ACNE PRODUCTS

Affected Drugs:
Epiduo

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: Esthetic purposes

Required Medical Information: 1) Diagnosis: acne vulgaris

Age Restrictions: N/A

Prescription Order Restrictions: 1) Dermatologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs: Actimmune

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Document one of the following: a. Chronic Granulomatous Disease OR b. Severe Malignant Osteopetrosis

Age Restrictions: N/A

Prescription Order Restrictions: 1) Endocrinologist, 2) Orthopedist, 3) Hematologist, 4) Oncologist, 5) Infectious Disease Specialist, 6) Rheumatologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs: Adagen

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Use as preparatory or support therapy for bone marrow transplantation, 2) Severe Thrombocytopenia with Platelet less than 10,000

Required Medical Information: 1) Document the following: a. patient has a diagnosis of Severe Combined Immunodeficiency Disease, b. patient is not suitable for or has failed bone marrow transplantation, c. Plasma adenosine deaminase (ADA) deficiency, d. Red blood cell deoxyadenosine nucleotide (dATP) more than 0.001µmol/mL, 2) Platelets more than 10,000

Age Restrictions: N/A

Prescription Order Restrictions: 1) Specialist in metabolic or genetic disorders, 2) Immunologist

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

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

**Affected Drugs:**
Adcirca

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Concomitant use of nitrate therapy on a regular or intermittent basis. 2) Concomitant use of Guanylate Cyclase stimulators (such as Adempas)

**Required Medical Information:** 1) Diagnosis: Pulmonary Arterial Hypertension, WHO Group 1, 2) Cardiac catheterization results: a. Mean pulmonary artery pressure greater than or equal to 25 mmHg OR, b. Pulmonary capillary wedge pressure less than or equal to 15 mmHg, 3) Acute vasodilator testing result (required for patients with Idiopathic Pulmonary Arterial Hypertension ONLY).

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Pulmonologist, 2) Cardiologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs:  
Adefovir Dipivoxil

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Chronic hepatitis B, 2) Document the following: a. Positive Hepatitis B surface antigen (HBsAg) test, b. serum aminotransferases levels

Age Restrictions: 12 years of age or older

Prescription Order Restrictions: 1) Gastroenterologist, 2) Infectologist, 3) Hepatologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Adempas

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Pregnancy, 2) Co-administration with nitrates or nitric oxide donors (such as amyl nitrite) in any form, 3) Concomitant administration with phosphodiesterase (PDE) inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or nonspecific PDE inhibitors (such as dipyridamole or theophylline).

**Required Medical Information:** 1) Diagnosis: a. Pulmonary Arterial Hypertension, WHO Group 1 OR b. Persistent/Recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH), WHO Group 4, 2) Document the following: Cardiac catheterization results. a. Mean pulmonary artery pressure greater than or equal to 25 mmHg OR, b. Pulmonary capillary wedge pressure less than or equal to 15 mmHg, 3) For Pulmonary Arterial Hypertension, WHO Group 1: Document previous failure to: Sildenafil. 4) For Persistent/Recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH), WHO Group 4: no prerequisites are required.

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Pulmonologist, 2) Cardiologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
- Afinitor
- Afinitor Disperz

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:**
1) Diagnosis: a. advanced breast cancer, b. locally advanced or metastatic neuroendocrine tumors of pancreatic, gastrointestinal or lung origin, c. advanced renal cell carcinoma, d. renal angiomyolipoma and TSC, OR e. supependymal giant cell astrocytoma and TSC.,
2) For advanced breast cancer document the following: a. patient is postmenopausal, b. the stage of breast cancer, c. hormone receptor positive results d. HER2 negative results, c. failure to treatment with letrozole or anastrozole, d. prescribed in combination with exemestane.,
3) For locally advanced or metastatic neuroendocrine tumors: document disease is unresectable,
4) For advanced renal cell carcinoma: Document failure of treatment with sunitinib or sorafenib,
5) For renal angiomyolipoma and TSC: a. Document patient not requiring immediate surgery,
6) For subependymal Giant Cell Astrocytoma and TSC: Document the following: a. Patient is not candidate for curative surgical resection

**Age Restrictions:** N/A

**Prescription Order Restrictions:**
1) Hematologist
2) Oncologist
3) Urologist

**Coverage Duration:** End of contract year

**Other Criteria:** Afinitor Disperz is indicated ONLY for the treatment of patients with subependymal giant cell astrocytoma and TSC.

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

**Affected Drugs:**
Alecensa

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Diagnosis: Anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC). 2) Presence of disease progression on or intolerant to crizotinib, 3) Bilirubin level: a. 0.2 to 0.8mg/dL, 4) Liver Function Test

**Age Restrictions:** 18 years of age and older

**Prescription Order Restrictions:** 1) Oncologist, 2) Pulmonologist, 3) Hematologist

**Coverage Duration:** End of contract year

**Other Criteria:** 1) The safety of ALECENSA in patients with severe renal impairment (creatinine clearance less than 30 mL/min) or end-stage renal disease has not been studied. 2) No dose adjustment is recommended for patients with mild hepatic impairment (total bilirubin less than or equal to upper limit of normal (ULN) and aspartate transaminase (AST) greater than ULN or total bilirubin greater than 1.0 to 1.5 times ULN and any AST). The safety of ALECENSA in patients with moderate or severe hepatic impairment has not been studied.

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

Affected Drugs:
Alimta

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Patients with squamous cell non-small cell lung cancer. 2) Creatinine clearance (CRCL) less than 45 mL/min

Required Medical Information: 1) Diagnosis: a. locally advanced or metastatic nonsquamous non-small cell lung cancer OR b. mesothelioma, 2) For locally advanced or metastatic non squamous non-small cell lung cancer: a. For initial treatment: prescribed in combination with cisplatin, b. For patients with prior chemotherapy: indicated as a single agent OR c. For maintenance treatment (ONLY): document disease has not progressed after four cycles of platinum-base chemotherapy, 2) For mesothelioma document the following: a. patient is not a candidate for curative surgery, AND b. prescribed in combination with cisplatin, 3) Document the following lab results: CMP, and CRCL greater than 45 ml/min

Age Restrictions: N/A

Prescription Order Restrictions: 1) Hematologist, 2) Oncologist

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
**ALPHA 1-PROTEINASE INHIBITOR, HUMAN 50 MG/ML**

**Affected Drugs:**
Prolastin-C

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Immunoglobulin A (IgA) deficiency with antibodies against IgA. 2) Alpha-1-proteinase-associated liver disease

**Required Medical Information:** 1) Serum alpha1-antitrypsin (AAT) levels less than 11 mcmol/L, 2) FEV1 levels less than 80%, 3) Provide Hepatitis B immunization dates

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Specialist in metabolic or genetic disorders, 2) Pulmonologist

**Coverage Duration:** End of contract year

**Other Criteria:** Part D vs. Part B evaluation also applies. (*)

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

Affected Drugs: Alunbrig

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC). 2) Presence of disease progression or intolerance to crizotinib

Age Restrictions: 18 years of age or older.

Prescription Order Restrictions: 1) Oncologist, 2) Hematologist, 3) Pulmonologist

Coverage Duration: End of contract year

Other Criteria: Previous use of Zykadia.

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

Affected Drugs:
Amitiza

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: Known or suspected mechanical gastrointestinal obstruction

Required Medical Information: 1) Diagnosis: a. chronic idiopathic constipation, b. opioid-induced constipation OR c. irritable bowel syndrome with constipation

Age Restrictions: 18 years or older

Prescription Order Restrictions: 1) Gastroenterologist, 2) Pain specialist

Coverage Duration: End of contract year

Other Criteria: 1) Chronic Idiopathic Constipation and Opioid induced constipation: 24 mcg capsules, 2) Irritable bowel syndrome with constipation: 8mcg capsules

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

**Affected Drugs:**
Ampyra

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) History of seizures, 2) Moderate or severe renal impairment (CrCl less than 50ml/min)

**Required Medical Information:** 1) Diagnosis: Multiple Sclerosis, 2) Creatinine Clearance more than 50ml/min

**Age Restrictions:** 18 years or older

**Prescription Order Restrictions:** Neurologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
ANABOLIC STEROIDS

Affected Drugs:
Anadrol-50
Oxandrolone

Covered Uses: All FDA-approved indications not otherwise excluded from Part D. 2) HIV-wasting

Exclusion Criteria: 1) Known or suspected nephrosis (the nephrotic phase of nephritis). 2) Known or suspected hypercalcemia. 3) Known or suspected carcinoma of the breast in women with hypercalcemia. 4) Known or suspected carcinoma of the prostate or breast in male patients. 5) Pregnancy

Required Medical Information: N/A

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Aranesp (Albumin Free)

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Uncontrolled hypertension

**Required Medical Information:** 1) Initial prescription: a. Hgb is less than 10 g/dL, b. CBC, c. Total iron binding capacity, d. Iron levels, e. Ferritin levels, f. Vitamin B12 level, g. Folate level, h. Serum creatinine, i. BUN. 2) For reauthorizations: a. Patient who received erythropoietin in previous month: an increase in Hgb of at least 1g/dL after at least 12 weeks of therapy, b. Documentation of adequate iron stores. Adequate iron stores: serum ferritin is at least 100 mg/mL or transferrin saturation is at least 20%.

**Age Restrictions:** N/A

**Prescription Order Restrictions:** 1) Nephrologist 2) Hematologist 3) Oncologist

**Coverage Duration:** 12 weeks

**Other Criteria:** 1) Part D vs. Part B evaluation also applies. (*)

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

**Affected Drugs:**
Arcalyst

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Active or chronic infection, 2) Concurrent therapy live vaccines or TNF.

**Required Medical Information:** 1) Patient has a diagnosis of cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS). 2) Provide annually, negative tuberculosis (TB) skin test results. For positive latent TB, patient must have completed or receiving treatment for Latent Tuberculosis Infection prior to initiating Arcalyst.

**Age Restrictions:** 12 years of age and older

**Prescription Order Restrictions:** 1) Rheumatologist, 2) Immunologist 3) Geneticist, 4) Dermatologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs: Bosulif

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Philadelphia positive chronic myelogenous leukemia, 2) Document the following: a. positive results for Philadelphia chromosome, b. disease phase, c. resistance/ intolerance to prior therapy

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Hematologist, 2) Oncologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Brilinta

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Active pathological bleeding. 2) History of intracranial hemorrhage


Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
BUPRENO PHINE

Affected Drugs:
Buprenorphine HCl
Buprenorphine HCl-Naloxone HCl
Suboxone

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Document the following: a. opioid dependence AND b. patient is not receiving other opioids written by a different prescriber.

Age Restrictions: 16 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: 1) Quantity of up to 120 units/30 day supply allowed for Suboxone

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

Affected Drugs:
Cabometyx

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Documented diagnosis: Advanced Renal Cell Carcinoma (RCC), 2) Document prior use of anti-angiogenic therapy (i.e. sunitinib (Sutent), temsirolimus (Torisel), bevacizumab (Avastin) (in combination with IFN-a), pazopanib (Votrient), axitinib (Inlyta), and high-dose interleukin-2 or sorafenib (Nexavar).

Age Restrictions: 18 years of age and older

Prescription Order Restrictions: 1) Oncologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Caprelsa
Vandetanib

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Patients with congenital Long QT syndrome 2) Patients with hypocalcemia, hypokalemia, and hypomagnesemia.

**Required Medical Information:** 1) Diagnosis: locally advanced or metastatic medullary thyroid cancer, 2) Document: a. disease is unresectable and b. CMP results

**Age Restrictions:** 18 years or older

**Prescription Order Restrictions:** 1) Hematologist/Oncologist, 2) Endocrinologist

**Coverage Duration:** End of contract year

**Other Criteria:** For hypocalcemia (normal values are 4.5 – 5.5 mEq/L), hypokalemia (normal values are 3.5 – 5.3 mEq/L), hypomagnesemia (normal values are 1.5 – 2.5 mEq/L).

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

Affected Drugs:
Carbaglu

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: a) Adjunctive therapy for the treatment of acute hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS), b) Maintenance therapy for the treatment of chronic hyperammonemia due to the deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) 2) Plasma ammonia levels (Normal range 10 to 80 mcg/dL)

Age Restrictions: N/A

Prescription Order Restrictions: 1) Geneticist 2) Physician experienced in metabolic disorder

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Cayston

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Diagnosis of cystic fibrosis with pseudomonas aeruginosa in the lungs, 2) Culture results, 3) FEV1 must be more than 25% or less than 75% predicted

**Age Restrictions:** 7 years of age and older

**Prescription Order Restrictions:** 1) Pulmonologist, 2) Infectious Disease Specialist

**Coverage Duration:** 6 months

**Other Criteria:** The recommended dose of Cayston for both adults and pediatric patients 7 years of age and older is one single-use vial (75 mg of aztreonam) reconstituted with 1 ml of sterile diluent administered 3 times a day for a 28-day course (followed by 28 days off Cayston therapy)

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

Affected Drugs:
Chantix
Chantix Continuing Month Pak
Chantix Starting Month Pak

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) If patient is currently taking branded Zyban, branded Zyban will be discontinued while patient is taking Chantix.

Required Medical Information: 1) Document: intended use as part of smoking cessation treatment, 2) For renewals document: medical justification that indicates patient has stopped smoking

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: 6 months

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
CHORIONIC GONADOTROPIN

Affected Drugs:
Chorionic Gonadotropin

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Precocious puberty, 2) Pregnancy, 3) Prostate cancer or other androgen-dependent neoplasm, 4) Used for weight loss

Required Medical Information: 1) Diagnosis: a. prepubertal cryptorchidism not due to anatomic obstruction, b. hypogonadotropic hypogonadism secondary to pituitary deficiency, 2) Negative pregnancy affirmation

Age Restrictions: 4 years or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

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

Affected Drugs:
Cometrix (100 mg Daily Dose)
Cometrix (140 mg Daily Dose)
Cometrix (60 mg Daily Dose)

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Metastatic medullary thyroid cancer

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Hematologist, 2) Oncologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Cosentyx
Cosentyx Sensoready Pen

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Documented diagnosis: 1) Moderate to severe plaque psoriasis: at least 5% BSA or crucial body areas such as the hands, feet, face, or genitals. 2) Active Psoriatic Arthritis (PsA). 3) Active Ankylosing Spondylitis (AS): a. Inadequate response to at least 2 NSAIDs, 4) Negative Tuberculosis test, If positive must be on treatment

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Dermatologist, 2) Rheumatologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Cotellic

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Patients with wild-type BRAF melanoma.

Required Medical Information: 1) Diagnosis: Unresectable or metastatic melanoma, 2) Positive BRAF V600E or V600K mutation test, 3) Cotellic will be used in combination with vemurafenib, 4) Liver Function Test

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Oncologist, 2) Hematologist

Coverage Duration: End of contract year

Other Criteria: 1) The safety of COTELLIC has not been established in patients with a baseline LVEF that is either below institutional lower limit of normal (LLN) or below 50%.

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

**Affected Drugs:**
Cresemba Oral Capsule

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:**
1) Coadministration with strong CYP3A4 inhibitors, such as ketoconazole or high-dose ritonavir,
2) Coadministration with strong CYP3A4 inducers, such as rifampin, carbamazepine, St. John’s wort, or long acting barbiturates

**Required Medical Information:**
1) Diagnosis: Invasive aspergillosis or mucormycosis, 2) Liver Function Test

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Infectologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
Cystagon

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Diagnosis: nephropathic cystinosis

**Age Restrictions:** N/A

**Prescription Order Restrictions:** 1) Nephrologist, 2) Pediatric nephrologist, 3) Geneticist, 4) Specialist in metabolic or genetic disorders

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Affected Drugs:  
Cystaran

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Corneal cystine crystal accumulation in patients with cystinosis.

Age Restrictions: N/A

Prescription Order Restrictions: 1) Ophthalmologist, 2) Specialist in metabolic or genetic disorders

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Effient
Prasugrel

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) active pathological bleeding 2) history of transient ischemic attack or stroke

Required Medical Information: 1) Diagnosis: Acute Coronary Syndrome

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Eliquis

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Active pathological bleeding.

**Required Medical Information:** 1) Document one of the following: a. non-valvular atrial fibrillation (Afib), b. Deep Vein Thrombosis (DVT), c. Pulmonary Embolism (PE) OR d. prophylaxis of DVT following hip or knee replacement surgery,

**Age Restrictions:** 18 years or older

**Prescription Order Restrictions:** N/A

**Coverage Duration:** End of contract year

**Other Criteria:** 1) Reduction of Risk of Stroke and Systemic Embolism in Patients with Nonvalvular Atrial Fibrillation: 5 mg taken orally twice daily. 2) Dosage Adjustments: a. In patients with nonvalvular atrial fibrillation: The recommended doses 2.5 mg twice daily in patients with any 2 of the following characteristics: i. age equal or greater than 80 years, ii. body weight equal or less than 60 kg, iii. serum creatinine greater than or equal to 1.5mg.dL.

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

Affected Drugs: Empliciti

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Multiple Myeloma, 2) Document if patient has received at least one to three prior therapies, and use in combination with lenalidomide and dexamethasone must be documented

Age Restrictions: N/A

Prescription Order Restrictions: 1) Hematologist, 2) Oncologist

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

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

Affected Drugs:
Enbrel
Enbrel SureClick

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis 2) For Rheumatoid arthritis and Polyarticular Juvenile Idiopathic arthritis document: disease is moderate to severe, 3) For Plaque Psoriasis document: 5% BSA or crucial body areas such as the hands, feet, face, or genitals, 4) For Ankylosing Spondylitis: Inadequate response to at least 2 NSAIDs, 5) Latent tuberculosis test result. If positive must be on treatment, 6) Negative Hep B test or currently on treatment, 7) Psoriatic arthritis: no medical information required.

Age Restrictions: N/A

Prescription Order Restrictions: 1) Dermatologist, 2) Rheumatologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Baraclude
Entecavir

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: chronic hepatitis B virus infection, 2) Document the following: a. Hepatitis B surface antigen (HBsAg), b. Liver Function Test

Age Restrictions: 2 years of age or older

Prescription Order Restrictions: 1) Gastroenterologist, 2) Infectologist 3) Hepatologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs: Entresto

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: History of angioedema related to previous ACE inhibitor or ARB therapy.

Required Medical Information: 1) Diagnosis of symptomatic chronic heart failure (NYHA class II-IV) with Left ventricular ejection fraction (LVEF) less than 40%, 2) Prior use: a. ACEI OR b. ARBs

Age Restrictions: 18 years and older

Prescription Order Restrictions: 1. Cardiologist

Coverage Duration: End of contract year

Other Criteria: If currently on an ACE inhibitor or ARB, Entresto will replace them.

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Affected Drugs:
Epclusa

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Documented diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5 or 6, 2) Documentation of hepatic fibrosis status by one of the following: a. Clinical evidence stating the cirrhosis status as attested by the prescribing physician, b. Liver biopsy METAVIR score, or alternative scoring equivalent, c. Radiological imaging of the liver, d. Transient elastography (FibroScan) score, e. FibroTest (FibroSure) score, f. APRI score, 3) For transplant patients, provide viral load, 4) Prior use status of PEG-IFN, RBV, HCV protease or polymerase inhibitors, 5) Renal Impairment and creatinine clearance status more than 30 ml/min

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Hepatologist, 2) Gastroenterologist or, 3) Infectious Disease Specialist

Coverage Duration: 12 weeks

Other Criteria: Duration for genotypes 1, 2, 3, 4, 5 and 6 during 12 weeks, with or without ribavirin, according to the clinical scenario assessed by the pharmacist in full compliance with the updated HCV guidelines recommendations at the time.

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Affected Drugs: Procrit

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Uncontrolled hypertension

Required Medical Information: 1) Document the following: a. anemia diagnosis OR b. reduction of allogeneic RBC transfusions in patients undergoing elective, noncardiac, nonvascular surgery, 2) For treatment of anemia document the cause: a. CKD, b. zidovudine in HIV-affected patients, OR c. myelosuppressive chemotherapy, 3) For anemia diagnosis initial prescription: a. Hgb is less than 10 g/dL, 4) For anemia associated to zidovudine in HIV Patients: a. Concomitant use of Zidovudine at a maximum dose of 4200 mg/week, 5) For reduction of allogenic red blood cell transfusions in patients undergoing elective noncardiac, nonvascular surgery document: a. Hgb levels must be greater than 10 and less than or equal to 13 g/dL AND b. patient is at high risk for perioperative blood loss AND c. type of surgery, 6) For renewals: a. Patient who received erythropoietin in previous month: an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy, b. Documentation of adequate iron stores. Adequate iron stores: serum ferritin is at least 100 ng/mL or transferrin saturation is at least 20%.

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: 12 weeks

Other Criteria: 1) Part D vs. Part B evaluation also applies. (*)

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

**Affected Drugs:**
Erivedge

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Pregnancy

**Required Medical Information:** 1) Diagnosis: a. Metastatic Basal Cell Carcinoma (BCC) OR, b. Locally advanced BCC that has recurred following surgery or the patient is not a candidate for radiation or surgery. 2) Document the following: a. patient has recurred following surgery OR b. patient is not a candidate for radiation or surgery, 3) Negative pregnancy affirmation

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Hematologist, 2) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs: Esbriet

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis of Idiopathic Pulmonary Fibrosis

Age Restrictions: 18 years or older

Prescription Order Restrictions: 1) Pulmonologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs: Fabrazyme

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis of Fabry disease

Age Restrictions: N/A

Prescription Order Restrictions: 1) Cardiologist, 2) Nephrologist, 3) Specialist in metabolic or genetic disorders

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

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

Affected Drugs: Farydak

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: multiple myeloma, 2) Document the following: a. prescribed in combination with bortezomib and dexamethasone, b. patient has received at least 2 prior regimens, including Bortezomib and an immunomodulatory agent (e.g. thalomid, lenalidomide and pomalidomide)

Age Restrictions: 18 years or older

Prescription Order Restrictions: 1) Oncologist 2) Hematologist

Coverage Duration: End of contract year

Other Criteria: Therapy will be discontinued after a lifetime total of 16 cycles of treatment

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
FENTANYL PATCH

Affected Drugs:
FentaNYL

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Patients who are not opioid tolerant. (Patients are considered opioid tolerant if they have been taking at least 60 mg of oral morphine per day, 25 mcg of transdermal fentanyl/hr, 30 mg of oral oxycodone daily, 8 mg of oral hydromorphone daily, 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer), 2) Patients with acute or intermittent pain, postoperative pain and/ or mild pain, 3) Patients who do not require continuous opioid analgesia.

Required Medical Information: 1) Document ALL of the following: a. medical justification that indicates that the patient requires daily, around-the-clock long term opioid treatment AND b. previous failure or intolerability to non-opioid analgesics and immediate–release opioids

Age Restrictions: 2 years or older

Prescription Order Restrictions: 1) Pain specialist, 2) Hematologist, 3) Oncologist

Coverage Duration: 6 months

Other Criteria: N/A

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

Affected Drugs: Ferriprox

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Transfusional iron overload in patients with other chronic anemias.

Required Medical Information: 1) Diagnosis: transfusional iron overload due to thalassemia syndromes, 2) Document the following: a. Absolute neutrophil count (ANC), b. CBC with differential, AND d. failure to current chelation therapy

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Hematologist, 2) Oncologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs: Firazyr

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Hereditary angioedema

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Flucytosine

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Document: a. diagnosis of serious infection AND b. culture results

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs: Forteo

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: a. postmenopausal women with osteoporosis, b. men with primary or hypogonadal osteoporosis, OR c. osteoporosis associated with sustained systemic glucocorticoid therapy, 2) Document the following: a. T-score = 2.5, b. previous osteoporosis therapy: a. failure/intolerance to biphosphonates c. patient is at increased risk of fracture: a. history of osteoporotic fracture, b. multiple risk factors for fracture, OR d. failure or intolerability to prior available osteoporosis therapy.

Age Restrictions: 18 years or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: Therapy will be discontinued after a lifetime total of 24 months of treatment

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

Affected Drugs: Gattex

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis Short Bowel Syndrome (SBS) in adults who are dependent on parenteral support. 2) Laboratories: 1. Liver Function test: a. ALT and AST b. Bilirubin c. Amylase and Lipase

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Gastroenterologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Gilotrif

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A


**Age Restrictions:** 18 years or older

**Prescription Order Restrictions:** 1) Pulmonologist, 2) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
Imatinib Mesylate

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Diagnosis: a. Philadelphia positive chronic myeloid leukemia (Ph+CML), b. Philadelphia positive acute lymphoblastic leukemia (Ph+ALL), c. myelodysplastic/myeloproliferative disease d. aggressive systemic mastocytosis, e. hypereosinophilic syndrome and/or chronic eosinophilic leukemia f. dermatofibrosarcoma protuberans (DFSP), OR g. gastrointestinal stromal tumors (GIST), 2) For previously treated Ph+CML document: failure to interferon-alpha therapy, 3) For adults with Ph+ALL document: disease relapse, 4) For pediatric Ph+ALL document: a. newly diagnosed AND b. prescribed in combination with chemotherapy, 5) For DFSP document: disease is unresectable, recurrent and/or metastatic, 6) For GIST document: a. CD117 positive results, AND b. one of the following: 1. disease is unresectable and/or metastatic, 2. Use of Imatinib for adjuvant therapy following resection, OR 3. GIST is resectable and Imatinib will be used to improve surgical morbidity by reducing tumor size preoperatively,

**Age Restrictions:** N/A

**Prescription Order Restrictions:** 1) Hematologist, 2) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
GROWTH HORMONE

Affected Drugs:
Genotropin
Genotropin MiniQuick
Humatrope
Norditropin
Norditropin FlexPro
Norditropin NordiFlex
Nutropin AQ NuSpin 10
Nutropin AQ NuSpin 20
Nutropin AQ NuSpin 5
Serostim

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Active malignancy, active proliferative or severe non-proliferative diabetic retinopathy, acute critical illness, 2) Closed epiphyses for pediatric patients, 3) Prader-Willi syndrome, in patients who are severely obese, have a history of upper airway obstruction or sleep apnea, or have severe respiratory impairment, sudden death has been reported, 4) Underlying intracranial tumor, evidence of progression or recurrence, 5) Post kidney transplant, 6) Respiratory insufficiency

Required Medical Information: 1) Total or partial deficiency of endogenous growth hormone evidenced by 1 or more of the following indicators: a. Minimum of 2 or more abnormal growth hormone provocative tests, secretion of the Growth Hormone is less than 10ng/ml, b. Delayed bone age of 2 or more years (2 standard deviations below the mean for chronological age), c. Slowed growth rate demonstrated by deviation from normal growth curves (growth rate below 7cm per year for children 3 years old and younger and less than 4-5cm per year for children from 3 years old until puberty), 2) For HIV-wasting: a. Current antiretroviral therapy, 3) For adult GHD (meets one of the following): a. Failed to stim tests with peak below 5 g/L, b. 3 or more PTH deficiency, c. Child onset GHD with no mutations embriopathic lesions or irreversible structural lesions/damage, low pre-treatment IGF-1 and failed 1 stim test (peak below 5 g/L) prior to starting GH treatment.

Age Restrictions: N/A

Prescription Order Restrictions: 1) Endocrinologist, 2) Infectious Disease Specialist, 3) Nephrologist

Coverage Duration: HIV-wasting: 12 weeks. All other indications: End of contract year

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Other Criteria: 1) For renewal of PWS only: body composition has improved, 2) Renewal for adult GHD: IGF-1 levels will be evaluated to confirm appropriateness of continued tx, 3) Renewal for HIV-wasting: BMI has improved or stabilized.

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

Affected Drugs:
Harvoni

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Documented diagnosis of chronic hepatitis C genotype 1a, 1b, 4, 5, or 6. 2) Documentation of hepatic fibrosis status by one of the following: a) Clinical evidence stating the cirrhosis status as attested by the prescribing physician, b) Liver biopsy METAVIR score, or alternative scoring equivalent, c) Radiological imaging of the liver, d) Transient elastography (FibroScan) score, e) FibroTest (FibroSure) score, f) APRI score, 3) Indicate if patient is naïve or experienced (i.e. prior use of PEG-IFN, RBV, HCV protease or polymerase inhibitors), 4) Renal Impairment and creatinine clearance status (value should be more than 30ml/min) 5) For transplant patients, provide viral load.

Age Restrictions: 12 years of age or older

Prescription Order Restrictions: 1) Hepatologist, 2) Gastroenterologist, 3) Infectious Disease Specialist

Coverage Duration: 12 to 24 weeks based on HCVs and patients characteristics – see Other Criteria

Other Criteria: Duration for genotypes 1a, 1b, 4, 5 and 6 will range between 12 and 24 weeks depending on the clinical scenario assessed by the pharmacist in full compliance with the updated HCV guidelines recommendations at the time.

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

Affected Drugs:
Hetlizoz

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Non 24-Hour Sleep-Wake Disorder (Non-24).

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
HIGH RISK MEDICATIONS

Affected Drugs:
Benztropine Mesylate
Butalbital-APAP-Caffeine
Cyclobenzaprine HCl
Cyproheptadine HCl
Disopyramide Phosphate
Ergoloid Mesylates
Estradiol
Estradiol-Norethindrone Acet
GuanFACINE HCl
HydrOXYzine HCl
Indomethacin
Megestrol Acetate Oral Suspension
Methocarbamol
Methyldopa
Norpace CR
Premarin
Promethazine HCl

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Provider acknowledgement that medication is a HRM in the elderly and that the patient has failed and/or tried at least one non-high risk alternative

Age Restrictions: PA applies to patients 65 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: 1) For cyclobenzaprine only: 21 days, renewals: 21 days. 2) All other drugs: End of Contract Year


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

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
**HIGH RISK MEDICATIONS 2**

**Affected Drugs:**
- Amitriptyline HCl
- Clomipramine HCl
- Doxepin HCl
- Imipramine HCl
- Imipramine Pamoate
- Megestrol Acetate Oral Tablet
- Trihexyphenidyl HCl
- Trimipramine Maleate

**Covered Uses:** All medically accepted indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Provider acknowledgement that medication is a HRM in the elderly and that the patient has failed and/or tried at least one non-high risk alternative

**Age Restrictions:** PA applies to patients 65 years of age or older

**Prescription Order Restrictions:** N/A

**Coverage Duration:** End of contract year

**Other Criteria:** Must have prior utilization of one or more alternative medications available on formulary which include but are not limited to: 1) For Amitriptyline, Clomipramine, Doxepin, Imipramine, Trimipramine: a. Amoxapine, Desipramine, Nortriptyline, SSRIs, SNRIs, Bupropion, 2) Megestrol Oral Tablets: a. Dronabinol, b. Tamoxifen, 3) For Trihexyphenidyl: a. Carbidopa/Levodopa, b. Pramipexole, c. Ropinirole

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
HUMAN PAPILLOMAVIRUS (HPV) VACCINE

Affected Drugs:
Gardasil 9

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: N/A

Age Restrictions: 1) For girls and women between the ages of 9 and 26 years (Gardasil), 2) For boys and men between the ages of 9 and 26 years (Gardasil).

Prescription Order Restrictions: N/A

Coverage Duration: 1) Following the schedule: 0, 2, and 6 months for Gardasil

Other Criteria: N/A

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

**Affected Drugs:**
- Humira
- Humira Pen
- Humira Pen-Crohns Starter
- Humira Pen-Psoriasis Starter

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Active infection (including TB), 2) Combination therapy with other biologic agent(s).

**Required Medical Information:** 1) Diagnosis: a. rheumatoid arthritis, b. psoriatic arthritis, c. ankylosing spondylitis, d. juvenile idiopathic arthritis, e. Crohn’s disease, f. ulcerative colitis, g. plaque psoriasis, h. hidradenitis suppurativa, OR uveitis 2) Latent tuberculosis test result. If positive must be on treatment, 3) Negative Hep B test or currently on treatment, 4) For Crohn’s Disease document: a. Inadequate response to at least 2 of the following: Corticosteroids, Sulfasalazine, Azathioprine Mesalamine, 6-mercaptopurine, or Methotrexate, 5) For Pediatric Crohn’s disease document: Inadequate response to at least 2 of the following: Corticosteroids, Azathioprine, 6-mercaptopurine, or Methotrexate, 6) For Plaque Psoriasis: 5% BSA or crucial body areas such as hands, feet, genitals, head, 7) For Ankylosing Spondylitis: Inadequate response to at least 2 of the following: Corticosteroids, Azathioprine, 6-mercaptopurine, or Methotrexate, 8) For Ulcerative Colitis document: inadequate response to at least 2 of the following: Corticosteroids, Azathioprine, or 6-mercaptopurine. 9) For hidradenitis suppurativa, juvenile idiopathic arthritis, uveitis, and psoriatic arthritis: no medical information is required.

**Age Restrictions:** 1) For Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Adult Crohn’s disease, Ulcerative Colitis, Plaque Psoriasis and Hidradenitis Suppurativa: 18 years of age or older 2) For Juvenile Idiopathic Arthritis: 2 years of age or older. 3) For Pediatric Crohn’s disease: 6 years of age or older

**Prescription Order Restrictions:** 1) Rheumatologist, 2) Gastroenterologist, 3) Dermatologist, 4) Ophthalmologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
Ibrance

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Documented diagnosis for Metastatic Breast Cancer HER2 negative, 2) If used in combination with letrozole, document if patient is post-menopausal, 3) If used in combination with fulvestrant, document disease progression following endocrine therapy.

**Age Restrictions:** 18 years or older

**Prescription Order Restrictions:** 1) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs:
Iclusig

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: a. T3151-positive chronic myeloid leukemia (CML), b. T3151-positive Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL), c. chronic myeloid leukemia, OR Ph+ALL, 2) For T315I-positive CML document the following: a. disease phase, b. positive results for T3151 mutation, 3) For T315I positive Ph+ ALL document the following: a. positive results for T3151 mutation, b. positive results for Philadelphia chromosome, 4) For chronic myeloid leukemia document the following: a. disease phase, b. document intolerance or contraindication to other tyrosine kinase inhibitor therapy, 5) For Ph+ ALL document the following: a. positive results for Philadelphia chromosome, b. document intolerance or contraindication to other tyrosine kinase inhibitor therapy, 6) For renewals: document response to treatment

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Oncologist 2) Hematologist

Coverage Duration: 1) Initial: 3 months, 2) Renewals: end of contract year

Other Criteria: N/A

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

Affected Drugs:
Ilaris

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Active or chronic infection, 2) Concurrent therapy live vaccines or TNF.

Required Medical Information: 1) Patient has a diagnosis of: a) Cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (FCAS), Muckle-Wells syndrome (MWS), b) Systemic onset juvenile chronic arthritis, c. Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), d. Hyperimmunoglobulin D Syndrome (HIDS)/ Mevalonate Kinase Deficiency (MKD), OR e. Familial Mediterranean Fever (FMF) 2) For positive latent tuberculosis infection (LTBI), patient must have completed or receiving treatment for LTBI prior to initiating Ilaris.

Age Restrictions: 1) Cryopyrin-Associated periodic syndromes: 4 years of age or older 2) Systemic Juvenile Idiopathic arthritis: 2 years of age or older

Prescription Order Restrictions: 1) Rheumatologist, 2) Immunologist, 3) Dermatologist

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

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

**Affected Drugs:**
Imbruvica

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Diagnosis: a. mantle cell lymphoma (MCL), b. chronic lymphocytic leukemia (CLL)/Small Lymphocytic Lymphoma (SLL) with or without 17p deletion, c. Waldenstrom’s macroglobulinemia (WM), d. marginal zone lymphoma, OR e) chronic graft versus host disease (cGVHD), 2) For MCL: document prior treatment, 3) For marginal zone lymphoma: document prior use of anti-CD20 therapy. 4) For cGVHD: document failure of one or more lines of systemic therapy.

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Oncologist, 2) Hematology

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs:
Azasan
AzaTHIOprine
CycloSPORINE
CycloSPORINE Modified
Mycophenolate Mofetil
Mycophenolate Mofetil HCl
Mycophenolate Sodium
Nulojix
Rapamune
SandIMMUNE
Sirolimus
Tacrolimus
Zortress

Covered Uses: All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: 1) Part D vs. Part B evaluation also applies. (*)

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

Affected Drugs:
Increlex

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Epiphyseal closure, active malignancy, or concurrent use with GH therapy. 2) Patient has secondary causes of IGF-1 deficiency (e.g. hypothyroidism, malignancy, chronic systemic disease, skeletal disorders, malnutrition, celiac disease).

Required Medical Information: 1) Diagnosis: a. growth failure with severe primary IGFD OR b. growth hormone gene deletion with neutralizing antibodies to GH, 2) For growth failure with severe primary IGFD, document the following: a. Height standard deviation score, b. Growth hormone levels, c.IGF-1 standard deviation score

Age Restrictions: N/A

Prescription Order Restrictions: 1) Endocrinologist

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
INJECTABLE MULTIPLE SCLEROSIS

Affected Drugs:
Avonex
Avonex Pen
Avonex Prefilled
Betaseron
Copaxone
Glatopa

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Multiple Sclerosis (MS)

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Neurologist

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
**INJECTABLE TESTOSTERONE**

**Affected Drugs:**
Depo-Testosterone  
Testosterone Cypionate  
Testosterone Enanthate

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** Carcinoma of the breast or known or suspected prostate cancer

**Required Medical Information:** 1) Diagnosis

**Age Restrictions:** N/A

**Prescription Order Restrictions:** N/A

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs: Inlyta

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: advanced renal cell carcinoma (RCC), 2) Document progression of disease after at least 1 prior systemic therapy for RCC. Examples of prior systemic therapies for RCC include regimens containing bevacizumab, pazopanib, sorafenib, sunitinib, temsirolimus, and cytokines (interferon alpha or interleukin-2).

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Hematologist, 2) Oncologist, 3) Urologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Iressa

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Documented Diagnosis of metastatic non-small cell lung cancer whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Oncologist, 2) Pulmonologist, 3) Hematologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Carimune NF
Gammagard
Gammagard S/D Less IgA
Gammaplex
Gamunex-C

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: IgA deficiency with antibodies to IgA and a history of hypersensitivity, history of anaphylaxis or severe systemic reaction to human immune globulin or product components. For Carimune, history of anaphylaxis or severe systemic reaction to human immune globulin or product components.

Required Medical Information: 1) Diagnosis, 2) Document at least one prior systemic therapy, 3) CBC with diff, 3) BMP

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

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

Affected Drugs:
Jadenu
Jadenu Sprinkle

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Creatinine Clearance (CRCL) less than 40 mL/min, 2) Severe hepatic impairment, 3) Platelet count less than 50,000/mcL, 4) Patient with poor performance status and high-risk myelodysplastic syndrome (MDS) or advanced malignancies,

Required Medical Information: 1) Creatinine clearance greater than 40 ml/min, 2) Document lack of severe hepatic impairment, 3) Bilirubin: a. 0.2 to 0.8mg/dL, 4) Platelets more than 50,000/mcL

Age Restrictions: Two years of age and older

Prescription Order Restrictions: 1) Hematologist, 2) Oncologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Jakafi

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Document if the patient has intermediate or high-risk myelofibrosis (MF): a. Intermediate and high-risk MF patients include anyone over the age of 65 or who have or have had any of the following: anemia, constitutional symptoms, elevated white blood cell or blast counts or platelet counts less than 100 X 10^9/L, b. To continue therapy beyond 6 months, document spleen size reduction or symptom improvement since initiation of therapy with Jakafi (50% reduction from pretreatment baseline in palpable spleen length, or a 35% reduction in spleen volume on MRI or CT), 2) Document if the patient has polycythemia vera (PV): a. If patient had an inadequate response to or are intolerant to hydroxyurea.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: 1) For MF: Initial: 6 months, renewals: End of Contract Year 2) For PV: End of contract year

Other Criteria: N/A

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


**JAUSTAPID**

**Affected Drugs:**
Juxtapid

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Pregnancy, 2) Concomitant use with strong or moderate CYP3A4 inhibitors, 3) Moderate or severe hepatic impairment or active liver disease including unexplained persistent abnormal liver function tests.

**Required Medical Information:** 1) Diagnosis: homozygous familial hypercholesterolemia, 2) Document the following: 1. Liver Function Test, 2. Bilirubin levels: a. 0.2 to 0.8mg/dL, c. Negative pregnancy affirmation, 3) For untreated LDL-C provide values above 500mg/dL for diagnosis of HoFH, 4) Prior use of Statins, or Ezetimibe for at least 90 days of consecutive therapy in the past 12 months.

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Cardiologist 2) Geneticist 3) Endocrinologist

**Coverage Duration:** End of contract year

**Other Criteria:** 1) Patient must start at an initial dose of 5mg.

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

Affected Drugs: Kalydeco

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) patients homozygous for the F508del mutation in the CFTR gene


Age Restrictions: 2 years of age and older

Prescription Order Restrictions: 1) Pulmonologist

Coverage Duration: Initial: 3 months, renewals: end of contract year

Other Criteria: 1) For Renewals document the following: a) Improvement of FEV1 Levels, 2) Decreased number of pulmonary exacerbations.

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

Affected Drugs:  
Kineret  

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Patients currently on TNF blocking agents

Required Medical Information: 1) Diagnosis: a. moderate to severe active rheumatoid arthritis OR b. neonatal-onset multisystem inflammatory disease (NOMID), 2) For rheumatoid arthritis document failure/intolerance to at least one of the following: Humira, Ocrecia, or Xeljanz, 3) Negative latent tuberculosis test result, if is positive must be on treatment, 4) Negative Hep B test or currently on treatment.

Age Restrictions: For rheumatoid arthritis: 18 years or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Kisqali
Kisqali Femara

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Document diagnosis for advance or metastatic breast cancer, 2) Document concurrent use of aromatase inhibitors (e.g., anastrozole, exemestane, letrozole), 3) Biomarkers test result evidencing: a) Human epidermal growth factor receptor 2 (HER2)-negative, b) Positive hormone receptor (HR)

Age Restrictions: N/A

Prescription Order Restrictions: Oncologist

Coverage Duration: End of contract year

Other Criteria: 1) For Kisqali Femara Co-Pack, concurrent use of aromatase inhibitors (e.g., anastrozole, exemestane, letrozole) is not required.

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

**Affected Drugs:**
Korlym

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Pregnancy, 2) Use of simvastatin or lovastatin and CYP3A substrates with narrow therapeutic range, 3) Concurrent long-term corticosteroid use, 4) Women with history of unexplained vaginal bleeding 5) Women with endometrial hyperplasia with atypia or endometrial carcinoma

**Required Medical Information:** 1) Diagnosis: Hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing’s syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery, 2) Negative pregnancy affirmation

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** N/A

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs:
Kuvan

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: hyperphenylalaninemia due to tetrahydrobiopterin-(BH4)-responsive PKU 2) For renewal: doctor must document a decrease in phenylalanine levels

Age Restrictions: N/A

Prescription Order Restrictions: 1) Geneticist, 2) Physician specialized in metabolic or genetic disorders

Coverage Duration: Initial: 3 months, renewals: end of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Kynamro

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** Moderate or severe hepatic impairment (Child-Pugh class B or C) or active liver disease, including unexplained persistent elevations of serum transaminases.

**Required Medical Information:** 1) Document the following: patient has a diagnosis of Homozygous familial hypercholesterolemia (HoFH) AND will be used as an adjunct to lipid lowering medications, 2) Liver function test 3) Bilirubin level: a. 0.2 to 0.8mg/dL (Do Not exceed more than 2 times their normal values)

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Cardiologist 2) Geneticist, 3) Endocrinologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
LABA/ICS COMBINATIONS

Affected Drugs:
Advair Diskus
Advair HFA
Breo Ellipta
Fluticasone-Salmeterol
Symbicort

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) concurrent use of other Long Acting Beta Agonist (LABA)

Required Medical Information: 1) For Advair, Breo Ellipta and Symbicort: Diagnosis of Asthma or COPD, 2) For Fluticasone-Salmeterol: Diagnosis of Asthma.

Age Restrictions: 1) Advair Diskus: 4 years and older, 2) Advair HFA: 12 years and older, 3) Symbicort: for asthma 6 years and older, Other indications: 12 years and older, 4) Breo Ellipta: 18 years and older, 5) For Fluticasone-Salmeterol: 12 years and older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: 1) Advair HFA indicated ONLY for asthma, 2) Advair Diskus 250/50 is the ONLY approved dose for COPD

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

Affected Drugs:
Lenvima 10 MG Daily Dose
Lenvima 14 MG Daily Dose
Lenvima 18 MG Daily Dose
Lenvima 20 MG Daily Dose
Lenvima 24 MG Daily Dose
Lenvima 8 MG Daily Dose

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: differentiated thyroid cancer (DTC) or renal cell cancer (RCC). 2) For DTC: document the tumor is locally recurrent or metastatic, progressive, failure or unresponsive to radioactive iodine treatment, 3) For RCC: a) Document the patient has advance RCC and has used one prior-angiogenic therapy (for example: Sutent, Torisel, Inlyta, Nexavar, Votrient or Avastin plus Interferon). b) Document patient will use levatinib in combination with everolimus.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: Oncologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Leukine

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Hypersensitivity to yeast-derived products. 2) Use of Leukine within 24 hours preceding or following chemotherapy or radiotherapy. 3) Use of Leukine for prophylaxis of FN. 4) When Leukine is used for treatment of acute FN: patient received prophylactic Neulasta during the current chemotherapy cycle. 5) When Leukine is used for acute myelogenous leukemia (AML): excessive leukemic myeloid blasts (greater than or equal to 10%) in the bone marrow or peripheral blood.

Required Medical Information: 1) Diagnosis, 2) CBC with differential, 3) Complete Metabolic Panel (CMP), 4) Body weight

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
LIDOCAINE PATCH

**Affected Drugs:**
Lidocaine

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Diagnosis: pain associated with post-herpetic neuralgia

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** N/A

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
Linezolid

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Carcinoid syndrome (unless monitored for signs/symptoms of serotonin syndrome), 2) Concomitant use of MAOIs (e.g. phenelzine, isocarboxazid) or use within 2 weeks of taking an MAOI, 3) Concomitant use of serotonin reuptake inhibitors, tricyclic antidepressants, triptans, meperidine, or buspirone (unless monitored for signs/symptoms of serotonin syndrome), 4) Concomitant use of sympathomimetic agents (e.g. pseudoephedrine), vasopressive agents (e.g. epinephrine, norepinephrine), or dopaminergic agents (e.g. dopamine, dobutamine) (unless monitored for potential blood pressure increases), 5) Uncontrolled hypertension (unless monitored for potential blood pressure increases), 6) Pheochromocytoma (unless monitored for potential blood pressure increases), 7) Thyrotoxicosis (unless monitored for potential blood pressure increases).

**Required Medical Information:** 1) Diagnosis: a. nosocomial pneumonia, b. community-acquired pneumonia, c. skin infection, OR d. Vancomycin-resistant Enterococcus faecium infection, 2) Culture results

**Age Restrictions:** N/A

**Prescription Order Restrictions:** N/A

**Coverage Duration:** 31 days

**Other Criteria:** N/A

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

Affected Drugs:
Linzess

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: Known or suspected mechanical gastrointestinal obstruction

Required Medical Information: 1) Diagnosis: a. irritable bowel syndrome with constipation OR b. chronic idiopathic constipation

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: Gastroenterologist

Coverage Duration: End of contract year

Other Criteria: 1) Chronic Idiopathic Constipation: 145 mcg capsules and 72mcg capsules, 2) Irritable bowel syndrome: predominant constipation: 290mcg capsules

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

**Affected Drugs:**
Lonsurf

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Documentation of previously treated with: a) fluoropyrimidine-, oxaliplatin-, and b) irinotecan-containing chemotherapy, and c) anti-VEGF therapy, and d) if RAS wild type, anti-EGFR therapy

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Hematologist, 2) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs: Lynparza

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: a) advanced ovarian cancer, b) recurrent epithelial ovarian cancer, c) recurrent fallopian tube cancer, or d) recurrent primary peritoneal cancer, 2) For advance ovarian cancer document the following: a. gBRCA mutation, b. prior treatment with at least three chemotherapy regimens, 3) For all other indications document prior treatment with a platinum containing regimen.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Oncologist 2) Hematologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:  
Mekinist

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: a. metastatic melanoma OR b. metastatic non-small cell lung cancer, 2) For metastatic melanoma, document the following: a. disease is unresectable AND b. positive results for BRAF V600E or V600K mutations, 3) For metastatic non-small cell lung cancer document the following: a. positive results for BRAF V600E mutations AND b. must be used in combination with dabrafenib.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Oncologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs: Meperidine HCl

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: moderate to severe pain OR 2) document procedure

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: For procedures: One month. For any other purposes: 3 months

Other Criteria: N/A

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

Affected Drugs: Modafinil

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A


Age Restrictions: 17 years of age and older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Memantine HCl
Namenda XR
Namenda XR Titration Pack

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis, 2) Folstein Mini-Mental Status Exam (MMSE) Score less or equal to 20

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Natpara

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Patients who are at increased baseline risk for osteosarcoma (including those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, pediatric and young adult patients with open epiphyses, patients with hereditary disorders predisposing to osteosarcoma or patients with a history of prior external beam or implant radiation therapy involving the skeleton), 2) Patients with hypoparathyroidism caused by calcium-sensing receptor mutations, 3) Patients with acute post-surgical hypoparathyroidism

Required Medical Information: 1) Diagnosis: hypocalcemia in patients with hypoparathyroidism 2) Previous and current use of calcium and vitamin D (provide dosing and length of therapy) 3) Calcium and albumin levels and/or corrected calcium calculation.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Endocrinologist

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
NEUPOGEN / NEULASTA

Affected Drugs:
Neulasta
Neupogen

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) For Neupogen: Hypersensitivity to E. coli-derived proteins, 2) For Neulasta: not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation.

Required Medical Information: 1) For Neupogen document: a. cancer patients receiving chemotherapy OR b. cancer patients undergoing bone marrow transplantation OR c. patients undergoing leukapheresis OR d. severe chronic neutropenia OR e. exposure to myelosuppressive doses of radiation, 2) For Neulasta document: a. cancer patient receiving chemotherapy OR b. exposure to myelosuppressive doses of radiation, 3) Document the following lab results: a. Platelet counts AND b. CBC with differential

Age Restrictions: N/A

Prescription Order Restrictions: 1) Hematologist, 2) Oncologist, 3) Infectious Disease Specialist

Coverage Duration: 3 months

Other Criteria: Part D vs. Part B evaluation also applies. (*)

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

Affected Drugs: Neupro

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A


Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
NexAVAR

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Combination with carboplatin and paclitaxel in patients with squamous cell lung cancer

**Required Medical Information:** 1) Diagnosis: a. hepatocellular carcinoma (HCC), b. renal cell carcinoma (RCC), OR c. locally recurrent or metastatic differentiated thyroid carcinoma (DTC), 2) For HCC: document disease is unresectable, 3) For RCC document one of the following: a. Disease relapse, b. Stage IV and medically or surgically unresectable disease, c. Progression despite cytokine therapy, 4) For locally recurrent or metastatic DTC document: failure /unresponsive to radioactive iodine treatment.

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Oncologist, 2) Nephrologist, 3) Gastroenterologist, 4) Hepatologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
Ninlaro

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Diagnosis: Multiple Myeloma, 2) Document if patient has received at least one prior therapy, 3) Use in combination with lenalidomide and dexamethasone must be documented.

**Age Restrictions:** N/A

**Prescription Order Restrictions:** 1) Hematologist, 2) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** Indicated on days 1, 8, and 15 of a 28-day cycle.

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

Affected Drugs: Northera

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Orthostatic dizziness, lightheadedness, or the “feeling that you are about to black out” in adult patients with symptomatic neurogenic orthostatic hypotension caused by primary autonomic failure (Parkinson's disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Cardiologist, 2) Neurologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Noxafil

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Concomitant use with ergot alkaloids (ergotamine and dihydroergotamine), HMG-CoA reductase inhibitors primarily metabolized by CYP3A4 (e.g., atorvastatin, lovastatin, and simvastatin), sirolimus, or CYP3A4 substrates that prolong the QT interval (pimozide and quinidine).

Required Medical Information: 1) Document: a. Intended use for prophylaxis of invasive aspergillosis and candida infections due to being severely immunocompromised OR b. Diagnosis of oropharyngeal candidiasis, 2) For prophylaxis of invasive aspergillosis and candida infections: Document patient is at high risk to develop these infections such as one of the following: a. HCST (Hemopoietic stem cell transplantation), b. GVHD (graft-versus-host disease), OR c. Patients with hematologic malignancies with prolonged neutropenia from chemotherapy, 3) For oropharyngeal candidiasis, document failure or intolerant to itraconazole and/or fluconazole. 4) Liver Function Test

Age Restrictions: 13 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Nuedexta

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:**
1) Concomitantly taking other drugs containing quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong QT interval and are metabolized by CYP2D6.
2) Patient has a prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or heart failure.
3) Patient has complete atrioventricular (AV) block without implanted pacemaker or is at high risk of complete AV block.

**Required Medical Information:**
1) Documented Diagnosis of neurological disease associated with Pseudobulbar affect

**Age Restrictions:**
18 years of age or older

**Prescription Order Restrictions:**
N/A

**Coverage Duration:**
End of contract year

**Other Criteria:**
N/A

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

Affected Drugs:
Nuplazid

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis of hallucinations and delusions associated with Parkinson’s disease psychosis.

Age Restrictions: N/A

Prescription Order Restrictions: 1) Neurologist, 2) Psychiatrist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Octreotide Acetate
SandoSTATIN
SandoSTATIN LAR Depot

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: a. acromegaly, b. diarrhea and/or flushing episodes associated with metastatic carcinoid tumor OR c. diarrhea associated with VIP-secreting tumors, 2) For acromegaly document: inadequate response/unable to tolerate surgery, pituitary irradiation, and bromocriptine at maximally tolerated doses, 3) For Sandostatin LAR Depot: prior treatment with sandostatin

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Affected Drugs: Odomzo

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Pregnancy

Required Medical Information: 1) Documented diagnosis of locally advanced BCC that has recurred following surgery or the patient is not a candidate for radiation or surgery, 2) Negative pregnancy affirmation

Age Restrictions: N/A

Prescription Order Restrictions: 1) Hematologist/Oncologist, 2) Oncologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Ofev

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis of Idiopathic pulmonary fibrosis.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Pulmonologist

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Affected Drugs:  
Opsumit

Covered Uses:  All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria:  1) Pregnancy

Required Medical Information:  1) Diagnosis of Pulmonary Arterial Hypertension, WHO Group 1, 2) Cardiac catheterization results: a. Mean pulmonary artery pressure (greater than or equal to 25mmHg) OR, b. Pulmonary capillary wedge pressure (less than or equal to 15mmHg), 3) Acute vasodilator testing result (required for patients with Idiopathic Pulmonary Arterial Hypertension ONLY). 4) Document previous failure to: Sildenafil.

Age Restrictions:  18 years of age or older

Prescription Order Restrictions:  1) Pulmonologist, 2) Cardiologist

Coverage Duration:  End of contract year

Other Criteria:  N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
**ORAL MULTIPLE SCLEROSIS**

**Affected Drugs:**
Aubagio
Gilenya
Tecfidera

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** For Gilenya only: 1) Patients who in the last 6 months experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class III/IV heart failure, 2) History or presence of Mobitz Type II second-degree or third-degree atroventricular (AV) block or sick sinus syndrome, unless patient has a functioning pacemaker, 3) Baseline QTc interval greater or equal to 500 ms, 4) Treatment with Class la or Class III anti-arrhythmic drugs. 5) For Aubagio only: a. Patients with severe hepatic impairment, b. Pregnancy, c. Coadministration with leflunomide

**Required Medical Information:** 1) Diagnosis: Multiple Sclerosis

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Neurologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
ORAL TESTOSTERONES

Affected Drugs:
Striant

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Male patients who have carcinoma of the breast or known or suspected prostate cancer

Required Medical Information: 1) Diagnosis: a. Hypogonadotropic hypogonadism OR b. Primary hypogonadism

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Orencia
Orencia ClickJect

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Concomitant use of biologic rheumatoid arthritis therapy (e.g. anakinra). 2) Tumor necrosis factor (TNF) antagonists, live vaccines, or use of live vaccines within 3 months of discontinuation of abatacept is not recommended.

Required Medical Information: 1) Diagnosis: a. adult rheumatoid arthritis, b. juvenile idiopathic arthritis, OR c. adult psoriatic arthritis, 2) Document previous use/intolerance of at least 2 of the following: a. DMARDs, b. Methotrexate, 3) Latent tuberculosis test result. If positive must be on treatment, 4) Negative Hep B test or currently on treatment, 5) For psoriatic arthritis: no medical information is required

Age Restrictions: 2 years of age or older

Prescription Order Restrictions: 1) Rheumatologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Orfadin

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Document the following: a. patient has a diagnosis of hereditary tyrosinemia type 1.

**Age Restrictions:** N/A

**Prescription Order Restrictions:** 1) Physician specializing in metabolic or genetic disorders, 2) Geneticist, 3) Gastroenterologist, 4) Hematologist, 5) Nephrologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
Orkambi

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1. Diagnosis of Cystic Fibrosis (CF) in patients with F508del, 2. Baseline FEV1 levels results, 3. Liver Function Test

**Age Restrictions:** 6 years and older

**Prescription Order Restrictions:** Pulmonologist

**Coverage Duration:** Initial: 3 months, renewals: End of contract year

**Other Criteria:** 1) For Renewals document the following: a) Improvement of FEV1 Levels, OR, b) Decreased number of pulmonary exacerbations.

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

**Affected Drugs:**
Otezla

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Documented diagnosis for moderate to severe plaque psoriasis: At least 5% BSA or crucial body areas such as the hands, feet, face, or genitals, 2) Creatinine Clearance (CrCl), 3) For Psoriatic arthritis: No requirements

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Dermatologist, 2) Rheumatologist

**Coverage Duration:** End of contract year

**Other Criteria:** 1) Creatinine Clearance less than 30ml/ml dose should be reduced to 30mg once daily

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

Affected Drugs:
Paricalcitol

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Hypercalcemia, 2) Vitamin D toxicity

Required Medical Information: 1) Document the following: a. intended use for prevention and treatment secondary hyperparathyroidism AND patient has chronic kidney disease (CKD) stage 3, 4, or 5, 2) Provide with the prescription the laboratory results for the following test (the test should be done within 30 days of the prescription, except intact parathyroid hormone (iPTH) which is valid for 90 days): 1. Serum Phosphorous: a. For CKD Stage 3 and 4 levels should be 2.7-4.6 mg/dL b. For CKD Stage 5 levels should be 3.5-5.5mg/dL, 2. Plasmatic IPTH: a. For CKD Stage 3 levels should be greater than 70 pg/mL, d. For CKD Stage 4 levels should be greater than 110 pg/mL, c. For CKD Stage 5 levels should be greater than 300pg/mL, 3. CMP.

Age Restrictions: 10 years or older

Prescription Order Restrictions: 1) Endocrinologist, 2) Nephrologist, 3) Oncologist, 4) Hematologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Pegasys
Pegasys ProClick

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Hepatic decompensation (Child-Pugh score greater than 6 [class B or C]) in cirrhotic patients before treatment, 2) Autoimmune hepatitis.


Age Restrictions: 5 years of age or older

Prescription Order Restrictions: 1) Gastroenterologist, 2) Infectologist, 3) Hepatologist

Coverage Duration: 12 to 24wks for HCV genotypes 1, 2, 3, 4, 5 & 6 depending on updated HCV guidelines. 48wks for HBV

Other Criteria: N/A

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

**Affected Drugs:**
PegIntron
Peg-Intron Redipen

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Hepatic decompensation (Child-Pugh score greater than 6 [class B or C]) in patients with cirrhotic chronic hepatitis C before or during therapy. 2) Autoimmune hepatitis.

**Required Medical Information:** 1) Diagnosis: Chronic hepatitis C, 2) Document: a. CRCL, b. HCV genotype, 3) For Peg Intron Monotherapy: only in patients with compensated liver disease if there are contraindications or significant intolerance to ribavirin,

**Age Restrictions:** N/A

**Prescription Order Restrictions:** 1) Gastroenterologist, 2) Infectologist

**Coverage Duration:** 1) Pegintron Monotx: end of contract year, 2) Pegintron/Ribavirin: 48 wks. for GT1, 24 wks. for GT 2, 3

**Other Criteria:** Coverage duration will depend on the clinical scenario assessed by the pharmacist in full compliance with the updated HCV guidelines recommendations at the time.

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

Affected Drugs:  
Plegridy  
Plegridy Starter Pack

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Multiple Sclerosis, 2) Liver Function Test

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Neurologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Pomalyst

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Pregnancy

Required Medical Information: 1) Diagnosis: multiple myeloma, 2) Document the following: a. prescribed in combination with dexamethasone, AND b. prior treatment with at least 2 therapies including lenalomide and bortezomib and have demonstrated disease progression on or within 60 days of completion of last therapy, 3) Negative pregnancy affirmation

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Oncologist, 2) Hematologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Pradaxa

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Active pathological bleeding 2) Mechanical Prosthetic heart valve

**Required Medical Information:** 1) Document one of the following: a. non-valvular atrial fibrillation, b. Deep Vein Thrombosis (DVT), c. Pulmonary Embolism (PE) OR d. prophylaxis of DVT following hip or knee replacement surgery,

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** N/A

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs:
Promacta

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: a. thrombocytopenia with chronic Idiopathic Thrombocytopenia (ITP), b. thrombocytopenia with hepatitis C infection OR, c. severe aplastic anemia, 2) For Chronic ITP document the following: a. Previous Corticosteroids use, b. Previous Immunoglobulin use. c. or Splenectomy, 3) For thrombocytopenia with chronic hepatitis C: Evidence that the patient is on or will initiate interferon-based therapy, 4) For Severe Aplastic Anemia: Document failure to immunosuppressive therapy.

Age Restrictions: N/A

Prescription Order Restrictions: 1) Hematologist, 2) Hepatologist, 3) Infectious disease specialist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs: Ranexa

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Concurrent use of CYP3A inducers (e.g., rifampin, rifabutin, rifapentine, phenobarbital, phenytoin, carbamazepine, and St. John’s wort). 2) Concurrent use of strong CYP3A inhibitors (e.g., ketoconazole, itraconazole, clarithromycin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir), 3) Hepatic cirrhosis

Required Medical Information: 1) Diagnosis: chronic angina

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Cardiologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs: Ravicti

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Patients less than 2 months old.

Required Medical Information: 1) Diagnosis of Urea cycle disorders (UCDs)

Age Restrictions: 2 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Relistor

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Known or suspected mechanical gastrointestinal obstruction

**Required Medical Information:** 1) Diagnosis, 2) Patient demonstrated an inadequate treatment response or intolerance or contraindication to a drug regimen of polyethylene glycol 3350 (PEG 3350), 3) Document patients opioid regimen for chronic pain management, 4) Creatinine Clearance

**Age Restrictions:** N/A

**Prescription Order Restrictions:** N/A

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs:
Repatha
Repatha Pushtronex System
Repatha SureClick

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1. Diagnosis of: 1) heterozygous familial hypercholesterolemia 2) homozygous familial hypercholesterolemia or 3) clinical atherosclerotic cardiovascular disease, 2. LDL-C greater than 100mg/dL 3. Must demonstrate 6 months of continuous high intensity statin use, 4. Documented failure or intolerance to two or more high-intensity statin therapies, 5. If patient has heterozygous familial hypercholesterolemia or homozygous familial hypercholesterolemia, retrial with another statin is not required

Age Restrictions: 13 years of age or older

Prescription Order Restrictions: 1. Cardiologist, 2. Endocrinologist

Coverage Duration: End of contract year

Other Criteria: a. Therapeutic failure means an inability to reach LDL-C less than 100mg/dL after a 6-month trial of continuous high intensity statin use. If a retrial with statins is not contraindicated, will require documentation of 2 trials with a different dose or alternative high-intensity statin: (i.e. atorvastatin 40 & 80 mg, rosuvastatin 20 & 40mg with or without ezetimibe 10mg) or in clinically appropriate cases a combination drug (e.g., Vytorin), b. Intolerance to statin therapy means: Confirmed, intolerable statin-related adverse effects or significant biomarker abnormalities including increased 3-fold of the Upper Limit LFT’s, rhabdomyolysis, intolerable myalgia or myopathy, or myositis.
RESTASIS

Affected Drugs: Restasis

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Document: Keratoconjunctivitis sicca, 2) Failure to conventional Lubricant or corticosteroids.

Age Restrictions: 16 years of age or older

Prescription Order Restrictions: 1) Ophthalmologist

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Affected Drugs: Revlimid

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Pregnancy, 2) Chronic Lymphocytic Leukemia

Required Medical Information: 1) Diagnosis: a. multiple myeloma (MM), b. transfusion-dependent anemia due to myelodysplastic syndrome, c. mantle cell lymphoma (MCL), d. MM, as maintenance following autologous hematopoietic stem cell transplantation (auto-HSCT) 2) For MM: Prescribed in combination with dexamethasone, 3) For transfusion dependent anemia due to myelodysplastic syndromes: Document 5q deletion, 4) For MCL: document the following: a. disease progression or relapse, b. prior use of at least 2 therapies, including Bortezomib, 5) Negative pregnancy affirmation

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Hematologist 2) Oncologist,

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Ribavirin

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Women who are pregnant or men whose female are pregnant. 2) Hemoglobinopathy, hemoglobin less than 8.5 g/dL. 3) Coadministration with didanosine in HIV coinfected patients. 4) Renal impairment (CRCL less than 50 mL/min) for Ribavirin only.

Required Medical Information: 1) Diagnosis: Chronic hepatitis C, 2) Document the following: a. Hgb levels, b. CRCL, c. Negative pregnancy affirmation

Age Restrictions: N/A

Prescription Order Restrictions: 1) Gastroenterologist, 2) Infectious Disease specialist, 3) Hepatologist

Coverage Duration: Initial 12 weeks, for renewal: End of contract year

Other Criteria: For Hepatitis C: Ribavirin should always be prescribed in combination with other agents

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

Affected Drugs: Riluzole

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: amyotrophic lateral sclerosis (ALS)

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Neurologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

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RUBRACA

Affected Drugs: Rubraca

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: advanced ovarian cancer with BRCA mutation 2) Prior treatment with at least 2 chemotherapies

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: Oncologist

Coverage Duration: End of Contract Year

Other Criteria: N/A

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

Affected Drugs: 
Rydapt

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A


Age Restrictions: 18 years of age or older.

Prescription Order Restrictions: 1) Oncologist

Coverage Duration: End of Contract Year

Other Criteria: N/A

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

Affected Drugs:  
Signifor  
Signifor LAR

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Document the following: a) For Signifor: a. Diagnosis of Cushing disease AND b. pituitary surgery is not an option or has not been curative, b) For Signifor LAR: a. Diagnosis of Acromegaly AND b. inadequate response to surgery and/or for whom surgery is not an option, 2) Prior to starting treatment document: 1. Liver Function Test, 2 Fasting Plasma Glucose (FPG), 3. HA1C Results, 4. ECG, 5. Serum Magnesium, 6. Serum Potassium

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: Endocrinologist

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

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

Affected Drugs:
Sildenafil Citrate

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Concomitant use of nitrate therapy on a regular or intermittent basis, 2) Concomitant use of Adempas

Required Medical Information: 1) Diagnosis of Pulmonary Arterial Hypertension, WHO Group 1, 2) Cardiac catheterization results: a. Mean pulmonary artery pressure (more than or equal to 25 mmHg), b. Pulmonary capillary wedge pressure (less than or equal to 15 mmHg), 3) Acute vasodilator testing result (required for patients with Idiopathic Pulmonary Arterial Hypertension ONLY).

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Pulmonologist, 2) Cardiologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Simvastatin

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Document: a. For new Starts: Prior use and/or failure to at least one statin in the last 12 months b. For renewals: Prior use of simvastatin 80mg consecutively in the last 12 months.

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Sirturo

Covered Uses: All FDA-approved indications not otherwise excluded from Part D


Required Medical Information: 1) Document of the following: a. pulmonary multi-drug resistant tuberculosis (MDR-TB) AND b. no other effective treatments available for the patient AND c. prescribed in combination with at least 3 other anti-mycobacterial drugs for MDR-TB.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Infectious Disease specialist, 2) Pulmonologist

Coverage Duration: 24 weeks

Other Criteria: N/A

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

Affected Drugs:
Sivextro

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: acute bacterial skin and/or skin structure infections, 2) Culture results

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: 6 days

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
SODIUM PHENYL BUTYRATE

Affected Drugs:
Sodium Phenylbutyrate

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: Management of acute hyperammonemia

Required Medical Information: 1) Diagnosis 2) Results of plasma ammonia levels

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
SOMATULINE DEPOT

Affected Drugs: Somatuline Depot

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: a. acromegaly OR b. locally advanced or metastatic gastroenteropancreatic neuroendocrine tumor (GEP-NET), 2) For acromegaly: Patient meets the following criteria for initiation of therapy: a. Pre-treatment high IGF-1 level for age/gender and b. Patient has had an inadequate or partial response to surgery and/or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy, 3) For continuation of therapy for acromegaly: a. IGF-1 level decreased or normalized, 4) For locally advanced or metastatic GEP-NETs: document disease is unresectable.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Endocrinologist, 2) Oncologist

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

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

Affected Drugs:
Somavert

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Patient meets the following criteria for initiation of therapy: a. Clinical evidence of acromegaly, b. Pre-treatment high IGF-1 level for age/gender, c. Patient has had an inadequate or partial response to octreotide or lanreotide OR patient is intolerant to or has a contraindication to octreotide or lanreotide, and d. Patient has had an inadequate or partial response to surgery and/or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy, e. Liver Function Tests, 2) For continuation of therapy: a. IGF-1 level decreased or normalized.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Endocrinologist

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

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

Affected Drugs:
Sovaldi

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Documentation of chronic hepatitis C genotype, 2) Documentation of hepatic fibrosis status by one of the following: a. Clinical evidence stating the cirrhosis status as attested by the prescribing physician, b. Liver biopsy METAVIR score, or alternative scoring equivalent, c. Radiological imaging of the liver, d. Transient elastography (FibroScan) score, e. FibroTest (FibroSure) score, f. APRI score, 3) Indicate if patient is naïve or experienced (i.e. prior use of PEG-IFN, RBV, HCV protease or polymerase inhibitors.) 4) For transplant patients, provide viral load, 5) Renal Impairment and creatinine clearance status more than 30 ml/min

Age Restrictions: 1) For genotype 2 or 3: 12 years of age or older 2) For genotype 1 or 4: 18 years of age or older

Prescription Order Restrictions: 1) Gastroenterologist, 2) Infectious Disease Specialist, 3) Hepatologist

Coverage Duration: 12 to 48 weeks based on HCV’s and patient’s characteristics – see Other Criteria

Other Criteria: Duration for genotypes 1a, 1b, 2, 3, and 4 will range between 12 and 48 weeks depending on the clinical scenario assessed by the pharmacist in full compliance with the updated HCV guidelines recommendations at the time.

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

**Affected Drugs:**
Sprycel

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Diagnosis: a. Philadelphia chromosome-positive chronic myeloid leukemia (Ph+CML) or b. Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL), 2) For newly diagnosed Ph+ CML: document patient is in chronic phase, 3) For previously treated Ph+ CML document: resistance or intolerance to prior therapy including imatinib, 4) For Ph+ALL document: resistance or intolerance to prior therapy

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Hematologist, 2) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs:
Stelara

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Documented diagnosis: Moderate to severe plaque psoriasis: at least 5% BSA or crucial body areas such as the hands, feet, face, or genitals, 2) Psoriatic arthritis, 3) Negative Tuberculosis test, If positive must be on treatment, 4) Moderately to severely active Crohn disease in adult patients who have failed or were intolerant to treatment with immunomodulators or corticosteroids, but who have never failed treatment with a tumor necrosis factor (TNF) blocker, or in patients who failed or were intolerant to treatment with 1 or more TNF blockers

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Dermatologist, 2) Rheumatologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Stivarga

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** Hepatic impairment, severe (Child-Pugh Class C)

**Required Medical Information:** 1) Diagnosis: a. metastatic colorectal cancer, b. locally advanced or metastatic gastrointestinal stromal tumor, OR c. Hepatocellular carcinoma (HCC), 2) For gastrointestinal stromal tumor document: a. disease is unresectable AND b. prior treatment with imatinib and sunitinib, 3) For metastatic colorectal cancer document: a. prior treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy, and anti-VEGF therapy, and if KRAS wild type, an anti-EGFR therapy, 4) Liver Function Test, 5) For hepatocellular carcinoma document: previous treatment with sorafenib.

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Hematologist, 2) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs:
Sutent

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: gastrointestinal stromal tumor (GIST), b. advanced renal cell carcinoma, OR c. locally advanced or metastatic pancreatic neuroendocrine tumors (pNET), 2) For GIST document: a. failure to or intolerance to imatinib, 3) For pNET document: tumor is unresectable

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Oncologist, 2) Hematologist, 3) Gastroenterologist, 4) Nephrologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Sylatron

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Autoimmune hepatitis, 2) Hepatic decompensation (Child-Pugh score greater than 6 [class B and C])

Required Medical Information: 1) Diagnosis: Melanoma with microscopic or gross nodal involvement, 2) Document the following: a. date of surgical resection AND b. will be used as adjuvant treatment

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Dermatologist, 2) Oncologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Tafinlar

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Wild-type BRAF melanoma

**Required Medical Information:** 1) Diagnosis: a. metastatic melanoma OR b. metastatic non-small cell lung cancer, 2) For metastatic melanoma, document the following: a. disease is unresectable, b. positive results for BRAF V600E or V600K mutations, c. If BRAF V600K mutation is positive: prescribed in combination with trametinib, OR d. If BRAF V600E mutation is positive: indicated as a single agent or in combination with trametinib, 3) For metastatic non-small cell lung cancer document the following: a. positive results for BRAF V600E mutations AND b. must be used in combination with trametinib, 4) BRAF V600E mutation: indicated as a single agent or in combination with trametinib.

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs: Tagrisso

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Pregnancy

Required Medical Information: 1) Diagnosis: Non-small cell lung cancer (NSCLC), 2) Positive EGFR T790M mutation test, 3) Failure or clinically significant adverse effects to one EGFR TKI therapy (for example: erlotinib, afatinib, and gefitinib among others).

Age Restrictions: N/A

Prescription Order Restrictions: 1) Oncologist, 2) Pulmonologist, 3) Hematologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:  
Tarceva

Covered Uses:  All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria:  1) Patients on platinum-based chemotherapy

Required Medical Information:  1) Diagnosis: a. metastatic or locally advanced non-small cell lung cancer (NSCLC) OR b. locally advanced or metastatic pancreatic cancer, 2) Metastatic or locally advanced NSCLC: a. For first line treatment document: results for EGFR exon 19 deletions or exon 21 L858R substitution mutations, b. For previously treated patients document: failure to at least one prior chemotherapy regimen, c. For maintenance treatment document: a. completion of four cycles of platinum-based first-line chemotherapy without disease progression AND b. Tarceva is being used as monotherapy, 3) For metastatic pancreatic cancer document: a. disease is unresectable AND b. prescribed in combination with gemcitabine.

Age Restrictions:  18 years of age or older

Prescription Order Restrictions:  1) Oncologist

Coverage Duration:  End of contract year

Other Criteria:  N/A

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

**Affected Drugs:**
Tasigna

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Uncorrected hypokalemia or hypomagnesemia, 2) long QT syndrome

**Required Medical Information:** 1) Diagnosis: Philadelphia chromosome positive chronic myeloid leukemia (Ph+CML), 2) Patients Disease Phase: a. chronic phase, b. accelerated phase, 3) For resistant or intolerant Ph+CML document the following: a. Resistance or intolerance to imatinib or dasatinib, b. Disease progression OR, c. Relapse after hematopoietic stem cell transplant.

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Oncologist, 2) Hematologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
Tazarotene
Tazorac

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Pregnancy, 2) Esthetics purposes

**Required Medical Information:** 1) Diagnosis: a. acne vulgaris OR b. plaque psoriasis, 2) Negative pregnancy affirmation

**Age Restrictions:** 12 years of age or older

**Prescription Order Restrictions:** 1) Dermatologist, 2) Rheumatologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
Thalomid

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** Pregnancy

**Required Medical Information:**
1) Diagnosis: a. multiple myeloma OR b. erythema nodosum leprosum (ENL),
2) For multiple myeloma: prescribed in combination with dexamethasone,
3) Negative pregnancy affirmation

**Age Restrictions:** 12 years of age or older

**Prescription Order Restrictions:**
1) Dermatologist, 2) Hematologist, 3) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
THERAPY FOR GAUCHER DISEASE

Affected Drugs:
Zavesca

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: Gaucher disease type 2 or 3

Required Medical Information: 1) Diagnosis: type 1 Gaucher disease, 2) Document the following: a. enzyme replacement is not a therapeutic option for the patient, b. CBC with platelets

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
THERAPY FOR MUCOPOLYSACCHARIDOSES

Affected Drugs:
Aldurazyme
Elaprase
Naglazyme

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: Patients with Mucopolysaccharidosis types III, IV, or VII

Required Medical Information: 1) Diagnosis: a. For Aldurazyme: Mucopolysaccharidosis I (MPS I), b. For Elaprase: Mucopolysaccharidosis II (MPS II), c. For Naglazyme: Mucopolysaccharidosis VI (MPS VI)

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: Part D vs. Part B evaluation also applies. (*)

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Affected Drugs:
Fentora
Lazanda

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Patients who are not opioid tolerant. (Patients are considered opioid tolerant if they have been taking at least 60 mg of oral morphine per day, 25 mcg of transdermal fentanyl/hr, 30 mg of oral oxycodone daily, 8 mg of oral hydromorphone daily, 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer), 2) Management of acute or postoperative pain, including headache/migraine and dental pain

Required Medical Information: 1) Document ALL of the following: a. medical justification that indicates use for the management of breakthrough pain in cancer patient who is already receiving and is tolerant to opioid therapy AND b. previous failure to short acting or long acting opioid analgesics

Age Restrictions: 18 years of age and older

Prescription Order Restrictions: 1) Oncologist 2) Pain specialist

Coverage Duration: 6 months

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
TOPICAL TESTOSTERONES

Affected Drugs:
AndroGel
AndroGel Pump
Testosterone

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Female, 2) Carcinoma of the breast or known or suspected prostate cancer, 3) late-onset hypogonadism

Required Medical Information: 1) Diagnosis: a. primary hypogonadism OR b. hypogonadotrophic hypogonadism, 2) Before the start of testosterone therapy patient had (or patient currently has) a confirmed low testosterone level (i.e. morning total testosterone less than 300 ng/dL, morning free testosterone less than 9 ng/dL) or absence of endogenous testosterone.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:
Tykerb

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Advanced or metastatic breast cancer, 2) Document positive results for HER2, 3) For patients with advanced or metastatic breast cancer document the following: a prescribed in combination with capecitabine. AND b. prior therapy with an anthracycline, a taxane, and trastuzumab. 3) For postmenopausal patients with hormone receptor positive metastatic breast cancer for whom hormonal therapy is indicated: prescribed in combination with letrozole.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Hematologist, 2) Oncologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Tymlos

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Diagnosis of postmenopausal women with osteoporosis at high risk for fracture, 2) Documented multiple risk factors for fracture AND failure or intolerance to other available osteoporosis therapy, OR history of osteoporotic fracture.

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** N/A

**Coverage Duration:** End of contract year

**Other Criteria:** Therapy will be discontinued after a lifetime total of 24 months of treatment

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

Affected Drugs:
Tysabri

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) History of progressive multifocal leukoencephalopathy, 2) Not to be use in patients with Crohns Disease if they are currently using antineoplastics immunosuppressants or inhibitors of TNF-alpha

Required Medical Information: 1) Diagnosis: Multiple Sclerosis (MS) OR b. Crohn’s disease (CD), 2) For MS: Tysabri must be used as monotherapy, 3) For CD document the following: a. patient has moderately to severely active Crohn’s disease with evidence of inflammation, b. inadequate response to, or are unable to tolerate, conventional CD therapies and inhibitors of TNF-alpha, 4) For renewals for CD: evidence of therapeutic benefit

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Neurologist, 2) Gastroenterologist

Coverage Duration: 1) For CD: a. initial 3 months, b. renewals: end of contract year 2) for MS: end of contract year

Other Criteria: 1) Part D vs. Part B evaluation also applies. (*)

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

Affected Drugs:
Uptravi

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: Patient has severe hepatic impairment

Required Medical Information: 1) Diagnosis: pulmonary arterial hypertension (PAH, WHO Group I), 2) Must meet the following requirements: 1. The patient has tried two oral therapies for PAH from two of the three following different categories (either alone or in combination) each for at least 60 days: a. one phosphodiesterase type 5 (PDE5) inhibitor (e.g., Sildenafil, Adcirca), b. One endothelin receptor antagonist (ERA) (e.g. Opsumit), c. Adempas OR 2. The patient is receiving, or has received in the past, one prostacyclin therapy for PAH (e.g., Ventavis)

Age Restrictions: 18 years of age and older

Prescription Order Restrictions: 1) Cardiologist, 2) Pulmonologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Venclexta
Venclexta Starting Pack

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** Concomitant use of strong inhibitors of CYP3A4 during initiation and ramp-up phase (first 5 weeks of treatment)

**Required Medical Information:** 1) Diagnosis: Chronic Lymphocytic Leukemia (CLL), 2) Document chromosome 17p deletion, detected by an FDA approved test (e.g. FISH test) AND previous use of at least one prior therapy for CLL.

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Hematologist, 2) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs:
Ventavis

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis of Pulmonary Arterial Hypertension, WHO Group 1, 2) Cardiac catheterization results: a. Mean pulmonary artery pressure (greater than or equal to 25 mmHg) AND, b. Pulmonary capillary wedge pressure (less than or equal to 15 mmHg), 3) Acute vasodilator testing result (required for patients with Idiopathic Pulmonary Arterial Hypertension ONLY).

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Pulmonologist, 2) Cardiologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Viberzi

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Known or suspected biliary duct obstruction, or Sphincter of Oddi disease or dysfunction, 2) A history of pancreatitis, or structural diseases of the pancreas, including known or suspected pancreatic duct obstruction. 3) Severe hepatic impairment (Child-Pugh Class C), 5) A history of chronic or severe constipation or sequelae from constipation, or known or suspected mechanical GI obstruction, 6) Patients without gallbladder.

**Required Medical Information:** 1) Documented diagnosis of irritable bowel syndrome with diarrhea, 2) Gallbladder status (if patient have gallbladder or it has been removed)

**Age Restrictions:** 18 years of age and older

**Prescription Order Restrictions:** 1) Gastroenterologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
Voriconazole

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Concomitant use of carbamazepine, CYP3A4 substrates (terfenadine, astemizole, cisapride, pimozide, or quinidine), ergot alkaloids, long-acting barbiturates, rifabutin, rifampin, ritonavir in high doses (400 mg every 12 hours), efavirenz in high doses (400mg q 24h or higher), sirolimus, or St John’s Wort.

**Required Medical Information:** 1) Diagnosis: a. invasive aspergillosis, b. candidemia, c. candidiasis, OR d. serious infections caused by Scedosporium apiospermum and Fusarium, 2) Document the following: a. culture results, b. Liver Function Test, 3) For candidemia document: a. patient is non-neutropenic, and b. CBC, 4) For serious infections caused by Scedosporium apiospermum and Fusarium: document intolerance/failure to other therapy

**Age Restrictions:** 12 years of age or older

**Prescription Order Restrictions:** N/A

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs: Votrient

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Adipocytic soft tissue sarcoma

Required Medical Information: 1) Diagnosis: a. advanced renal cell carcinoma or b. advanced soft tissue sarcoma, 2) For advanced soft tissue sarcoma document: prior chemotherapy

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Oncologist, 2) Nephrologist

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Affected Drugs: Xalkori

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Metastatic non-small cell lung cancer, 2) Positive results for ALK mutation or ROS-1 mutation

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Oncologist, 2) Pulmonologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

Affected Drugs:  
Xarelto  
Xarelto Starter Pack

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) Active pathological bleeding.

Required Medical Information: 1) Document one of the following: a. non-valvular atrial fibrillation, b. Deep Vein Thrombosis (DVT), c. Pulmonary Embolism (PE) OR d. prophylaxis of DVT following hip or knee replacement surgery,

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Affected Drugs: Xatmep

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) For pJIA: Pregnancy

Required Medical Information: 1) Diagnosis: a) Acute lymphoblastic leukemia (ALL), b) Active polyarticular juvenile idiopathic arthritis (pJIA). 2) For ALL: Document combination chemotherapy maintenance regimen, 3) For pJIA: a) Patient has had an inadequate therapeutic response to, OR is intolerant to, an adequate trial of first-line therapy including full dose non-steroidal anti-inflammatory agents (NSAIDs), b) Negative pregnancy affirmation.

Age Restrictions: 18 years and younger

Prescription Order Restrictions: 1) Oncologist, 2) Rheumatologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Xeljanz
Xeljanz XR

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** Patients currently on biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine

**Required Medical Information:** 1) Diagnosis: Moderate or severe active rheumatoid arthritis, 2) Document previous use/intolerance of at least 1 or more DMARDs and/or Methotrexate, 3) Latent tuberculosis test result

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Rheumatologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
Xifaxan

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Document one of any of the following Diagnosis: a) Irritable bowel syndrome with diarrhea (IBS-D), b) Hepatic encephalopathy (HE), Prophylaxis

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** N/A

**Coverage Duration:** 1) For TD: 3 days, 2) For IBS-D: Initial: 14 days, Renewals: 14 days 3) For HE: End of contract year

**Other Criteria:** For IBS-D, therapy will be discontinued after a lifetime total of 42 days.

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

**Affected Drugs:**
Xtandi

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:**
1) Diagnosis: metastatic castration-resistant prostate cancer, 2) Documented previous use of Docetaxel.

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:**
1) Oncologist, 2) Hematologist, 3) Urologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs:
Xyrem

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) If the patient is taking alcohol (ethanol), sedative/hypnotic drugs, or other CNS depressants.

Required Medical Information: 1) Patient has a diagnosis of narcolepsy and experiences episodes of cataplexy OR, 2) Patient has a diagnosis of narcolepsy and experiences excessive daytime sleepiness with symptoms that limit the ability to perform normal daily activities.

Age Restrictions: N/A

Prescription Order Restrictions: N/A

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Zejula

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Diagnosis: a) recurrent epithelial ovarian cancer, b) recurrent fallopian tube cancer, or c) recurrent primary peritoneal cancer, 2) Prior treatment with a platinum containing regimen.

**Age Restrictions:** 18 years of age or older.

**Prescription Order Restrictions:** 1) Oncologist, 2) Hematologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

**Affected Drugs:**
Zelboraf

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Patients with QTc greater than 500 ms, 2) Patients with wild-type BRAF melanoma

**Required Medical Information:** 1) Diagnosis: metastatic melanoma, 2) Document the following: a, disease is unresectable AND b. positive results for the BRAF V600E mutations c. ECG d. serum electrolytes

**Age Restrictions:** 18 years of age or older

**Prescription Order Restrictions:** 1) Oncologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

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

Affected Drugs:
Zolinza

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: N/A

Required Medical Information: 1) Diagnosis: Cutaneous T-cell lymphoma, 2) Document the following: a. disease is progressive, persistent or recurrent, b. failure/intolerance to at least two prior systemic therapies. 3) Liver Function Test

Age Restrictions: 18 years or older

Prescription Order Restrictions: 1) Oncologist, 2) Hematologist

Coverage Duration: End of contract year

Other Criteria: N/A

(*) Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
**ZOSTER VACCINE**

**Affected Drugs:**
Zostavax

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** 1) Anaphylactoid or anaphylactic reaction to neomycin, gelatin history (contact dermatitis to neomycin is not a contraindication). 2) Concomitant chemotherapy or radiation therapy live vaccine should not be administered for at least 3 months unless benefit outweighs risk of adverse reactions. 3) Concomitant immunosuppressive therapy, including immunosuppressive doses of corticosteroids (manufacturer), long-term corticosteroid therapy (prednisolone 20 mg or 2 mg/kg daily or equivalent corticosteroid for 2 weeks or longer). 4) HIV-associated infections and AIDS. 5) Pregnancy, avoid pregnancy for 3 months following vaccination. 6) Tuberculosis, active and untreated, defer vaccination (Zostavax(R)).

**Required Medical Information:** N/A

**Age Restrictions:** 50 years of age or older

**Prescription Order Restrictions:** N/A

**Coverage Duration:** One dose per lifetime. Duration of authorization not applicable.

**Other Criteria:** N/A

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

Affected Drugs:
Zydelig

Covered Uses: All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria: 1) History of toxic epidermal necrolysis

Required Medical Information: 1) Diagnosis: a. relapsed chronic lymphocytic leukemia (CLL), b. relapsed follicular B-cell non-Hodgkin lymphoma, or c. relapsed small lymphocytic lymphoma (SLL), 2) For CLL document: 1) prescribed in combination with rituximab AND 2) failure to at least 1 prior systemic therapy, 3) For relapsed follicular B-cell Non-Hodgkin's lymphoma OR relapsed SLL document: failure to at least 2 prior systemic therapies.

Age Restrictions: 18 years of age or older

Prescription Order Restrictions: 1) Oncologist 2) Hematologist

Coverage Duration: End of contract year

Other Criteria: N/A

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

**Affected Drugs:**
Zytiga

**Covered Uses:** All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria:** N/A

**Required Medical Information:** 1) Diagnosis: metastatic, castration-resistant prostate cancer, 2) Prescribed in combination with prednisone.

**Age Restrictions:** 18 years or older

**Prescription Order Restrictions:** 1) Oncologist, 2) Hematologist, 3) Urologist

**Coverage Duration:** End of contract year

**Other Criteria:** N/A

(*') Drug may be covered under Medicare Part B or D depending upon circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
### Drugs that may be covered under Medicare Part B or Part D

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<td>Acetylcysteine INH</td>
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<td>Albuterol Sulfate INH</td>
</tr>
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<td>Amikacin Sulfate INJ</td>
<td>Aminophylline IV</td>
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