

**L.A. Care Cal MediConnect Plan (Medicare-Medicaid Plan)**

Prior Authorization Criteria  
 Last Updated 9/1/2018

**Products Affected**

- *adapalene/benzoyl peroxide 0.1-2.5% gel*
- *avita 0.025% gel*
- *tretinoin 0.025% cream*
- *tretinoin 0.04% gel*
- *tretinoin 0.05% gel*
- *tretinoin 0.1% gel*
- *avita 0.025% cream*
- *tretinoin 0.01% gel*
- *tretinoin 0.025% gel*
- *tretinoin 0.05% cream*
- *tretinoin 0.1% cream*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— ADAGEN 250UNIT/ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

- ADEMPAS 0.5MG TAB
- ADEMPAS 1MG TAB
- ADEMPAS 2MG TAB

- ADEMPAS 1.5MG TAB
- ADEMPAS 2.5MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For diagnosis of Pulmonary Arterial Hypertension, trial of one (1) of the following: Letairis, Opsumit or Tracleer. For diagnosis of Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4), trial of prior therapy is not required.

**Products Affected**

- AFINITOR 10MG TAB (New Starts Only)
- AFINITOR 2MG ORAL SUSP (New Starts Only)
- AFINITOR 5MG ORAL SUSP (New Starts Only)
- AFINITOR 7.5MG TAB (New Starts Only)
- AFINITOR 2.5MG TAB (New Starts Only)
- AFINITOR 3MG ORAL SUSP (New Starts Only)
- AFINITOR 5MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— ALECENSA 150MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— ALIQOPA 60MG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- ALUNBRIG 180MG TAB (New Starts Only)
- ALUNBRIG 90MG TAB (New Starts Only)

- ALUNBRIG 30MG TAB (New Starts Only)
- ALUNBRIG TAB STARTER PACK (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- AMINO ACIDS ORAL POWDER\*
- NUTRITIONAL SUPPLEMENT FLAVOR PACK\*
- NUTRITIONAL SUPPLEMENT PACK\*

- CHOLEXTRA POWDER\*
- NUTRITIONAL SUPPLEMENT LIQUID\*
- PERIFLEX PKU LIQUID\*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	
Exclusion Criteria	
Required Medical Info	Authorization of metabolic enteral nutrition products administered orally or through a feeding tube is restricted to beneficiaries with a diagnosis of inborn errors of metabolism (genetic, metabolic condition).
Age Restrictions	
Prescriber Restriction	
Coverage Duration	
Other Criteria	Additional Enteral Products covered per the Medi-Cal Fee For Service guidelines



## Products Affected

– AMPYRA 10MG ER TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- testosterone 1% (25mg) gel
- testosterone 1% gel pump

- testosterone 1% (50mg) gel

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two morning testosterone levels fall below the normal range for a healthy adult male. Patient must have tried and failed ANDRODERM and ANDROGEL. For formulary methyltestosterone product, if prescribed for delay in sexual development or metastasis from malignant tumor of breast, inoperable metastatic disease (skeletal) in women 1 to 5 years postmenopausal, testosterone levels and previous trial of ANDRODERM and ANDROGEL not required. For patients on testosterone replacement therapy, documentation of at least one (1) morning testosterone level from the last 12 months is required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- ANDRODERM 2MG/24HR PATCH
- ANDROGEL 1% (25MG) GEL
- ANDROGEL 1.62% (1.25GM) GEL
- ANDROGEL 1.62% GEL

- ANDRODERM 4MG/24HR PATCH
- ANDROGEL 1% (50MG) GEL
- ANDROGEL 1.62% (2.5GM) GEL

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Two morning testosterone levels fall below the normal range for a healthy adult male. For patients on testosterone replacement therapy, documentation of at least one (1) morning testosterone level from the last 12 months is required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

- ABELCET 5MG/ML INJ
- CANCIDAS 50MG INJ
- CASPOFUNGIN ACETATE 50MG INJ
- ERAXIS 100MG INJ
- MYCAMINE 50MG INJ
- AMBISOME 50MG INJ
- CANCIDAS 70MG INJ
- CASPOFUNGIN ACETATE 70MG INJ
- MYCAMINE 100MG INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- APTIOM 200MG TAB (New Starts Only)
- APTIOM 600MG TAB (New Starts Only)

- APTIOM 400MG TAB (New Starts Only)
- APTIOM 800MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— ARCALYST 220MG INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatology Specialist, Dermatology Specialist, or Immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- *fondaparinux sodium 12.5mg/ml (0.4ml) syringe*
- *fondaparinux sodium 12.5mg/ml (0.8ml) syringe*

- *fondaparinux sodium 12.5mg/ml (0.6ml) syringe*
- *fondaparinux sodium 5mg/ml syringe*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Body weight less than 50 kg (venous thromboembolism prophylaxis only).
Required Medical Info	If prescribed for acute DVT, patient must have a trial with or contraindication to enoxaparin. For all other FDA-approved indications, trial of enoxaparin not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- ABILIFY 300MG MAINTENA INJ (New Starts Only)
- ABILIFY 400MG MAINTENA INJ (New Starts Only)
- *aripiprazole 10mg odt (New Starts Only)*
- *aripiprazole 1mg/ml oral soln (New Starts Only)*
- ARISTADA 441MG/1.6ML SYRINGE (New Starts Only)
- ARISTADA 882MG/3.2ML SYRINGE (New Starts Only)
- FANAPT 12MG TAB (New Starts Only)
- FANAPT 2MG TAB (New Starts Only)
- FANAPT 6MG TAB (New Starts Only)
- FANAPT TITRATION PACK (New Starts Only)
- INVEGA 156MG/ML SYRINGE (New Starts Only)
- INVEGA 273MG/0.875ML SYRINGE (New Starts Only)
- INVEGA 410MG/1.315ML SYRINGE (New Starts Only)
- INVEGA 78MG/0.5ML SYRINGE (New Starts Only)
- LATUDA 120MG TAB (New Starts Only)
- LATUDA 40MG TAB (New Starts Only)
- LATUDA 80MG TAB (New Starts Only)
- *paliperidone 3mg er tab (New Starts Only)*
- *paliperidone 9mg er tab (New Starts Only)*
- REXULTI 0.5MG TAB (New Starts Only)
- REXULTI 2MG TAB (New Starts Only)
- REXULTI 4MG TAB (New Starts Only)
- RISPERDAL 25MG INJ (New Starts Only)
- RISPERDAL 50MG INJ (New Starts Only)
- SAPHRIS 2.5MG SL TAB (New Starts Only)
- VRAYLAR 1.5/3MG MIXED PACK (New Starts Only)
- VRAYLAR 3MG CAP (New Starts Only)
- VRAYLAR 6MG CAP (New Starts Only)
- ABILIFY 300MG MAINTENA PF SYRINGE (New Starts Only)
- ABILIFY 400MG MAINTENA PF SYRINGE (New Starts Only)
- *aripiprazole 15mg odt (New Starts Only)*
- ARISTADA 273MG/ML SYRINGE (New Starts Only)
- ARISTADA 662MG/2.4ML SYRINGE (New Starts Only)
- FANAPT 10MG TAB (New Starts Only)
- FANAPT 1MG TAB (New Starts Only)
- FANAPT 4MG TAB (New Starts Only)
- FANAPT 8MG TAB (New Starts Only)
- INVEGA 117MG/0.75ML SYRINGE (New Starts Only)
- INVEGA 234MG/1.5ML SYRINGE (New Starts Only)
- INVEGA 39MG/0.25ML SYRINGE (New Starts Only)
- INVEGA 546MG/1.75ML SYRINGE (New Starts Only)
- INVEGA 819MG/2.625ML SYRINGE (New Starts Only)
- LATUDA 20MG TAB (New Starts Only)
- LATUDA 60MG TAB (New Starts Only)
- *paliperidone 1.5mg er tab (New Starts Only)*
- *paliperidone 6mg er tab (New Starts Only)*
- REXULTI 0.25MG TAB (New Starts Only)
- REXULTI 1MG TAB (New Starts Only)
- REXULTI 3MG TAB (New Starts Only)
- RISPERDAL 12.5MG INJ (New Starts Only)
- RISPERDAL 37.5MG INJ (New Starts Only)
- SAPHRIS 10MG SL TAB (New Starts Only)
- ~~SAPHRIS 5MG SL TAB (New Starts Only)~~
- ~~VRAYLAR 1.5MG CAP (New Starts Only)~~
- ~~VRAYLAR 4.5MG CAP (New Starts Only)~~



<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed or was intolerant to 2 of the following for each indication: Bipolar Disorder: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. Schizophrenia: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone. Irritability with Autistic Disorder: aripiprazole, risperidone. Patient has tried and failed or was intolerant to 1 of the following for each indication: Bipolar Depression: olanzapine. Major Depressive Disorder: aripiprazole. Tourette Syndrome: aripiprazole. Acute Manic/Mixed Episodes with Bipolar Disorder: aripiprazole. No trials required for the following indications: Schizoaffective Disorder.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

- AUSTEDO 12MG TAB
- AUSTEDO 9MG TAB

- AUSTEDO 6MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has chorea due to Huntington's Disease. Patient has intolerance to or failure of therapy with tetrabenazine.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— BAXDELA 450MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— BELEODAQ 500MG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— BENLYSTA 200MG/ML AUTO-INJECTOR

— BENLYSTA 200MG/ML SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Member has active lupus nephritis OR severe active CNS lupus OR member is taking IV cyclophosphamide or other biologics.
Required Medical Info	For initial therapy: Member is required to be taking a concurrent corticosteroid unless contraindicated AND has trial and failure of two of the following: hydroxychloroquine, methotrexate, azathioprine OR mycophenolate. For continuation therapy: documentation of disease improvement is required.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For initial therapy: Diagnosis of active systemic lupus erythematosus is defined by anti-double stranded DNA value of greater than 30 IU/mL OR low complement (C3/C4). For continuation therapy: lab values not required.

## Products Affected

- BOSULIF 100MG TAB (New Starts Only)
- BOSULIF 500MG TAB (New Starts Only)

- BOSULIF 400MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- BRIVIACT 100MG TAB (New Starts Only)
- BRIVIACT 10MG/ML INJ (New Starts Only)
- BRIVIACT 25MG TAB (New Starts Only)
- BRIVIACT 75MG TAB (New Starts Only)
- BRIVIACT 10MG TAB (New Starts Only)
- BRIVIACT 10MG/ML ORAL SOLN (New Starts Only)
- BRIVIACT 50MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— *buprenorphine 2mg sl tab*

— *buprenorphine 8mg sl tab*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient is under prescriber supervision for the induction period for treatment of dependence to long-acting opioids or methadone.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

- CABOMETYX 20MG TAB (New Starts Only)
- CABOMETYX 60MG TAB (New Starts Only)

- CABOMETYX 40MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– CALQUENCE 100MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– CAPRELSA 100MG TAB (New Starts Only)

– CAPRELSA 300MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Endocrinologist or Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– CARBAGLU 200MG ORAL SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– CAYSTON 75MG INH SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– CESAMET 1MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

## Products Affected

– CHOLBAM 250MG CAP

– CHOLBAM 50MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hepatologist or Pediatric Gastroenterologist.
Coverage Duration	Initial will be 3 months, then if criteria is met approved for the rest of the plan year.
Other Criteria	Renewal requires documentation of stable or improved liver function.

## Products Affected

- BERINERT 500UNIT INJ
- FIRAZYR 30MG/3ML SYRINGE
- HAEGARDA 3000UNT INJ

- CINRYZE 500UNIT INJ
- HAEGARDA 2000UNT INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– COLCHICINE 0.6MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	If for gout, trial of Mitigare required. If for Familial Mediterranean fever, trial of Mitigare is not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- COMETRIQ 100MG DAILY DOSE CARTON PACK (New Starts Only)
- COMETRIQ 140MG DAILY DOSE CARTON PACK (New Starts Only)
- COMETRIQ 60MG DAILY DOSE CARTON PACK (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— CORLANOR 5MG TAB

— CORLANOR 7.5MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The patient is on a maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– COSENTYX 150MG/ML AUTO-INJECTOR

– COSENTYX 150MG/ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance to or failure of therapy with Humira
Age Restrictions	
Prescriber Restriction	For Psoriatic Arthritis or Ankylosing Spondylitis: Prescribed by, or in consultation with Rheumatology Specialist. For Plaque Psoriasis: Prescribed by, or in consultation with a Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— COTELLIC 20MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– CYRAMZA 100MG/10ML INJ (New Starts Only)

– CYRAMZA 500MG/50ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– CYSTAGON 150MG CAP

– CYSTAGON 50MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Endocrinologist, Medical Geneticist, or Metabolic Physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– CYSTARAN 0.44% OPHTH SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of corneal cystine crystal accumulation in patients with cystinosis.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Ophthalmologist or Medical Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– DARZALEX 100MG/5ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- *dronabinol 10mg cap*
- *dronabinol 5mg cap*

- *dronabinol 2.5mg cap*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of loss of appetite due to AIDS OR chemotherapy induced nausea and vomiting.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

## Products Affected

– DUPIXENT 300MG/2ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Intolerance to or failure of therapy with a medium to very high potency topical steroid AND a topical calcineurin inhibitor.
Age Restrictions	Member must be 18 years of age or older
Prescriber Restriction	Prescribed by, or in consultation with an Allergist, Immunologist, or Dermatologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Documentation of medium to severe atopic dermatitis, defined as SCORAD score of 20 or greater OR EASI score of 7.1 or greater

**Products Affected**

– EMPLICITI 300MG INJ (New Starts Only)

– EMPLICITI 400MG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- ENBREL 25MG INJ
- ENBREL 50MG/ML SURECLICK INJ
- ENBREL 25MG/0.5ML SYRINGE
- ENBREL 50MG/ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA or Psoriatic Arthritis requires Trial of or failure of therapy with methotrexate (at least 20mg/wk). Plaque Psoriasis: Trial of, or intolerance to, methotrexate at a dose of 15mg/week or trial of, or intolerance to, soriatane. Trial of or contraindication to NSAIDS for ankylosing spondylitis. For all indications, require documentation or attestation of negative TB test and history of tuberculosis.
Age Restrictions	
Prescriber Restriction	Rheumatoid Arthritis, Psoriatic Arthritis and Ankylosing Spondylitis: Prescriber must be a Rheumatologist. All Plaque Psoriasis: Prescriber must be a Dermatologist.
Coverage Duration	Approved for the duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- ENTRESTO 24-26MG TAB
- ENTRESTO 97-103MG TAB

- ENTRESTO 49-51MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— EPCLUSA 400-100MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments
Age Restrictions	Member must be 18 years of age or older
Prescriber Restriction	Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist
Coverage Duration	Coverage duration of 12 weeks.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. For genotypes 1 and 4 only, failure or intolerance to Zepatier is required.

## Products Affected

— ERIVEDGE 150MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

— ERLEADA 60MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— ERWINAZE 10000UNIT INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– EXONDYS 100MG/2ML INJ

– EXONDYS 500MG/10ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- FARYDAK 10MG CAP (New Starts Only)
- FARYDAK 20MG CAP (New Starts Only)

- FARYDAK 15MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— FERRIPROX 100MG/ML ORAL SOLN

— FERRIPROX 500MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— FIRMAGON 120MG INJ (New Starts Only)

— FIRMAGON 80MG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— FOLOTYN 40MG/2ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hematologist or Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- FYCOMPA 0.5MG/ML ORAL SUSP (New Starts Only)
- FYCOMPA 12MG TAB (New Starts Only)
- FYCOMPA 4MG TAB (New Starts Only)
- FYCOMPA 8MG TAB (New Starts Only)
- FYCOMPA 10MG TAB (New Starts Only)
- FYCOMPA 2MG TAB (New Starts Only)
- FYCOMPA 6MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– GARDASIL 9 INJ

– GARDASIL 9 SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	PA not required for members age 9-26.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– GATTEX 5MG INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of short bowel syndrome with less than 200cm of remnant functional intestine. Dependent on parenteral support for at least 12 months and at least 3 days per week.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- GILOTRIF 20MG TAB (New Starts Only)
- GILOTRIF 40MG TAB (New Starts Only)

- GILOTRIF 30MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- GENOTROPIN 0.2MG SYRINGE
- GENOTROPIN 0.6MG SYRINGE
- GENOTROPIN 1.2MG SYRINGE
- GENOTROPIN 1.6MG SYRINGE
- GENOTROPIN 12MG CARTRIDGE
- GENOTROPIN 2MG SYRINGE
- NORDITROPIN 10MG/1.5ML PEN INJ
- NORDITROPIN 30MG/3ML PEN INJ
- GENOTROPIN 0.4MG SYRINGE
- GENOTROPIN 0.8MG SYRINGE
- GENOTROPIN 1.4MG SYRINGE
- GENOTROPIN 1.8MG SYRINGE
- GENOTROPIN 1MG SYRINGE
- GENOTROPIN 5MG CARTRIDGE
- NORDITROPIN 15MG/1.5ML PEN INJ
- NORDITROPIN 5MG/1.5ML PEN INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	The criteria for approval of growth hormones in adults require the diagnosis of Somatropin Deficiency Syndrome (defined by failure to stimulate Growth Hormone secretion (peak GH level of 10mcg/L or less) by one of the acceptable provocative tests). This may include adults who as children had Growth Hormone deficiency or adults with known pituitary disease.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– HETLIOZ 20MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient is totally blind.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- JUXTAPID 10MG CAP
- JUXTAPID 30MG CAP
- JUXTAPID 5MG CAP
- KYNAMRO 200MG/ML SYRINGE
- JUXTAPID 20MG CAP
- JUXTAPID 40MG CAP
- JUXTAPID 60MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Untreated LDL greater than 500 mg/dL OR treated LDL greater than or equal to 300 mg/dL. Concurrent use of maximum statin dose (atorvastatin or rosuvastatin) and one other lipid lowering agent (include dates and reasons for discontinuation). For patients with statin intolerance, concurrent use of maximum statin dose not required. Chart documentation showing the most recent full lipid panel, including Apo-B within the past 12 months.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Lipidologist, Cardiologist, or an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- HUMIRA 10MG/0.1ML SYRINGE
- HUMIRA 20MG/0.2ML SYRINGE
- HUMIRA 40MG/0.4ML AUTO-INJECTOR
- HUMIRA 40MG/0.8ML AUTO-INJECTOR
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (3) 40MG/0.8ML I
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (6) 40MG/0.8ML I
- HUMIRA PEN - CROHN'S STARTER PACK 40MG/0.8ML INJ
- HUMIRA 10MG/0.2ML SYRINGE
- HUMIRA 20MG/0.4ML SYRINGE
- HUMIRA 40MG/0.4ML SYRINGE
- HUMIRA 40MG/0.8ML SYRINGE
- HUMIRA PEDIATRIC CROHN'S STARTER PACK (3) 80MG/0.8ML I
- HUMIRA PEDIATRIC CROHN'S STARTER PACK SYRINGE (2) 40M
- HUMIRA PEN - PSORIASIS STARTER PACK 40MG/0.8ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA or Psoriatic Arthritis requires intolerance to or failure of therapy with methotrexate (at least 20mg/wk). Plaque Psoriasis: Failure of, or intolerance to, methotrexate at a dose of 15mg/week or failure of, or intolerance to, soriatane. If for Hidradenitis Suppurativa (HS), patient must have at least 3 cysts. Trial of or contraindication to NSAIDS for ankylosing spondylitis. For all indications, require documentation or attestation of negative TB test and history of tuberculosis.
Age Restrictions	
Prescriber Restriction	Rheumatoid Arthritis, Psoriatic Arthritis and Ankylosing Spondylitis: Prescriber must be a Rheumatologist. All Plaque Psoriasis and Hidradenitis Suppurativa (HS): Prescriber must be a Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– HYDROXYPROGESTERONE CAPROATE 250MG/ML INJ (New Start)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

- IBRANCE 100MG CAP (New Starts Only)
- IBRANCE 75MG CAP (New Starts Only)

- IBRANCE 125MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– ICLUSIG 15MG TAB (New Starts Only)

– ICLUSIG 45MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– IDHIFA 100MG TAB (New Starts Only)

– IDHIFA 50MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Documentation of IDH2 mutation as detected by an FDA approved test
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– ILARIS 150MG/ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— *imatinib 100mg tab (New Starts Only)*

— *imatinib 400mg tab (New Starts Only)*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

- IMBRUVICA 140MG CAP (New Starts Only)
- IMBRUVICA 280MG TAB (New Starts Only)
- IMBRUVICA 560MG TAB (New Starts Only)

- IMBRUVICA 140MG TAB (New Starts Only)
- IMBRUVICA 420MG TAB (New Starts Only)
- IMBRUVICA 70MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– IMFINZI 120MG/2.4ML INJ (New Starts Only)

– IMFINZI 500MG/10ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– INCRELEX 40MG/4ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the long-term treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



**Products Affected**

– INLYTA 1MG TAB (New Starts Only)

– INLYTA 5MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- ESBRIET 267MG CAP
- ESBRIET 801MG TAB
- OFEV 150MG CAP

- ESBRIET 267MG TAB
- OFEV 100MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Definitive diagnosis of idiopathic pulmonary fibrosis defined by the following: No known cause of lung fibrosis AND one of the following: A. Surgical lung biopsy revealing histopathological pattern of unspecified interstitial pneumonia (UIP) B. High-resolution computed tomography indicates definite UIP pattern C. High-resolution computed tomography indicates possible UIP pattern AND surgical lung biopsy reveals a histopathological pattern of probable UIP.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Will not be used in combination with other medications used to treat IPF.

## Products Affected

— IRESSA 250MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– ISTODAX 10MG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hematologist or an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– itraconazole 100mg cap

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For onychomycosis or diffuse dermatologic fungal infections: 1. If not prescribed by a Dermatologist or Podiatrist OR fungal infection is confirmed by a positive KOH test. 2. For onychomycosis, must fail terbinafine. For dermatologic infections, must fail one topical anti-fungal medication.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist, Pulmonary Specialist, or Dermatology Specialist.
Coverage Duration	Approved for 6 months.
Other Criteria	

## Products Affected

- BIVIGAM 10% INJ
- FLEBOGAMMA 10% INJ
- GAMASTAN 360UNIT/2ML INJ
- GAMMAGARD 2.5GM/25ML INJ
- GAMMAKED 1GM/10ML INJ
- GAMMAPLEX 10GM/200ML INJ
- GAMMAPLEX 5GM/50ML INJ
- OCTAGAM 25GM/500ML INJ
- PRIVIGEN 20GM/200ML INJ
- CARIMUNE 6GM INJ
- GAMASTAN 1800UNIT/10ML INJ
- GAMMAGARD 10GM INJ
- GAMMAGARD 5GM INJ
- GAMMAPLEX 10GM/100ML INJ
- GAMMAPLEX 20GM/200ML INJ
- GAMUNEX 1GM/10ML INJ
- OCTAGAM 2GM/20ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

## Products Affected

- JAKAFI 10MG TAB (New Starts Only)
- JAKAFI 20MG TAB (New Starts Only)
- JAKAFI 5MG TAB (New Starts Only)

- JAKAFI 15MG TAB (New Starts Only)
- JAKAFI 25MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hematologist or an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- JYNARQUE 45/15 THERAPY PACK
- JYNARQUE 90/30 THERAPY PACK

- JYNARQUE 60/30 THERAPY PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member has an eGFR of 25 ml/min/1.73m <sup>2</sup> or greater.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Nephrologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– KADCYLA 100MG INJ (New Starts Only)

– KADCYLA 160MG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- KALYDECO 150MG TAB
- KALYDECO 75MG GRANULES PACKET

- KALYDECO 50MG GRANULES PACKET

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– KEYTRUDA 100MG/4ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– KORLYM 300MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- KUVAN 100MG POWDER FOR ORAL SOLN
- KUVAN 500MG POWDER FOR ORAL SOLN

- KUVAN 100MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For continuing therapy the patient must have shown a 20% drop in Phenylalanine levels after 2 months of Kuvan treatment.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Medical Geneticist or Metabolic Physician.
Coverage Duration	Initial approval of 3 months, then if criteria is met, approved for the rest of the contract year.
Other Criteria	

**Products Affected**

– KYPROLIS 30MG INJ (New Starts Only)

– KYPROLIS 60MG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– LARTRUVO 10MG/ML INJ (New Starts Only)

– LARTRUVO 190MG/19ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- LENVIMA (8) 4MG PACK (New Starts Only)
- LENVIMA 14 PACK (New Starts Only)
- LENVIMA 20 10MG PACK (New Starts Only)
- LENVIMA 10 10MG PACK (New Starts Only)
- LENVIMA 18 PACK (New Starts Only)
- LENVIMA 24 PACK (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– LETAIRIS 10MG TAB

– LETAIRIS 5MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Cardiologist or Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– LEUKINE 250MCG INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial of or intolerance to filgrastim-sndz (Zarxio) AND tbo-filgrastim (Granix).
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— *lidocaine 5% patch*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Management of neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia.
Exclusion Criteria	
Required Medical Info	Trial and failure of gabapentin of four weeks or more.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

- LINZESS 145MCG CAP
- LINZESS 72MCG CAP

- LINZESS 290MCG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Trial and failure of polyethylene glycol (Miralax/Glycolax)
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– LONSURF 15-6.14MG TAB (New Starts Only)

– LONSURF 20-8.19MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- LYNPARZA 100MG CAP (New Starts Only)
- LYNPARZA 50MG CAP (New Starts Only)

- LYNPARZA 150MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– MAVYRET 100-40MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease Physician or Transplant Physician.
Coverage Duration	Coverage duration of 8 to 16 weeks. Applied consistent with current AASLD-IDSA guidance.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

## Products Affected

— *megestrol acetate 125mg/ml oral susp*

— *megestrol acetate 40mg/ml oral susp*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

— *megestrol acetate 20mg tab (New Starts Only)*

— *megestrol acetate 40mg tab (New Starts Only)*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– MEKINIST 0.5MG TAB (New Starts Only)

– MEKINIST 2MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— MOVANTIK 12.5MG TAB

— MOVANTIK 25MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Initial Therapy: Member must meet all criteria. 1. Opioid-induced constipation. 2. Trial and failure of polyethylene glycol (Miralax/Glycolax)
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– MULTAQ 400MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— MYLOTARG 4.5MG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- *acetylcysteine 10% inh soln*
- *acyclovir 50mg/ml inj*
- *adrucil 500mg/10ml inj*
- *albuterol 0.417mg/ml (1.25mg/3ml) inh soln*
- *albuterol 1mg/ml (0.5%) inh soln*
- *aminosyn 8.5% with electrolytes, sulfite-free inj*
- *aminosyn ii 8.5% with electrolytes, sulfite-free inj*
- AMINOSYN-HBC 7%, SULFITE-FREE INJ
- AMINOSYN-PF 7% INJ
- AMPHOTERICIN B 50MG INJ
- *aprepitant 125mg/80mg pack*
- *aprepitant 80mg cap*
- ARANESP 100MCG/ML INJ
- ARANESP 150MCG/0.3ML SYRINGE
- ARANESP 200MCG/ML INJ
- ARANESP 25MCG/ML INJ
- ARANESP 300MCG/ML INJ
- ARANESP 40MCG/ML INJ
- ARANESP 60MCG/0.3ML SYRINGE
- ARGATROBAN 1MG/ML INJ
- ASTAGRAF 1MG XL CAP
- ATGAM 50MG/ML INJ
- AZASAN 75MG TAB
- *azathioprine 50mg tab*
- *budesonide 0.125mg/ml inh soln*
- *budesonide 0.5mg/ml inh soln*
- *calcitriol 0.0005mg cap*
- *calcitriol 0.001mg/ml oral soln*
- CLINIMIX 4.25/10 INJ
- *acetylcysteine 20% inh soln*
- *adriamycin 2mg/ml inj*
- *albuterol 0.21mg/ml (0.63mg/3ml) inh soln*
- *albuterol 0.83mg/ml (0.083%) inh soln*
- AMINOSYN 7% WITH ELECTROLYTES, SULFITE-FREE INJ
- AMINOSYN II 10% INJ
- AMINOSYN II 8.5%, SULFITE-FREE INJ
- AMINOSYN-PF 10%, SULFITE-FREE INJ
- AMINOSYN-RF 5.2%, SULFITE-FREE INJ
- *aprepitant 125mg cap*
- *aprepitant 40mg cap*
- ARANESP 100MCG/0.5ML SYRINGE
- ARANESP 10MCG/0.4ML SYRINGE
- ARANESP 200MCG/0.4ML SYRINGE
- ARANESP 25MCG/0.42ML SYRINGE
- ARANESP 300MCG/0.6ML SYRINGE
- ARANESP 40MCG/0.4ML SYRINGE
- ARANESP 500MCG/ML SYRINGE
- ARANESP 60MCG/ML INJ
- ASTAGRAF 0.5MG XL CAP
- ASTAGRAF 5MG XL CAP
- AZASAN 100MG TAB
- AZATHIOPRINE 10MG/ML INJ
- *bleomycin 15unit/ml inj*
- *budesonide 0.25mg/ml inh soln*
- *calcitriol 0.00025mg cap*
- *calcitriol 0.001mg/ml inj*
- *cladribine 1mg/ml inj*
- CLINIMIX 4.25/20 INJ

- CLINIMIX 4.25/25 INJ
- CLINIMIX 5/15 INJ
- CLINIMIX 5/25 INJ
- CLINIMIX E 2.75/5 INJ
- CLINIMIX E 4.25/25 INJ
- CLINIMIX E 5/15 INJ
- CLINIMIX E 5/25 INJ
- CROMOLYN SODIUM 10MG/ML INH SOLN
- CYCLOPHOSPHAMIDE 50MG CAP
- *cyclosporine 25mg cap*
- *cyclosporine, modified 100mg cap*
- *cyclosporine, modified 25mg cap*
- CYTARABINE 20MG/ML INJ
- *doxercalciferol 0.0005mg cap*
- *doxercalciferol 0.0025mg cap*
- *doxorubicin hydrochloride 2mg/ml inj*
- *duramorph 1mg/ml inj*
- ENGERIX-B 20MCG/ML SYRINGE
- ENVARUSUS 1MG ER TAB
- EPOGEN 10000UNIT/ML INJ
- EPOGEN 2000UNIT/ML INJ
- EPOGEN 4000UNIT/ML INJ
- FREAMINE 6.9% INJ
- *gengraf 100mg cap*
- *gengraf 25mg cap*
- *heparin sodium, porcine 10000unit/ml inj*
- HEPARIN SODIUM, PORCINE 100UNIT/ML INJ
- *heparin sodium, porcine 40unit/ml inj*
- *heparin sodium, porcine 50unit/ml inj*
- HYPERRAB 150UNIT/ML (10ML) INJ

- CLINIMIX 4.25/5 INJ
- CLINIMIX 5/20 INJ
- CLINIMIX E 2.75/10 INJ
- CLINIMIX E 4.25/10 INJ
- CLINIMIX E 4.25/5 INJ
- CLINIMIX E 5/20 INJ
- *clinisol 15% inj*
- CYCLOPHOSPHAMIDE 25MG CAP
- *cyclosporine 100mg cap*
- *cyclosporine 50mg/ml inj*
- *cyclosporine, modified 100mg/ml oral soln*
- *cytarabine 100mg/ml inj*
- DIPHTHERIA/TETANUS TOXOID INJ
- *doxercalciferol 0.001mg cap*
- *doxercalciferol 0.002mg/ml inj*
- *duramorph 0.5mg/ml inj*
- ENGERIX-B 10MCG/0.5ML SYRINGE
- ENVARUSUS 0.75MG ER TAB
- ENVARUSUS 4MG ER TAB
- EPOGEN 20000UNIT/ML INJ
- EPOGEN 3000UNIT/ML INJ
- *fluorouracil 50mg/ml inj*
- *ganciclovir 500mg inj*
- *gengraf 100mg/ml oral soln*
- *granisetron 1mg tab*
- *heparin sodium, porcine 1000unit/ml inj*
- *heparin sodium, porcine 20000unit/ml inj*
- *heparin sodium, porcine 5000unit/ml inj*
- HEPATAMINE 8% INJ
- HYPERRAB 150UNIT/ML (2ML) INJ

- *ibandronate 1mg/ml inj*
- IMOVAX 2.5UNIT/ML INJ
- *ipratropium bromide 0.02% inh soln*
- *levalbuterol 0.31mg inh soln*
- *levalbuterol 1.25mg inh soln*
- *levocarnitine 100mg/ml oral soln*
- *methylprednisolone 125mg inj*
- *methylprednisolone 62.5mg/ml inj*
- *mycophenolate mofetil 200mg/ml oral susp*
- *mycophenolate mofetil 500mg inj*
- *mycophenolic acid 180mg dr tab*
- NEBUPENT 300MG INH SOLN
- NULOJIX 250MG INJ
- *ondansetron 0.8mg/ml oral soln*
- *ondansetron 4mg odt*
- *ondansetron 8mg odt*
- *pamidronate disodium 3mg/ml inj*
- *pamidronate disodium 9mg/ml inj*
- *paricalcitol 0.002mg cap*
- *paricalcitol 0.004mg cap*
- *plenamine 15% inj*
- *premasol 6% inj*
- PROCROT 10000UNIT/ML INJ
- PROCROT 2000UNIT/ML INJ
- PROCROT 40000UNIT/ML INJ
- PROGRAF 5MG/ML INJ
- PULMOZYME 1MG/ML INH SOLN
- RAPAMUNE 1MG/ML ORAL SOLN
- RECOMBIVAX 40MCG/ML INJ
- RECOMBIVAX HB 10MCG/ML INJ
- IMOGAM 150UNIT/ML (2ML) INJ
- *intralipid 200mg/ml inj*
- *ipratropium/albuterol 0.5-2.5mg/3ml inh soln*
- *levalbuterol 0.63mg inh soln*
- *levalbuterol 2.5mg inh soln*
- *levocarnitine 330mg tab*
- *methylprednisolone 40mg/ml inj*
- MIACALCIN 200UNIT/ML INJ
- *mycophenolate mofetil 250mg cap*
- *mycophenolate mofetil 500mg tab*
- *mycophenolic acid 360mg dr tab*
- NEPHRAMINE 5.4% INJ
- *nutrilipid 20% iv soln*
- *ondansetron 24mg tab*
- *ondansetron 4mg tab*
- *ondansetron 8mg tab*
- PAMIDRONATE DISODIUM 6MG/ML INJ
- *paricalcitol 0.001mg cap*
- *paricalcitol 0.002mg/ml inj*
- *paricalcitol 0.005mg/ml inj*
- PREMASOL 10% INJ
- PROCALAMINE 3% INJ
- PROCROT 20000UNIT/ML INJ
- PROCROT 3000UNIT/ML INJ
- PROCROT 4000UNIT/ML INJ
- PROSOL 20% INJ
- RABAVERT 2.5UNIT/ML INJ
- RECOMBIVAX 10MCG/ML SYRINGE
- RECOMBIVAX 5MCG/0.5ML SYRINGE
- REMODULIN 10MG/ML INJ



- REMODULIN 1MG/ML INJ
- REMODULIN 5MG/ML INJ
- SENSIPAR 30MG TAB
- SENSIPAR 90MG TAB
- *sirolimus 1mg tab*
- *tacrolimus 0.5mg cap*
- *tacrolimus 5mg cap*
- TETANUS/DIPHThERIA TOXOID INJ
- TRAVASOL 10% INJ
- VARUBI 90MG TAB
- *vincasar 1mg/ml inj*
- ZORTRESS 0.25MG TAB
- ZORTRESS 0.75MG TAB

- REMODULIN 2.5MG/ML INJ
- SANDIMMUNE 100MG/ML ORAL SOLN
- SENSIPAR 60MG TAB
- *sirolimus 0.5mg tab*
- *sirolimus 2mg tab*
- *tacrolimus 1mg cap*
- TENIVAC SYRINGE
- THYMOGLOBULIN 25MG INJ
- TROPHAMINE 10% INJ
- VINBLASTINE 1MG/ML INJ
- *vincristine sulfate 1mg/ml inj*
- ZORTRESS 0.5MG TAB

PA Criteria	Criteria Details
Covered Uses	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.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	
Other Criteria	

**Products Affected**

- NATPARA 100MCG CARTRIDGE
- NATPARA 50MCG CARTRIDGE

- NATPARA 25MCG CARTRIDGE
- NATPARA 75MCG CARTRIDGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— NERLYNX 40MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— NEXAVAR 200MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- NINLARO 2.3MG CAP (New Starts Only)
- NINLARO 4MG CAP (New Starts Only)

- NINLARO 3MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- NORTHERA 100MG CAP
- NORTHERA 300MG CAP

- NORTHERA 200MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— NOXAFIL 100MG DR TAB

— NOXAFIL 40MG/ML ORAL SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– NUCALA 100MG INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Peripheral blood eosinophil count of greater than or equal to 150 cells per microliter. History of 2 or more exacerbations in the previous year despite regular use of high-dose inhaled corticosteroids plus an additional controller(s). An exception is made for patients with intolerance or contraindication to high-dose inhaled corticosteroids and additional controller(s).
Age Restrictions	Member must be 12 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with an Allergy Specialist, Immunologist, or Pulmonary Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– NUPLAZID 17MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

- *armodafinil 150mg tab*
- *armodafinil 250mg tab*
- *modafinil 100mg tab*

- *armodafinil 200mg tab*
- *armodafinil 50mg tab*
- *modafinil 200mg tab*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis of narcolepsy, OR obstructive sleep apnea/hypopnea syndrome, OR shift work sleep disorder.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– OCALIVA 10MG TAB

– OCALIVA 5MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Hepatologist or Gastroenterologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For use in treatment of primary biliary cholangitis, patient has had an inadequate response to a year of therapy with ursodiol or experienced intolerance to ursodiol.

## Products Affected

— ODOMZO 200MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- ONFI 10MG TAB (New Starts Only)
- ONFI 20MG TAB (New Starts Only)

- ONFI 2.5MG/ML ORAL SUSP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— OPDIVO 100MG/10ML INJ (New Starts Only)

— OPDIVO 40MG/4ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– OPSUMIT 10MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Cardiologist or Pulmonologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- *fentanyl 0.2mg lozenge*
- *fentanyl 0.6mg lozenge*
- *fentanyl 1.2mg lozenge*
- FENTORA 100MCG BUCCAL TAB
- FENTORA 400MCG BUCCAL TAB
- FENTORA 800MCG BUCCAL TAB
- *fentanyl 0.4mg lozenge*
- *fentanyl 0.8mg lozenge*
- *fentanyl 1.6mg lozenge*
- FENTORA 200MCG BUCCAL TAB
- FENTORA 600MCG BUCCAL TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Breakthrough cancer pain and opioid tolerance. Documented tolerance to opioids defined as patients taking around the clock medicine consisting of at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl per hour, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

- ORENCIA 125MG/ML AUTO-INJECTOR
- ORENCIA 250MG INJ
- ORENCIA 87.5MG/0.7ML SYRINGE

- ORENCIA 125MG/ML SYRINGE
- ORENCIA 50MG/0.4ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA intolerance to or failure of therapy with Enbrel OR Humira. For Polyarticular Juvenile Idiopathic Arthritis intolerance to or failure of therapy with Enbrel.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

- ORFADIN 10MG CAP
- ORFADIN 2MG CAP
- ORFADIN 5MG CAP

- ORFADIN 20MG CAP
- ORFADIN 4MG/ML ORAL SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— ORKAMBI 100-125MG TAB

— ORKAMBI 200-125MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Lung function (FEV1, ppFEV1), 2) BMI, 3) Pulmonary exacerbation history to be collected initially and at continuation.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist.
Coverage Duration	Initial and continuation approval of 6 months to assess required medical info.
Other Criteria	

## Products Affected

- PRALUENT 150MG/ML AUTO-INJECTOR
- REPATHA 120MG/ML CARTRIDGE
- REPATHA 140MG/ML SYRINGE

- PRALUENT 75MG/ML AUTO-INJECTOR
- REPATHA 140MG/ML AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For initiation of therapy patient must: A) have one of the following conditions: 1) prior clinical atherosclerotic cardiovascular disease (ASCVD) (see Other Criteria), 2) heterozygous familial hypercholesterolemia (HeFH) (see Other Criteria), or 3) homozygous familial hypercholesterolemia (HoFH) (see Other Criteria), AND B) for patients with prior clinical ASCVD or HeFH, current LDL-C level is over 100 mg/dL or over 70 mg/dL with diabetes, AND one of the following requirements is met: 1) patient has been treated for 8 weeks or more with a high intensity statin (atorvastatin 40mg or greater OR rosuvastatin 20mg or greater), OR 2) patient is intolerant to statins demonstrated by the failure of 2 statins, including an attempt with a low- or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin). For continuation of therapy, patient must: A) have one of the following conditions: 1) prior clinical ASCVD (see Other Criteria), 2) HeFH (see Other Criteria), or 3) HoFH (see Other Criteria), AND B) demonstrate a reduction of LDL-C on PCSK9 inhibitor therapy.
Age Restrictions	
Prescriber Restriction	Prescribed by or in consultation with a Cardiologist, Lipidologist, or Endocrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Clinical ASCVD defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure, prior stroke or transient ischemic attack, or peripheral arterial disease of presumed atherosclerotic origin. Diagnosis of HeFH must be confirmed by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo B, OR PCSK9 gain of function mutation, 2) Untreated LDL-C greater than 190 mg/dl AND tendon xanthomas in patient or first/second degree relative, 3) Untreated LDL-C greater than 190 mg/dl AND either first degree relative less than 60 years of age or second degree relative less than 50 years of age with premature heart disease, OR 4) untreated LDL-C greater than 190 mg/dl AND first or second degree relative with total cholesterol greater than 290 mg/dL. Diagnosis of HoFH confirmed by the following: 1) two parents diagnosed with HeFH OR genetic confirmation of LDL receptor mutation, AND 2) untreated total cholesterol greater 290 mg/dL or LDL-C greater 190 mg/dL, AND 3) either

xanthomas present at 10 years of age or younger OR atherosclerotic disease at 20 years of age or younger.

## Products Affected

— PERJETA 420MG/14ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- POMALYST 1MG CAP (New Starts Only)
- POMALYST 3MG CAP (New Starts Only)

- POMALYST 2MG CAP (New Starts Only)
- POMALYST 4MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— CRINONE 4% VAGINAL GEL

— CRINONE 8% VAGINAL GEL

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



**Products Affected**

- PROMACTA 12.5MG TAB
- PROMACTA 50MG TAB

- PROMACTA 25MG TAB
- PROMACTA 75MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– QBRELIS 1MG/ML ORAL SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Approval requires attestation of patient's inability to swallow solid dosage forms of lisinopril.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– RAVICTI 1.1GM/ML ORAL SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial of sodium phenylbutyrate powder.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Metabolic Physician or Medical Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- RELISTOR 12MG/0.6ML INJ
- RELISTOR 8MG/0.4ML SYRINGE

- RELISTOR 12MG/0.6ML SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For the treatment of opioid-induced constipation (OIC) in adults with advanced illness who are receiving palliative care when response to laxative therapy has not been sufficient, member must have tried and failed 2 laxative/bowel therapies – polyethylene glycol + lactulose. For the treatment of OIC in adults with chronic non-cancer pain, member must have tried and failed Movantik.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for 4 months, subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— *sildenafil 20mg tab*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- KISQALI/FEMARA TAB CO-PACK 400MG (New Starts Only)
- REVLIMID 15MG CAP (New Starts Only)
- REVLIMID 20MG CAP (New Starts Only)
- REVLIMID 5MG CAP (New Starts Only)
- REVLIMID 10MG CAP (New Starts Only)
- REVLIMID 2.5MG CAP (New Starts Only)
- REVLIMID 25MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- KISQALI 200MG DAILY DOSE PACK (New Starts Only)
- KISQALI 600MG DAILY DOSE PACK (New Starts Only)
- KISQALI/FEMARA TAB CO-PACK 600MG (New Starts Only)
- KISQALI 400MG DAILY DOSE PACK (New Starts Only)
- KISQALI/FEMARA TAB CO-PACK 200MG (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– RITUXAN 100MG/10ML INJ (New Starts Only)

– RITUXAN 500MG/50ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For RA only: intolerance to or failure of therapy with Enbrel AND Humira.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

— ROZEREM 8MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For approval, a prior use of zolpidem is required OR patient has had history of scheduled drug dependence.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

- RUBRACA 200MG TAB (New Starts Only)
- RUBRACA 300MG TAB (New Starts Only)

- RUBRACA 250MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– RUCONEST 2100UNIT INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— RYDAPT 25MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— SABRIL 500MG TAB (New Starts Only)

— vigabatrin 50mg/ml oral soln (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– SHINGRIX INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	PA not required for members 50 and older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- SIGNIFOR 0.3MG/ML INJ
- SIGNIFOR 0.9MG/ML INJ

- SIGNIFOR 0.6MG/ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Prescribed for the treatment of an adult patient with Cushing disease AND Pituitary surgery is not an option OR Pituitary surgery was not curative.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– SIMPONI ARIA 50MG/4ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For moderate to severe RA, intolerance to or failure of therapy with Enbrel AND Humira.
Age Restrictions	
Prescriber Restriction	Prescribed by a Rheumatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– SIRTURO 100MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– SIVEXTRO 200MG INJ

– SIVEXTRO 200MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– *diclofenac sodium 3% gel (New Starts Only)*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– SOLTAMOX 10MG/5ML ORAL SOLN (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

- SOMAVERT 10MG INJ
- SOMAVERT 15MG INJ
- SOMAVERT 20MG INJ
- SOMAVERT 25MG INJ
- SOMAVERT 30MG INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- SPRITAM 1000MG ODT (New Starts Only)
- SPRITAM 500MG ODT (New Starts Only)

- SPRITAM 250MG ODT (New Starts Only)
- SPRITAM 750MG ODT (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member must have a trial or contraindication to generic levetiracetam.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- SPRYCEL 100MG TAB (New Starts Only)
- SPRYCEL 20MG TAB (New Starts Only)
- SPRYCEL 70MG TAB (New Starts Only)
- SPRYCEL 140MG TAB (New Starts Only)
- SPRYCEL 50MG TAB (New Starts Only)
- SPRYCEL 80MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– STIVARGA 40MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



**Products Affected**

– STRENSIQ 40MG/ML INJ

– STRENSIQ 80MG/0.8ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Endocrinologist, Pediatric Endocrinologist, Metabolic Physician, or Medical Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– SUCRAID 8500UNIT/ML ORAL SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- SUTENT 12.5MG CAP (New Starts Only)
- SUTENT 37.5MG CAP (New Starts Only)

- SUTENT 25MG CAP (New Starts Only)
- SUTENT 50MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

- SYLATRON 200MCG INJ (New Starts Only)
- SYLATRON 600MCG INJ (New Starts Only)

- SYLATRON 300MCG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– SYMPROIC 0.2MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Initial Therapy: Member must meet all criteria. 1) Opioid-induced constipation. 2) Trial and failure of polyethylene glycol (Miralax/Glycolax).
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– SYNAGIS 100MG/1ML INJ

– SYNAGIS 50MG/0.5ML INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Approve up to five (MAXIMUM) monthly doses of Synagis when an infant or child meets the criteria for one of the following conditions: Infants and children younger than 24 months with chronic lung disease of prematurity (CLD previously known as bronchopulmonary dysplasia) receiving medical therapy within 6 months before the start of the RSV season OR Infants born before 32 weeks of gestation even if they do not have CLD OR Infants born at 32 to less than 35 weeks of gestation, particularly when at least 1 of the following 2 risk factors is present: the infant attends child care, or 1 or more siblings or other children younger than 5 years live permanently in the same household OR Infants with congenital abnormalities of the airway or neuromuscular disease OR Infants and children 24 months or younger with hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an ICU Physician, Neonatologist, Pediatrician, Pulmonologist, Cardiologist, Infectious Disease Physician or Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— SYPRINE 250MG CAP

— *trientine 250mg tab*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– TAFINLAR 50MG CAP (New Starts Only)

– TAFINLAR 75MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



**Products Affected**

– TAGRISSO 40MG TAB (New Starts Only)

– TAGRISSO 80MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- TARCEVA 100MG TAB (New Starts Only)
- TARCEVA 25MG TAB (New Starts Only)

- TARCEVA 150MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— *bexarotene 75mg cap (New Starts Only)*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- TASIGNA 150MG CAP (New Starts Only)
- TASIGNA 50MG CAP (New Starts Only)

- TASIGNA 200MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– TECENTRIQ 60MG/ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

— *tetrabenazine 12.5mg tab*

— *tetrabenazine 25mg tab*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has chorea due to Huntington's Disease.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- THALOMID 100MG CAP (New Starts Only)
- THALOMID 200MG CAP (New Starts Only)

- THALOMID 150MG CAP (New Starts Only)
- THALOMID 50MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— trimethobenzamide 300mg cap

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



**Products Affected**

– TOBI PODHALER KIT 28MG PACK

– *tobramycin 60mg/ml inh soln*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Physician or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.

## Products Affected

- AMCINONIDE 0.1% CREAM
- *betamethasone valerate 0.12% foam*
- *clobetasol propionate 0.05% foam*
- *clobetasol propionate 0.05% lotion*
- *clobetasol propionate 0.05% shampoo*
- *clobetasol propionate 0.05% topical soln*
- *desonide 0.05% cream*
- DIFLORASONE DIACETATE 0.05% CREAM
- *fluticasone propionate 0.05% lotion*
- AMCINONIDE 0.1% OINTMENT
- *clobetasol propionate 0.05% cream*
- *clobetasol propionate 0.05% gel*
- *clobetasol propionate 0.05% ointment*
- *clobetasol propionate 0.05% spray*
- *clodan 0.05% shampoo*
- *desonide 0.05% lotion*
- DIFLORASONE DIACETATE 0.05% OINTMENT
- PSORCON 0.05% CREAM

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Requires trial of two formulary topical steroids
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- TRACLEER 125MG TAB
- TRACLEER 62.5MG TAB

- TRACLEER 32MG TAB FOR ORAL SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– TREANDA 100MG INJ (New Starts Only)

– TREANDA 25MG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- QUDEXY 100MG XR CAP (New Starts Only)
- QUDEXY 200MG XR CAP (New Starts Only)
- QUDEXY 50MG XR CAP (New Starts Only)
- TOPIRAMATE 150MG ER CAP (New Starts Only)
- TOPIRAMATE 25MG ER CAP (New Starts Only)
- TROKENDI 100MG XR CAP (New Starts Only)
- TROKENDI 25MG XR CAP (New Starts Only)
- QUDEXY 150MG XR CAP (New Starts Only)
- QUDEXY 25MG XR CAP (New Starts Only)
- TOPIRAMATE 100MG ER CAP (New Starts Only)
- TOPIRAMATE 200MG ER CAP (New Starts Only)
- TOPIRAMATE 50MG ER CAP (New Starts Only)
- TROKENDI 200MG XR CAP (New Starts Only)
- TROKENDI 50MG XR CAP (New Starts Only)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has tried and failed topiramate (TOPAMAX) AND Patient has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome OR is using for prophylaxis of migraine headache.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– TYKERB 250MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Tykerb is prescribed in combination with capecitabine (Xeloda) AND The patient has advanced or metastatic breast cancer with tumor over-expression of HER2 AND The patient has received prior therapy including an anthracycline and a taxane and trastumab. Tykerb is prescribed in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– TYSABRI 300MG/15ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For use in Multiple Sclerosis (MS), patient has a relapsing form of MS.
Age Restrictions	
Prescriber Restriction	If for MS: Prescribed by, or in consultation with a Neurologist or a Multiple Sclerosis (MS) Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For use in MS, patient has a relapsing form of MS and patient has tried dimethyl fumarate (Tecfidera) AND one of the following: beta-1a (Avonex), peginterferon beta-1a (Plegridy), or glatiramer (Copaxone). Exceptions to having tried an interferon product or glatiramer acetate (Copaxone) can be made if the patient is unable to administer injections due to dexterity issues or visual impairment.

**Products Affected**

- *budesonide 9mg ER tab*
- UCERIS 9MG ER TAB

– UCERIS 2MG/ACT FOAM

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has active mild to moderate ulcerative colitis and has tried and failed or was intolerant to mesalamine.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

- UPTRAVI 1000MCG TAB
- UPTRAVI 1400MCG TAB
- UPTRAVI 200MCG TAB
- UPTRAVI 600MCG TAB
- UPTRAVI TITRATION PACK
- UPTRAVI 1200MCG TAB
- UPTRAVI 1600MCG TAB
- UPTRAVI 400MCG TAB
- UPTRAVI 800MCG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– VALCHLOR 0.016% GEL (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has received prior skin-directed therapy such as topical steroids.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– VASCEPA 1GM CAP

– VASCEPA 500MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Patient has triglyceride level greater than or equal to 500 mg/dl.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- VELTASSA 16.8GM POWDER FOR ORAL SUSP
- VELTASSA 8.4GM POWDER FOR ORAL SUSP

- VELTASSA 25.2GM POWDER FOR ORAL SUSP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- VENCLEXTA 10/100/50MG STARTING PACK (New Starts Only)
- VENCLEXTA 10MG TAB (New Starts Only)
- VENCLEXTA 100MG TAB (New Starts Only)
- VENCLEXTA 50MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– VENTAVIS 10MCG/ML INH SOLN

– VENTAVIS 20MCG/ML INH SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- VERZENIO 100MG TAB (New Starts Only)
- VERZENIO 200MG TAB (New Starts Only)

- VERZENIO 150MG TAB (New Starts Only)
- VERZENIO 50MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- voriconazole 200mg inj
- voriconazole 40mg/ml oral susp

- voriconazole 200mg tab
- voriconazole 50mg tab

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Physician or Oncologist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– VOTRIENT 200MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– VYXEOS 44-100MG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

- BELVIQ TAB 10MG\*
- QSYMIA CAP 15-92MG\*
- QSYMIA CAP 7.5-46MG\*
- QSYMIA CAP 11.25-69MG\*
- QSYMIA CAP 3.75-23MG\*
- XENICAL CAP\*

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	
Exclusion Criteria	
Required Medical Info	Requires BMI greater than or equal to 35 and previous trial and failure of phentermine
Age Restrictions	
Prescriber Restriction	
Coverage Duration	
Other Criteria	

**Products Affected**

- *phentermine cap 15mg\**
- *phentermine cap 37.5mg\**

- *phentermine cap 30mg\**
- *phentermine tab 37.5mg\**

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	
Exclusion Criteria	
Required Medical Info	Requires BMI greater than or equal to 35
Age Restrictions	
Prescriber Restriction	
Coverage Duration	
Other Criteria	

**Products Affected**

– XALKORI 200MG CAP (New Starts Only)

– XALKORI 250MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– XATMEP 2.5MG/ML ORAL SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	For polyarticular juvenile idiopathic arthritis: patient must have trial of or inability to use oral methotrexate tablet. For acute lymphoblastic leukemia: trial of oral methotrexate tablet is not required.
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— XGEVA 120MG/1.7ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– XOLAIR 150MG INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1. If for moderate to severe persistent asthma: There must be objective evidence of reversible airway obstruction AND the patient's IgE level must be between 30 IU/ml and 700 IU/ml, AND the patient must have a positive skin test or RAST test for specific allergic sensitivity and one of the following: Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists OR a leukotriene modifier and systemic steroids OR high dose inhaled corticosteroids are required to maintain adequate asthma control OR intolerance or contraindication to the previously listed drugs. 2. If for chronic idiopathic urticaria, patient remains symptomatic despite H1 antihistamine treatment or has intolerance or contraindication to H1 antihistamine treatment.
Age Restrictions	If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old.
Prescriber Restriction	Prescribed by, or in consultation with an Allergy Specialist, Pulmonary Specialist, Dermatology Specialist or Immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– XTANDI 40MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Failure of or intolerance to abiraterone (Zytiga).
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– XULTOPHY 100UNIT-3.6MG/ML PEN INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	Member is unable to achieve an A1c of 7 or under after three (3) months of treatment with a maximally dosed GLP-1 receptor agonist or basal insulin greater than or equal to thirty (30) units per day, OR member is currently using basal insulin AND a GLP-1 receptor agonist
Age Restrictions	
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– XYREM 500MG/ML ORAL SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Neurologist, Pulmonologist, or Sleep Medicine Physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– YERVOY 50MG/10ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– YONDELIS 1MG INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– ZALTRAP 100MG/4ML INJ (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– *miglustat 100mg cap*

– ZAVESCA 100MG CAP

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with a Medical Geneticist, Hematologist, or Metabolic Physician.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– ZEJULA 100MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	



## Products Affected

– ZELBORAF 240MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– ZEPATIER 50-100MG TAB

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	1) Patient is diagnosed with chronic HCV (greater than 6 months) with genotype indicated 2) Current HCV-RNA titer 3) Documentation that member does or does not have cirrhosis 4) Previous Hepatitis C Treatments.
Age Restrictions	Member must be 18 years of age or older.
Prescriber Restriction	Prescribed by, or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease Physician or Transplant Physician.
Coverage Duration	Coverage duration of 12 to 16 weeks. Applied consistent with current AASLD-IDSa guidance.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

## Products Affected

– ZOLINZA 100MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— ZOSTAVAX 19400UNIT/0.65ML INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	PA not required for members 50 and older.
Prescriber Restriction	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

– ZYDELIG 100MG TAB (New Starts Only)

– ZYDELIG 150MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	DIAGNOSIS A: Patient has relapsed CLL, defined as CLL progression less than 24 months since the completion of the last prior therapy AND idelalisib (ZYDELIG) will be used in combination with rituximab (RITUXAN). DIAGNOSIS B and C: Patient has relapsed follicular B-cell non-Hodgkin lymphoma (FL) OR Patient has relapsed small lymphocytic lymphoma (SLL) AND Patient has received at least two (2) prior systemic therapies.
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

— ZYKADIA 150MG CAP (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

**Products Affected**

– ZYTIGA 250MG TAB (New Starts Only)

– ZYTIGA 500MG TAB (New Starts Only)

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Oncologist or Urologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	

## Products Affected

- linezolid 20mg/ml oral susp
- linezolid 600mg tab

- linezolid 2mg/ml inj

<b>PA Criteria</b>	<b>Criteria Details</b>
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Info	
Age Restrictions	
Prescriber Restriction	Prescribed by, or in consultation with an Infectious Disease Specialist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	