to one DMARD such as: methotrexate, leflunomide, sulfasalazine. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | Renewals: patient has had a positive clinical response to Xeljanz or Xeljanz XR. |

# XENAZINE

## Products Affected

- TETRABENAZINE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. Tardive dyskinesia and Tourette's syndrome. |
| **Exclusion Criteria** | Actively suicidal or has untreated or inadequately treated depression. Impaired hepatic function. Concomitant monoamine oxidase inhibitor (MAOI) or use within 14 days of stopping MAOI. Concomitant reserpine or use within 20 days of stopping reserpine. |
| **Required Medical Information** | Diagnosis of chorea associated with Huntington's disease. If treating for tardive dyskinesia, require failure of at least one previous therapy (e.g., amantadine, benzodiazepines, haloperidol, atypical antipsychotics, etc.) or Gilles de la Tourette's syndrome with failure or least one previous therapy (e.g., antipsychotic agents, clonidine). Patients who require doses greater than 50 mg/day will be genotyped for CYP2D6 to determine whether the patient is a poor, intermediate or extensive metabolizer. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | For renewal, patient must have a lack of disease progression or have improvement in symptoms. |

# XOSPATA

## Products Affected

- XOSPATA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of relapsed or refractory acute myeloid leukemia (AML). Patient has a FMS-like tyrosine kinase 3 (FLT3) mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# XTANDI

## Products Affected

- XTANDI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic castration-resistant prostate cancer (CRPC). The patient has tried and had an inadequate response, contraindication or intolerance to Zytiga. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# XYREM

## Products Affected

- XYREM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Taking alcohol or sedative hypnotic agents while taking Xyrem. |
| **Required Medical Information** | Patient has a diagnosis of narcolepsy with either cataplexy or excessive daytime sleepiness. For patients with a diagnosis of excessive daytime sleepiness, patient has had a previous trial with or a contraindication, intolerance, or allergy to modafinil, armodafinil, methylphenidate, dextroamphetamine, or mixed amphetamine salts. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# YONSA

## Products Affected

- YONSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has metastatic castration-resistant prostate cancer. Yonsa will be used in combination with methylprednisolone. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ZAVESCA

## Products Affected

- MIGLUSTAT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of mild to moderate type 1 Gaucher disease. Enzyme replacement therapy is not a therapeutic option due to allergy, hypersensitivity, or poor venous access. Miglustat will be used as monotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ZEJULA

## Products Affected

- ZEJULA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer. Patient had a complete or partial response to platinum-based chemotherapy. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ZELBORAF

## Products Affected

- ZELBORAF

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Diagnosis of unresectable or metastatic melanoma and patient has positive BRAF-V600E mutation OR patient has a diagnosis of Erdheim-Chester Disease (ECD) with BRAF V600E mutation. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ZEPATIER

## Products Affected

- ZEPATIER

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | Patient has moderate or severe hepatic impairment (Child-Pugh B or C). Patient is on OATP1B1/3 inhibitors, strong inducers of CYP3A or efavirenz. |
| **Required Medical Information** | Information required for review: genotype, prior treatments, cirrhosis status, desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status, NS5A polymorphism status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines as of the date of the request. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | 12 or 16 weeks per medical information provided |
| **Other Criteria** | N/A |

# ZOLINZA

## Products Affected

- ZOLINZA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of cutaneous T-cell lymphoma with progressive, persistent or recurrent disease. Patient has received at least two prior systemic therapies. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ZYDELIG

## Products Affected

- ZYDELIG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | For relapsed chronic lymphocytic leukemia, Zydelig is used in combination with rituximab. For relapsed follicular B-cell non-Hodgkin lymphoma and relapsed small lymphocytic lymphoma, patient has received at least two prior systemic therapies. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ZYKADIA

## Products Affected

- ZYKADIA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic non-small cell lung cancer and has anaplastic lymphoma kinase (ALK)-positive disease. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# ZYTIGA

## Products Affected

- ABIRATERONE
- ZYTIGA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D. |
| **Exclusion Criteria** | N/A |
| **Required Medical Information** | Patient has a diagnosis of metastatic castration-resistant prostate cancer (CRPC) OR metastatic high-risk castration-sensitive prostate cancer (CSPC). Zytiga will be used in combination with prednisone. |
| **Age Restrictions** | N/A |
| **Prescriber Restrictions** | N/A |
| **Coverage Duration** | Plan year |
| **Other Criteria** | N/A |

# PART B VERSUS PART D

## Products Affected

- ABELCET
- *acetylcysteine*
- ACTIMMUNE
- *acyclovir sodium intravenous solution*
- *albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml*
- AMBISOME
- AMINOSYN 7 % WITH ELECTROLYTES
- AMINOSYN 8.5 %-ELECTROLYTES
- AMINOSYN II 10 %
- AMINOSYN II 15 %
- AMINOSYN II 8.5 %
- AMINOSYN II 8.5 %-ELECTROLYTES
- AMINOSYN-HBC 7%
- AMINOSYN-PF 10 %
- AMINOSYN-PF 7 % (SULFITE-FREE)
- AMINOSYN-RF 5.2 %
- *amphotericin b*
- *aprepitant*
- ASTAGRAF XL
- AZASAN
- *azathioprine*
- BETHKIS
- BROVANA
- *budesonide inhalation*
- CANCIDAS
- *caspofungin intravenous recon soln 50 mg*
- CASPOFUNGIN INTRAVENOUS RECON SOLN 70 MG
- CESAMET
- CLINIMIX 5%/D15W SULFITE FREE
- CLINIMIX 5%/D25W SULFITE-FREE
- CLINIMIX 4.25%/D10W SULF FREE
- CLINIMIX 4.25%/D5W SULFIT FREE
- CLINIMIX 4.25%-D25W SULF-FREE
- CLINIMIX 5%-D20W(SULFITE-FREE)
- CLINIMIX E 2.75%/D10W SUL FREE
- CLINIMIX E 2.75%/D5W SULF FREE
- CLINIMIX E 4.25%/D10W SUL FREE
- CLINIMIX E 4.25%/D25W SUL FREE
- CLINIMIX E 4.25%/D5W SULF FREE
- CLINIMIX E 5%/D15W SULFIT FREE
- CLINIMIX E 5%/D20W SULFIT FREE
- CLINISOL SF 15 %
- *cromolyn inhalation*
- CYCLOPHOSPHAMIDE ORAL CAPSULE
- *cyclosporine modified*
- *cyclosporine oral capsule*
- DRONABINOL
- DUOPA
- EMEND ORAL SUSPENSION FOR RECONSTITUTION
- ENGERIX-B (PF) INTRAMUSCULAR SYRINGE
- ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE
- ENVARSUS XR
- EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML
- FIRMAGON KIT W DILUENT SYRINGE
- FREAMINE HBC 6.9 %
- *gengraf oral capsule 100 mg, 25 mg*
- *gengraf oral solution*
- *granisetron hcl oral*
- HEPATAMINE 8%
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- INTRON A INJECTION
- *ipratropium bromide inhalation*
- *ipratropium-albuterol*
- *levalbuterol hcl*
- *methotrexate sodium*
- *methotrexate sodium (pf) injection solution*
- *methylprednisolone oral tablet*
- MILLIPRED ORAL TABLET
- *mycophenolate mofetil*
- *mycophenolate sodium*
- NEBUPENT
- NEPHRAMINE 5.4 %

- *ondansetron*
- *ondansetron hcl oral*
- PERFOROMIST
- *plenamine*
- *prednisolone sodium phosphate oral tablet,disintegrating*
- PREDNISONE INTENSOL
- *prednisone oral tablet*
- PREMASOL 10 %
- PREMASOL 6 %
- PROCALAMINE 3%
- PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML
- PROSOL 20 %
- PULMOZYME
- RAPAMUNE ORAL SOLUTION
- RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML
- RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE
- SANDIMMUNE ORAL SOLUTION
- *sirolimus*
- SYNRIBO
- *tacrolimus oral*
- *tobramycin in 0.225 % nacl*
- TRAVASOL 10 %
- TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION
- TREXALL
- TROPHAMINE 10 %
- TROPHAMINE 6%
- VARUBI ORAL
- VENTAVIS
- XATMEP
- XGEVA
- 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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