Superior Health Plan STAR+PLUS
Medicare-Medicaid Plan (MMP)
2016 Prior Authorization Criteria

Instructions:
1. With this file, at the top, click **Edit**, then click **Find**.
2. In the **Find** box type the name of the medication you want to find.
3. Click **Find Next** button until you find the medications you're looking for.

Prior Authorization (PA)

What is Prior Authorization?
You must get our okay for certain drugs before using them. We call this *Prior Authorization* (PA). If your drug needs *prior authorization*, call Superior HealthPlan STAR+PLUS MMP (Superior) at 1-866-896-1844 from 8 a.m. to p.m., seven days a week. TTY users call 711. On weekends and federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. You will need to get our okay before you get your drug. If you don't get okay, Superior may not cover the drug.

Why is *Prior Authorization* required?
We are here to help you. To get more out of your drugs, certain drugs require *prior authorization* from Superior before you can get the drug. If your doctor wants you to try a new drug, we may need to say "yes" to this drug before you pick it up. *Prior Authorization* rules are made by the Pharmacy and Therapeutics Committee. They get ideas from providers and other experts.

How do I request an exception to the coverage rules?
You can ask Superior to make an exception to our rules. You can ask for us to make different types of exceptions. Please refer to your List of Drugs or Formulary. When you are asking for an exception, you should get a statement from your doctor with your completed Request for Medicare Prescription Drug Coverage Determination* form. You can get the Medicare Prescription Drug Coverage Determination form on our website at http://mmp.SuperiorHealthPlan.com, or by calling Members Services at 1-866-896-1844 from 8 a.m. to p.m., seven days a week. On weekends and federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. TTY users should call 711.

Once we get your completed form and the statement from your doctor, we must make our decision within 72 hours. If you or your doctor believe that you need the drug before waiting 72 hours, you can request a rush or fast review (expedited). If your request to rush your review is approved, we must give you a decision no later than 24 hours after we get the statement from your doctor.

* Please note – You cannot use this form for Medicare non-covered drugs: fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over the counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

Superior HealthPlan STAR+PLUS Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

Benefits may change on January 1 of each year.

Limitations, [copays] and restrictions may apply. For more information, call Superior STAR+PLUS MMP Member Services or read the Superior STAR+PLUS MP Member Handbook.

You can get this information for free in other languages. Call 1-866-896-1844 from 8 a.m. to p.m., seven days a week. TTY users call 711. On weekends and federal holidays, you may be

asked to leave a message. Your call will be returned within the next business day. The call is free.

Puede obtener esta información en otros idiomas gratis. Llame al 1-866-896-1844 de 8:00 a. m. a 8:00 p. m., los siete días de la semana. Los usuarios de TTY deben llamar al 711. Los fines de semana y los días feriados nacionales, es posible que se le pida que deje un mensaje. Le devolveremos la llamada durante el próximo día hábil. La llamada es gratuita.

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	Adempas is approved for all indications not otherwise excluded under Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For PAH and CTEPH, must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization or 2D ECHO to confirm the diagnosis of PAH (WHO Group 1).

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	Afinitor is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For use in patients with advanced renal cell carcinoma. The patient must have a documented treatment failure, consistent with pharmacy claims data, with an adequate trial with Sutent or Nexavar.

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	ALECENSA is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For metastatic NSCLC - patient is anaplastic lymphoma kinase (ALK)-positive AND has either progressed on or is intolerant to Xalkori.

AMPYRA

Products Affected

- Ampyra

PA Criteria	Criteria Details
Covered Uses	Ampyra is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

ANESTHETICS

Products Affected

- Lidocaine PTCH

PA Criteria	Criteria Details
Covered Uses	Lidoderm patches are approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

ANTIBACTERIALS - BETA LACTAM, OTHER

Products Affected

- Cayston

PA Criteria	Criteria Details
Covered Uses	Cayston is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For use in patients 7 years and older
Prescriber Restrictions	N/A
Coverage Duration	28 days
Other Criteria	N/A

ANTI-INFLAMMATORY AGENTS

Products Affected

- Indomethacin ORAL CAPS
- Indomethacin Er

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The prescriber has documented the indication for the continued use of the high risk medication including an explanation of the specific benefit with the medication and how that benefit outweighs the potential risk. The prescriber has documented the ongoing monitoring plan AND the prescriber must document that patient counseling has occurred outlining the potential risks of the medication.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for the high risk medication if the patient is 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Trial and failure of two formulary short acting NSAIDS

ARZERRA

Products Affected

- Arzerra INJ 100MG/5ML

PA Criteria	Criteria Details
Covered Uses	Arzerra is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Covered Uses	Aubagio is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient must not have severe hepatic impairment, be on concurrent treatment with leflunomide, or be pregnant.
Required Medical Information	Patient must have relapsing form of MS with MRI features consistent with MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Patient must have failed or have an intolerance to interferon Beta-1a, Copaxone, or Gilenya.

AVASTIN

Products Affected

- Avastin

PA Criteria	Criteria Details
Covered Uses	Avastin is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Metastatic colorectal cancer. For non-squamous non-small cell lung cancer, use in combination with carboplatin and paclitaxel for first line treatment of unresectable, locally advanced, recurrent or metastatic disease. For Glioblastoma, patient has progressive disease. For metastatic renal cell carcinoma, used in combination with interferon alfa.
Age Restrictions	Patients must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

AVONEX

Products Affected

- Avonex
- Avonex Pen

PA Criteria	Criteria Details
Covered Uses	Avonex is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient must not have a hypersensitivity to human albumin or interferon. Concurrent use with other disease-modifying agents in the treatment of MS.
Required Medical Information	Patient must have a relapsing form of MS or have experienced a first clinical episode of MS and have an MRI with features consistent with MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

BELEODAQ

Products Affected

- Beleodaq

PA Criteria	Criteria Details
Covered Uses	Beleodaq is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Covered Uses	Benlysta is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Previous anaphylaxis to Benlysta. Documentation that the patient does not have severe active lupus nephritis or severe active central nervous system lupus.
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Documented diagnosis of systemic lupus erythematosus (SLE) and an active, autoantibody-positive test who are receiving standard therapy comprising any of the following: anti-malarials, corticosteroids, immunosuppressives, and non-steroidal anti-inflammatory drugs.

BETASERON

Products Affected

- Betaseron

PA Criteria	Criteria Details
Covered Uses	Betaseron is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with a hypersensitivity to human albumin or natural or recombinant interferon. Concurrent use with other disease-modifying agents in the treatment of MS.
Required Medical Information	Patient must have a relapsing form of MS or experienced a first clinical episode of MS and must have an MRI with features consistent with MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

BLOOD GLUCOSE REGULATORS

Products Affected

- Byetta

PA Criteria	Criteria Details
Covered Uses	Byetta is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for patients with Type 1 diabetes. Not covered for weight-loss.
Required Medical Information	Diagnosis for use. Submission of current HbA1c level greater than 7.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Prior adherent use of standard first-line therapy including either metformin with a sulfonylurea or metformin with a thiazolodinedione, unless contraindicated.

BLOOD GLUCOSE REGULATORS - AMYLINOMIMETICS

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Covered Uses	Symlin is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Submission of current HbA1c level greater than 7.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Standard first line therapy for Diabetes type 2 includes trials on either metformin with a sulfonylurea or metformin with a thiazolodinedione, unless contraindicated. Standard first line therapy for Diabetes type 1 includes short-acting insulin in combination with basal insulin.

BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Aranesp, Epogen and Procrit are approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hemoglobin levels less than 10 grams per deciliter
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	For ongoing therapy in end stage renal disease and cancer patients, maintenance of hemoglobin levels between 10 and 12 grams per deciliter

BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS - CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Covered Uses	Cinryze is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for use. For hereditary angioedema: Documented failure of danazol.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval : 6 months. Extended approval: Annual review will be based on response to therapy
Other Criteria	N/A

BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS - PROMACTA

Products Affected

- Promacta ORAL TABS 25MG, 50MG

PA Criteria	Criteria Details
Covered Uses	Promacta is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Chronic Immune (Idiopathic) Thrombocytopenia, submission of platelet counts of less than 50,000 per microliter following standard treatment with corticosteroids, immunoglobulins, or after splenectomy. Platelet counts not required for chronic hepatitis C induced thrombocytopenia treatment to allow for interferon therapy initiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Covered Uses	Bosulif is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient must not have a hypersensitivity to bosutinib.
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Patient must have a documented diagnosis of chronic, accelerated or blast phase Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia AND documentation of resistance or intolerance to prior therapy.

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Covered Uses	Caprelsa is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease.
Age Restrictions	Patients must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist or endocrinologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

CARDIOVASCULAR AGENTS

Products Affected

- Ranexa

PA Criteria	Criteria Details
Covered Uses	Ranexa is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Trial and failure of long-acting nitrate therapy.

CENTRAL NERVOUS SYSTEM AGENTS

Products Affected

- Modafinil TABS 200MG

PA Criteria	Criteria Details
Covered Uses	Modafinil is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

CEREZYME

Products Affected

- Cerezyme

PA Criteria	Criteria Details
Covered Uses	Cerezyme is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation the patient has a confirmed diagnosis of Type 1 Gaucher disease severe enough to result in one of the following conditions: moderate to severe anemia, thrombocytopenia with bleeding tendency, bone disease, or significant hepatomegaly or splenomegaly.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Covered Uses	Cometriq is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of patients with progressive, metastatic medullary thyroid cancer.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

COPAXONE

Products Affected

- Glatopa

PA Criteria	Criteria Details
Covered Uses	Copaxone is approved for all FDA-approved used not otherwise excluded from Part D.
Exclusion Criteria	Patients with a hypersensitivity to glatiramer or mannitol. Concurrent use with other disease-modifying agents in the treatment of MS.
Required Medical Information	Patient must have relapsing MS or have experienced a first clinical episode of MS and must have an MRI with features consistent with MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	COTELLIC is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	BRAF V600 mutations for diagnosis of Melanoma
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Melanoma used in combination with Zelboraf.

DERMATOLOGICAL AGENTS

Products Affected

- Elidel
- Protopic
- Tacrolimus EXTERNAL OINT

PA Criteria	Criteria Details
Covered Uses	Elidel and Protopic are approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Trial and failure and adherent use of at least two medium to high potency topical corticosteroids (eg, amcinonide, fluticasone propionate, triamcinolone acetonide, betamethasone valerate, fluocinolone acetonide, hydrocortisone butyrate, mometasone furoate, desoximetasone, fluocinonide or betamethasone dipropionate).

ENZYME REPLACEMENTS/ MODIFIERS - KUVAN

Products Affected

- Kuvan

PA Criteria	Criteria Details
Covered Uses	Kuvan is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Reduction of blood phenylalanine levels from baseline to demonstrate BH4 responsive phenylketonuria
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 30 days, then through the end of the Plan contract year if PKU responsive
Other Criteria	N/A

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Covered Uses	Esbriet is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	IPF baseline - must have FVC greater than or equal to 50 percent of the predicted value AND IPF must be diagnosed with either computed tomography (CT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.

FENTANYL CITRATE ORAL TRANSMUCOSAL

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The drug is not indicated in the management of acute or post-operative pain. This medication must not be used on opioid non-tolerant patients. Not covered for patients with pain not associated with cancer.
Required Medical Information	For the management of breakthrough cancer pain in patients with malignancies who are already receiving and are tolerant to opioid therapy for their underlying cancer pain.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

FIRAZYR

Products Affected

- Firazyr

PA Criteria	Criteria Details
Covered Uses	Firazyr is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of HAE and where diagnosis is documented based on evidence of a normal C1 level and a low C4 level (C4 less than 14 mg/dL normal range 14 to 40 mg/dL, or C4 below the lower limit of normal as defined by the laboratory performing the test) plus: a) A low C1 inhibitor (C1INH) antigenic level (C1INH less than 19 mg/dL normal range 19 to 37 mg/dL or C1INH antigenic level below the lower limit of normal as defined by the laboratory performing the test) OR b) A normal C1INH antigenic level (C1INH greater than or equal to 19 mg/dL) and a low C1INH functional level (functional C1INH less than 50%, or below the lower limit of normal as defined by the laboratory performing the test) and patient must be experiencing at least one symptom of the moderate or severe attack (e.g., airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion) and medications known to cause angioedema (i.e. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an immunologist or rheumatologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	Gattex is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

GILENYA

Products Affected

- Gilenya

PA Criteria	Criteria Details
Covered Uses	Gilenya is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient's who have experienced any of the following in the last 6 months: MI, Class III or IV Heart failure, stroke, TIA, or unstable angina.
Required Medical Information	Patient must have a relapsing form of MS and an MRI with features of MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Covered Uses	Gilotrif is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of patients with metastatic non-small cell lung cancer. Documentation confirming the metastatic NSCLC tumors have epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 substitution mutation as detected by an FDA-approved test.
Age Restrictions	Patient must be 18 years old or older
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

GLEEVEC

Products Affected

- Gleevec
- Imatinib Mesylate

PA Criteria	Criteria Details
Covered Uses	Gleevec is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Hypersensitivity to imatinib or to any other component of imatinib.
Required Medical Information	When being used in pediatric patients with Ph+ ALL, must provide documentation of use of Gleevec in combination with chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Covered Uses	Harvoni is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of genotype (1a, 1b, 4, 5, or 6), previous hepatitis C treatment history, other medications that will be used with Harvoni, and presence or absence of cirrhosis.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist or an infectious disease specialist.
Coverage Duration	12-24 weeks depending on baseline viral load, previous treatment history, and cirrhosis status.
Other Criteria	Approval will be granted when one of the following is met: Chronic Hepatitis C Virus (HCV) infection genotype 1 AND member is treatment-naive with or without cirrhosis: 12 weeks total. Chronic Hepatitis C Virus (HCV) infection genotype 1 AND member is treatment-experienced (has failed prior peg interferon alfa (PEG) and ribavirin (RBV)) or PEG/ RBV + HCV protease inhibitor (HCV PI) without cirrhosis: 12 weeks total. Chronic Hepatitis C Virus (HCV) infection genotype 1 AND member is treatment-experienced (has failed prior PEG/ RBV or PEG/ RBV + HCV PI) with cirrhosis: 24 weeks total. Chronic Hepatitis C Virus (HCV) infection genotype 1 AND member is treatment-experienced (has failed prior PEG/ RBV or PEG/ RBV + HCV PI) with cirrhosis in combination with RBV: 12 weeks total. Chronic Hepatitis C Virus (HCV) infection genotype 4, 5, or 6 AND member is treatment-naive or treatment experienced with or without cirrhosis: 12 weeks total.

HERCEPTIN

Products Affected

- Herceptin

PA Criteria	Criteria Details
Covered Uses	Herceptin is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation the patient has human epidermal growth factor receptor (HER)-2 positive breast cancer, metastatic gastric or gastroesophageal junction adenocarcinoma prior to initial authorization.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	Hetlioz is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

HIGH RISK MEDICATION - DIGOXIN

Products Affected

- Digitek
- Digoxin INJ
- Digoxin ORAL SOLN
- Digoxin TABS 250MCG
- Lanoxin INJ
- Lanoxin TABS 250MCG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Documented trial and failure to doses up to 0.125mg per day OR the prescriber has documented the indication for the continued use of doses greater than 0.125mg per day. The prescriber has documented the ongoing monitoring plan AND the prescriber must document that patient counseling has occurred outlining the potential risks of the medication.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for the medication if the patient is 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

HIGH RISK MEDICATION - GLYBURIDE

Products Affected

- Glyburide ORAL TABS
- Glyburide Micronized
- Glyburide/metformin Hcl

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The prescriber has documented the indication for the continued use of the high risk medication including an explanation of the specific benefit with the medication and how that benefit outweighs the potential risk. The prescriber has documented the ongoing monitoring plan AND the prescriber must document that patient counseling has occurred outlining the potential risks of the medication.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for the high risk medication if the patient is 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Documented trial and failure to both glimepiride and glipizide, unless contraindicated.

HIGH RISK MEDICATION - NITROFURANTOIN

Products Affected

- Nitrofurantoin Macrocrystals
- Nitrofurantoin Monohydrate
- Nitrofurantoin Monohydrate/macrocrystals

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for use. Culture and sensitivity report. The prescriber has documented the indication for the continued use of the high risk medication including an explanation of the specific benefit with nitrofurantoin and how that benefit outweighs the potential risk.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for nitrofurantoin if the patient is 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Chronic suppressive therapy will only be covered if the culture and sensitivity report indicate nitrofurantoin is the only effective agent for the infection unless other effective agents are contraindicated. Patients will be allowed 10 days of therapy before prior authorization is required.

HIGH RISK MEDICATION - NONBENZODIAZEPINE HYPNOTICS

Products Affected

- Zaleplon
- Zolpidem Tartrate ORAL TABS
- Zolpidem Tartrate Er

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The prescriber has documented the indication for the continued use of the high risk medication including an explanation of the specific benefit with the medication and how that benefit outweighs the potential risk. The prescriber has documented the ongoing monitoring plan AND the prescriber must document that patient counseling has occurred outlining the potential risks of the medication.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for the high risk medication if the patient is 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Patients will be allowed 90 days of therapy before prior authorization is required.

HIGH RISK MEDICATIONS

Products Affected

- Alora
- Benztropine Mesylate ORAL TABS
- Chlorzoxazone
- Climara Pro
- Cyclobenzaprine Hcl ORAL TABS 10MG, 5MG
- Cyproheptadine Hcl SYRP
- Cyproheptadine Hcl TABS
- Dipyridamole ORAL TABS
- Disopyramide Phosphate
- Ergoloid Mesylates TABS
- Estradiol ORAL TABS
- Estradiol TRANSDERMAL PTWK
- Estropipate ORAL TABS
- Guanfacine Hcl
- Hydroxyzine Hcl INJ
- Hydroxyzine Hcl ORAL TABS
- Hydroxyzine Hcl SYRP
- Hydroxyzine Pamoate ORAL CAPS
- Megestrol Acetate SUSP 40MG/ML
- Menest
- Meprobamate
- Methocarbamol ORAL TABS
- Methyldopa
- Methyldopa/hydrochlorothiazide
- Orphenadrine Citrate Er
- Phenadoz SUPP 12.5MG
- Premarin ORAL TABS
- Premphase
- Prempro
- Promethazine Hcl INJ
- Promethazine Hcl ORAL TABS
- Promethazine Hcl RECTAL SUPP
- Promethazine Hcl SYRP
- Promethegan RECTAL SUPP 25MG, 50MG
- Reserpine TABS 0.25MG
- Talwin
- Ticlopidine Hcl
- Trihexyphenidyl Hcl
- Trimethobenzamide Hcl CAPS

PA Criteria	Criteria Details
Covered Uses	High Risk Medication is approved for all FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The prescriber has documented the indication for the continued use of the high risk medication including an explanation of the specific benefit with the medication and how that benefit outweighs the potential risk. The prescriber has documented the ongoing monitoring plan AND the prescriber must document that patient counseling has occurred outlining the potential risks of the medication.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for the high risk medication if the patient is 65 years old or older.

Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year if all conditions are met
Other Criteria	N/A

HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)

Products Affected

- Norditropin Flexpro INJ 15MG/1.5ML, 30MG/3ML, 5MG/1.5ML
- Saizen
- Saizen Click.easy

PA Criteria	Criteria Details
Covered Uses	Growth hormone is approved for all FDA-approved uses not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Medical information includes submission of information showing a growth hormone stimulation test with peak growth hormone concentration below 10 microgram per L in children and below 5.1 micrograms per L in adults.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY) - SEROSTIM

Products Affected

- Serostim

PA Criteria	Criteria Details
Covered Uses	Serostim is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY) - ZORBTIVE

Products Affected

- Zorbtive

PA Criteria	Criteria Details
Covered Uses	Zorbtive is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

HORMONAL AGENTS, SUPPRESSANT (PITUITARY) - SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Covered Uses	Somavert is approved for all FDA-approved uses not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	Iclusig is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Documented diagnosis of one of the following: 1. Chronic phase, accelerated phase or blast phase chronic myeloid leukemia (CML) AND Documented confirmation of the presence of the T315i mutation OR No other tyrosine kinase inhibitor (TKI) therapy is indicated (i.e. imatinib, nilotinib). 2. Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL) AND Documented confirmation of the presence of the T315i mutation OR No other tyrosine kinase inhibitor (TKI) therapy is indicated (i.e. imatinib, nilotinib).

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	Imbruvica is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mantle cell lymphoma, chronic lymphocytic leukemia (CLL), CLL with 17p deletion, or Waldenstrom's macroglobulinemia. For diagnosis of mantle cell lymphoma or chronic lymphocytic leukemia (CLL), documentation patient has received at least one prior therapy.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

IMMUNOLOGICAL AGENTS

Products Affected

- Enbrel
- Enbrel Sureclick
- Humira
- Humira Pen
- Humira Pen-crohns Diseasestarter
- Kineret
- Orencia
- Remicade

PA Criteria	Criteria Details
Covered Uses	Enbrel, Humira, Remicade, Orencia and Kineret are approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	For diagnosis of RA, psoriatic arthritis or psoriasis, trial and failure of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated. Systemic therapy may include methotrexate, leflunomide, hydroxychloroquine, cyclosporine, sulfasalazine, and azathioprine. For diagnosis of Crohn's Disease or Ulcerative Colitis, an inadequate response to immunosuppressants such as corticosteroids, azathioprine, or 6-mercaptopurine (6-MP).

IMMUNOLOGICAL AGENTS - ILARIS

Products Affected

- Ilaris

PA Criteria	Criteria Details
Covered Uses	Ilaris is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of current weight
Age Restrictions	Patient must be at least 2 years of age
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

IMMUNOLOGICAL AGENTS - OLYSIO

Products Affected

- Olysio

PA Criteria	Criteria Details
Covered Uses	Olysio is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for use and labs to support diagnosis including genotype. Documentation of previous or current therapy and outcome.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	12 weeks (no cirrhosis), 24 weeks with Sovaldi in cirrhosis for genotype 1
Other Criteria	Adults with genotype 1 chronic hepatitis C infection who are either treatment naive or have failed peg-interferon and ribavirin combination and meet all of the following: 1) if genotype 1a, patient must be negative for NS3 Q80K polymorphism. 2) must be used in combination with Sovaldi (sofosbuvir) with or without peg-interferon alfa and ribavirin.

IMMUNOLOGICAL AGENTS - PEG-INTRON, PEGASYS

Products Affected

- Pegasys
- Pegasys Proclick
- Pegintron
- Peg-intron Redipen

PA Criteria	Criteria Details
Covered Uses	Peg-Intron and Pegasys are approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Hepatitis C, submission of initial viral load and 12 week lab values showing a viral load of at least a 2 log decrease from baseline for HCV monotherapy or dual therapy with RBV alone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

IMMUNOLOGICAL AGENTS - SOVALDI

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Covered Uses	Sovaldi is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for use and labs to support diagnosis including genotype. Documentation of previous or current therapy and outcome.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	12 wks, 16 wks, 24 wks, or 48 wks based on genotype and regimen as outlined in Other Criteria.
Other Criteria	Adults with chronic hepatitis C infection, genotypes 1a, 1b, 2, 3, 4, 5 or 6 who meet one of the following: 1) for genotypes 1 in combination with Olysio in treatment naive or experienced pts with cirrhosis for 24 weeks or without cirrhosis for 12 weeks. 2) for genotype 2 in combination with ribavirin for treatment naive pts without cirrhosis for 12 weeks and with cirrhosis for 16 weeks, or 24 weeks for treatment experienced. 3) for genotype 3 pts in combination with ribavirin and peg-interferon alfa with or without cirrhosis for 12 weeks or 24 weeks in interferon ineligible pts. 4) for genotype 4 in combination with ribavirin + interferon for 12 weeks or 24 weeks in interferon ineligible. 5) for genotypes 5 or 6, in combination with interferon + ribavirin for 12 weeks. 6) for patients with hepatocellular carcinoma awaiting liver transplantation who meet MILAN criteria, for 48 weeks.

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Covered Uses	Inlyta is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For renal cell carcinoma: Requests for new starts are covered following trial and failure of one prior systemic therapy.

IRRITABLE BOWEL SYNDROME AGENTS

Products Affected

- Alosetron Hydrochloride

PA Criteria	Criteria Details
Covered Uses	Lotronex is approved for all FDA-approved uses not otherwise excluded from Part D
Exclusion Criteria	Male patients
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Female patient with severe diarrhea-predominant chronic irritable bowel syndrome of greater than 6 months duration

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Covered Uses	Jakafi is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of myelofibrosis, current platelet count, and complete blood count.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	Initial approval: 6 months. Extended approval through the end of the Plan contract year.
Other Criteria	Extended approval requires documentation of reduction in spleen volume or symptom improvement after 6 months of therapy.

KADCYLA

Products Affected

- Kadcyla INJ 100MG

PA Criteria	Criteria Details
Covered Uses	Kadcyla is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Single agent in treatment of patients with HER-2 positive metastatic breast cancer who previously received trastuzumab and a taxane, either separately or in combination. Documentation that the patient has either received prior therapy for metastatic disease or developed recurrence during or within six months of completing adjuvant therapy.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	Kalydeco is covered for all FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of a G551D, G178R, S549N, S549R, G551S, G1244E, S1251N, R117H, S1255P, or G1349D mutation in the CFTR gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

KEYTRUDA

Products Affected

- Keytruda INJ 50MG

PA Criteria	Criteria Details
Covered Uses	Keytruda is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of unresectable or metastatic melanoma where the patient has disease progression following ipilimumab (Yervoy) AND if the patient is BRAF V600 mutation positive, evidence of disease progression following a BRAF inhibitor (i.e. Mekinist, Tafinlar, Zelboraf).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	For females, the patient may not be pregnant. For all patients, no concurrent use of simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus and tacrolimus.
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

LAZANDA

Products Affected

- Lazanda

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The drug is not indicated in the management of acute or post-operative pain. This medication must not be used in opioid non-tolerant patients. Not covered for patients with pain not associated with cancer or who are opioid naive.
Required Medical Information	For the management of breakthrough cancer pain in patients with malignancies who are already receiving and are tolerant to opioid therapy for their underlying cancer pain.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Covered following trial and failure of oral generic transmucosal fentanyl citrate (generic Actiq).

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	Lonsurf is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Metastatic Colorectal Cancer, patient has been previously treated with a fluoropyrimidine (e.g., capecitabine, 5-FU) AND oxaliplatin AND irinotecan AND an anti-VEGF biologic (e.g., Avastin, Eylea) AND if the tumor or metastases are wild-type KRAS, Erbitux or Vectibix has been tried.

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Covered Uses	Mekinist is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented BRAF V600E or V600K mutations as detected by an FDA-approved test prior to initiation to treatment.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Can be used in combination with Tafinlar. If Mekinist is being used as a single agent, it is not indicated for use in patients who have received prior BRAF inhibitor therapy (i.e. Zelboraf, Tafinlar).

METABOLIC BONE DISEASE AGENTS - IV
OSTEOPOROSIS

Products Affected

- Forteo

PA Criteria	Criteria Details
Covered Uses	Forteo is approved for all FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Trial and failure of oral alendronate.

METABOLIC BONE DISEASE AGENTS - PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Covered Uses	Prolia is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Prolia is contraindicated in patients with hypocalcemia. Any pre-existing hypocalcemia must be corrected prior to initiating therapy.
Required Medical Information	Diagnosis for use. Documentation of past therapies and response
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

MISCELLANEOUS THERAPEUTIC AGENTS - BOTOX

Products Affected

- Botox

PA Criteria	Criteria Details
Covered Uses	Botox is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

MISCELLANEOUS THERAPEUTIC AGENTS - XENAZINE

Products Affected

- Tetrabenazine
- Xenazine

PA Criteria	Criteria Details
Covered Uses	Xenazine or generic (tetrabenazine) is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Diagnosis of chorea associated with Huntington disease

MOZOBIL

Products Affected

- Mozobil

PA Criteria	Criteria Details
Covered Uses	Mozobil is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of patient's current weight and absolute neutrophil count (ANC). All labs and patient's weight should be dated within 30 days prior to the request.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or hematologist
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Patient must have a documented failure to reach and/or maintain a target ANC with an adequate trial of Neupogen.

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	Natpara is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Chronic hypoparathyroidism. Before initiating therapy with Natpara, documentation serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient AND patient cannot be well-controlled on calcium supplements and active forms of vitamin D alone per the prescribing physician.

NEUPOGEN

Products Affected

- Neupogen

PA Criteria	Criteria Details
Covered Uses	Neupogen is approved for all medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of patient's weight, diagnosis, and absolute neutrophil count. Labs and weight should be within 30 days prior to the request.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Confirm use is associated with one of the following: 1. Non-myeloid malignancies receiving a myelosuppressive chemotherapy regimen associated with a significant risk of severe neutropenia with fever 2. Induction or consolidation treatment for Acute Myeloid Leukemia (AML) 3. Bone marrow transplantation 4. Peripheral Blood Progenitor Cell (PBPC) Collection 5. Severe Chronic Neutropenia (SCN) with ANC less than 500/ml 6. Advanced HIV with ANC under 1000/ml to allow scheduled dosing of myelosuppressive anti-retroviral medications (e.g. zidovudine and ganciclovir).

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Covered Uses	Nexavar is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in patient with a known severe hypersensitivity to sorafenib or any component of the product.
Required Medical Information	Approved for hepatocellular carcinoma when it is unresectable. Approved for renal cell carcinoma that is advanced. Approved for locally recurrent or metastatic progressive differentiated thyroid carcinoma that is refractory to iodine treatment.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	NINLARO is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Multiple Myeloma, used in combination with Revlimid and dexamethasone AND pt has received at least ONE previous therapy for multiple myeloma (e.g., Velcade, Kyprolis, Thalomid, Revlimid, Pomalyst, Alkeran, dexamethasone, prednisone).

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	ODOMZO is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For locally advanced Basal Cell Carcinoma for patients when the BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery or radiation therapy, according to the prescribing physician.

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	Ofev is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Must be 18 years old or older.
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	IPF baseline - must have FVC greater than or equal to 50 percent of the predicted value AND IPF must be diagnosed with either findings on computed tomography (CT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.

QUININE

Products Affected

- Quinine Sulfate CAPS

PA Criteria	Criteria Details
Covered Uses	Quinine is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not approved for treatment or prevention of leg cramps, prevention of malaria or in patients with complicated P. falciparum.
Required Medical Information	Indicated only for the treatment of uncomplicated Plasmodium falciparum malaria. Quinine sulfate has been shown to be effective in geographical regions where resistance has been documented to chloroquine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	N/A

REBIF

Products Affected

- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack

PA Criteria	Criteria Details
Covered Uses	Rebif is approved for all FDA-approved indications not otherwise excluded under Part D.
Exclusion Criteria	Patients with a hypersensitivity to human albumin or natural or recombinant interferon. Concurrent use with other disease-modifying agents in the treatment of MS.
Required Medical Information	Patient must have a relapsing form of MS or have experienced a first clinical episode of MS and must have an MRI with features consistent with MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

RESPIRATORY TRACT AGENTS

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	Xolair is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Submission of IgE serum levels between 30 and 700 IU per milliliter.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Adherent use of combined therapy with inhaled corticosteroids with long acting beta agonists in the 90 days prior to the request.

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Covered Uses	Revlimid is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for patients who are pregnant.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

RITUXAN

Products Affected

- Rituxan INJ 500MG/50ML

PA Criteria	Criteria Details
Covered Uses	Rituxan is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized for 6 months.
Other Criteria	For the diagnosis of rheumatoid arthritis, Rituxan is being used in combination with methotrexate AND patient has had an inadequate response or intolerance to Enbrel or Humira.

SILDENAFIL - IV

Products Affected

- Sildenafil INJ

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with organic nitrates (e.g. isosorbide, nitroglycerin). Sildenafil is not covered for the diagnosis of ED/impotence.
Required Medical Information	Diagnosis of pulmonary arterial hypertension (PAH)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 4 months. Extended approval: Annually with documentation of response
Other Criteria	N/A

SILDENAFIL - PAH

Products Affected

- Sildenafil TABS

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with organic nitrates (e.g. isosorbide, nitroglycerin). Sildenafil is not covered for the diagnosis of ED/impotence.
Required Medical Information	Diagnosis of pulmonary arterial hypertension (PAH)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 4 months. Extended approval: Annually with documentation of response
Other Criteria	Sildenafil - PAH is only approved for 20mg three times a day.

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Covered Uses	Sprycell is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	A documented diagnosis of one of the following: 1. Newly diagnosed Philadelphia chromosome-positive chronic phase chronic myeloid leukemia (Ph+ CP-CML) AND resistance or intolerance to prior therapy with nilotinib (Tasigna). 2. Chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome-positive chronic myeloid leukemia (CML) AND resistance or intolerance to prior therapy with imatinib (Gleevec). 3. Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) AND resistance or intolerance to prior therapy with imatinib (Gleevec).

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	Stivarga is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Treatment of locally advanced, unresectable or metastatic gastrointestinal stromal tumors (GIST) in patients who have previously received imatinib or sunitinib OR for the treatment of patients with metastatic colorectal cancer who have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF (vascular endothelial growth factor) therapy (e.g. Avastin). If KRAS wild type colorectal cancer, an anti-EGFR (endothelial growth factor receptor) therapy (e.g. Erbitux, Vectibix) must have been part of the treatment protocol.

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Covered Uses	Sutent is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Gastrointestinal stromal tumor AND after disease progression on or intolerance to imatinib.

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	TAGRISSO is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For NSCLC, patient must have metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC AND has progressed on or after an EGFR tyrosine kinase inhibitor (e.g., Tarceva, Iressa, or Gilotrif).

TARCEVA

Products Affected

- Tarceva
- Tasigna

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Tarceva, documentation for patient with pancreatic cancer that the medication is being used in combination with gemcitabine. For ALL, prior therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Tarceva is covered 1) for the treatment of locally advanced or metastatic NSCLC after failure of at least one prior chemotherapy regimen. 2) Covered for first line treatment for locally advanced or metastatic NSCLC, with or without platinium-based therapy, in patients with a known active EGFR mutation or overexpression. 3) Covered for maintenance treatment in patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) whose disease has not progressed after four cycles of platinum-based first-line chemotherapy. 4) Covered in combination with gemcitabine (Gemzar) for the first-line treatment of patients with locally advanced, unresectable or metastatic pancreatic cancer. Tasigna is covered for chronic phase and accelerated phase Ph+ CML, resistant or intolerant to prior therapy.

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Covered Uses	Tysabri is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with a history of or existing PML or hypersensitivity to natalizumab. In the diagnosis of MS, concurrent use with other disease modifying agents in the treatment of MS. In the diagnosis of Crohn's, concurrent use with immunosuppressive agents (AZA, 6-MP, Azulfidine).
Required Medical Information	For the diagnosis of MS patient must have a relapsing form of MS or experienced a first clinical episode and must have an MRI with features consistent with MS.
Age Restrictions	Patients must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist, MS specialist, or gastroenterologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	In the diagnosis of MS, patient must have failed or be intolerant to interferon Beta-1a, Copaxone, or Gilenya. In the diagnosis of Crohn's, patient must have failed or be intolerant to Cimzia Humira, or Remicade.

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

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

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Covered Uses	Votrient is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	Xalkori is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation patient is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test. Positive result confirming ALK using Vysis ALK Break Apart FISH Probe Kit or equivalent.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

YERVOY

Products Affected

- Yervoy INJ 50MG/10ML

PA Criteria	Criteria Details
Covered Uses	Yervoy is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

ZALTRAP

Products Affected

- Zaltrap INJ 100MG/4ML

PA Criteria	Criteria Details
Covered Uses	Zaltrap is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	A documented diagnosis of metastatic colorectal cancer AND documentation of the following: resistance to or progression of the disease following an oxaliplatin-containing regimen and will be used in combination with 5-fluorouracil, leucovorin, and irinotecan.

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	Zelboraf is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of unresectable or metastatic malignant melanoma in patients with V600E mutation of the BRAF gene as detected by an FDA-approved test. Positive result confirming mutation using Cobas 4800 BRAF V600 Mutation Test or equivalent.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Covered Uses	Zydelig is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of serious allergic reaction including anaphylaxis and toxic epidermal necrolysis.
Required Medical Information	Labs within 30 days of request to include: ALT/AST, Complete Blood Cell count.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must oncologist or hematologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Relapsed Chronic Lymphocytic Leukemia, Zydelig will be used in combination with rituximab (Rituxan). For Relapsed Follicular B-cell non-Hodgkin Lymphoma and Relapsed Small Lymphocytic Lymphoma, patient has received at least two prior systemic therapies such as Rituxan, Treanda, or other chemotherapy.

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Covered Uses	Zykadia is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Patient has a diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) AND has progressed on or is intolerant to crizotinib (Xalkori).

ZYTIGA

Products Affected

- Zytiga

PA Criteria	Criteria Details
Covered Uses	Zytiga is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that prednisone will be used in combination.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- Acetylcysteine INHALATION SOLN
- Albuterol Sulfate INHALATION NEBU
- Alkeran INJ
- Aminosyn 7%/electrolytes
- Aminosyn 8.5%/electrolytes
- Aminosyn II
- Aminosyn II 8.5%/electrolytes
- Aminosyn M
- Aminosyn-hbc
- Aminosyn-pf
- Aminosyn-pf 7%
- Aminosyn-rf
- Azathioprine TABS
- Carimune Nanofiltered INJ 6GM
- Cellcept Intravenous
- Clinimix 2.75%/dextrose 5%
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 20%
- Clinimix 4.25%/dextrose 25%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 5%/dextrose 25%
- Clinimix E 2.75%/dextrose 10%
- Clinimix E 2.75%/dextrose 5%
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 25%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinimix E 5%/dextrose 25%
- Colistimethate Sodium INJ
- Cromolyn Sodium NEBU
- Cyclophosphamide ORAL CAPS
- Cyclosporine INJ
- Cyclosporine ORAL CAPS
- Cyclosporine Modified
- Dronabinol
- Emend ORAL CAPS 0, 40MG
- Engerix-b
- Freamine Hbc 6.9%
- Gamastan S/d
- Gammagard Liquid INJ 2.5GM/25ML
- Gamunex-c INJ 1GM/10ML
- Gengraf
- Hepatamine
- Intralipid
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol Hcl INHALATION NEBU 0.31MG/3ML, 0.63MG/3ML
- Mycophenolate Mofetil
- Nebupent
- Nephramine
- Nulojix
- Nutrilipid
- Ondansetron Hcl ORAL SOLN
- Ondansetron Hcl ORAL TABS
- Ondansetron Odt
- Plenamine
- Premasol
- Procalamine
- Prograf
- Prosol
- Pulmozyme
- Rapamune SOLN
- Recombivax Hb
- Simulect INJ 20MG
- Sirolimus ORAL TABS
- Tacrolimus ORAL CAPS
- Thymoglobulin
- Tobramycin NEBU
- Travasol
- Trophamine
- Tyvaso
- Xopenex NEBU 1.25MG/3ML
- Zortress

Details

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

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