PA Criteria

Prior Authorization Group  ABILIFY MAINTENA
Drug Names  ABILIFY MAINTENA
Covered Uses  All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria  Patient has a diagnosis of dementia-related psychosis.

Required Medical Information

Required Medical Information

Age Restrictions  Plan Year
Prescriber Restrictions
Coverage Duration  Plan Year
Other Criteria
### Prior Authorization Group
- **ACTHAR HP**

### Drug Names
- ACTHAR HP

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

### Exclusion Criteria
- Receipt of live or live attenuated vaccines within 6 weeks of H.P. Acthar Gel, suspected congenital infection (infants), scleroderma, osteoporosis, systemic fungal infection, peptic ulcer disease, ocular herpes simplex, congestive heart failure, recent surgery, uncontrolled hypertension, known hypersensitivity to porcine proteins, primary adrenocortical insufficiency or hyperfunction.

### Required Medical Information
- For the following diagnoses, patient must have an inadequate response to a trial of parenteral corticosteroids: 1) For rheumatic diseases (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis): H.P. Acthar gel must be used as adjunctive treatment, 2) For nephrotic syndrome: H.P. Acthar gel must be requested for induction of diuresis or for remission of proteinuria, 3) For multiple sclerosis (MS): H.P. Acthar gel is being used for MS exacerbation, 4) Collagen diseases (e.g., systemic lupus erythematosus, dermatomyositis, or polymyositis), 5) Dermatologic disorders (e.g., severe erythema multiforme, Stevens-Johnson syndrome), 6) Ophthalmic disorders, acute or chronic (e.g., iritis, keratitis, optic neuritis), 7) Symptomatic sarcoidosis, 8) Serum sickness.

### Age Restrictions
- For infantile spasms initial request: patient is less than 2 years of age.

### Prescriber Restrictions

### Coverage Duration
- MS exacerbation: 3 weeks. Serum sickness: 1 month. All other diagnoses: 6 months.

### Other Criteria
- For infantile spasms: for continuation of therapy, patient must show substantial clinical benefit from therapy.

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### Prior Authorization Group
- **ACTIMMUNE**

### Drug Names
- ACTIMMUNE

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

### Exclusion Criteria

### Required Medical Information

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
- Plan Year

### Other Criteria
- Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
**Prior Authorization Group**
ADAGEN

**Drug Names**
ADAGEN

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

**Exclusion Criteria**
Severe thrombocytopenia.

**Required Medical Information**
Severe combined immunodeficiency disease (SCID) is due to adenosine deaminase (ADA) deficiency. Condition failed to respond to bone marrow transplantation or patient is not currently a suitable candidate for bone marrow transplantation.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
Plan Year

**Other Criteria**

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**Prior Authorization Group**
ADCIRCA

**Drug Names**
ADCIRCA

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

**Exclusion Criteria**
Patient requires nitrate therapy on a regular or intermittent basis.

**Required Medical Information**
NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
Plan Year

**Other Criteria**

---

**Prior Authorization Group**
ADEMPAS

**Drug Names**
ADEMPAS

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

**Exclusion Criteria**
1) Patient is taking a nitrate or nitric oxide donor medication (eg, amyl nitrite) on a regular or intermittent basis. 2) Patient is taking a phosphodiesterase inhibitor (eg, sildenafil, tadalafil, vardenafil, dipyridamole, theophylline).

**Required Medical Information**
1) For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): a. Persistent or recurrent CTEPH after pulmonary endarterectomy, OR Inoperable CTEPH, AND b. CTEPH was confirmed by right heart catheterization AND by CT, MRI or pulmonary angiography. 2) For pulmonary arterial hypertension (PAH) (WHO Group 1): a. PAH was confirmed by right heart catheterization, AND b. NYHA Functional Class II or III symptoms.

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

**Prescriber Restrictions**

**Coverage Duration**
Plan Year

**Other Criteria**

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### Prior Authorization Group
- **AFINITOR**

### Drug Names
- AFINITOR, AFINITOR DISPERZ

### Covered Uses
- All FDA-approved indications not otherwise excluded from Part D, lung neuroendocrine tumors (LNETs), Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.

### Exclusion Criteria

#### Required Medical Information
- For renal cell carcinoma: patient tried and failed treatment with Sutent (sunitinib), Nexavar (sorafenib), or Votrient (pazopanib). For pancreatic neuroendocrine tumor: patient has unresectable, locally advanced or metastatic disease. For LNETs: tumors are low or intermediate grade (typical or atypical carcinoid) and patient has unresectable or advanced disease (stage IIb-IV). For breast cancer: 1) patient has hormone receptor positive, HER2-negative metastatic disease that was previously treated with letrozole or anastrozole, and 2) Afinitor will be used in combination with exemestane. For subependymal giant cell astrocytoma with tuberous sclerosis complex (TSC): patient is not a candidate for curative surgical resection. For Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma: 1) patient has disease that did not respond to primary therapy or disease that is progressive or relapsed, and 2) Afinitor will be used as a single agent. For renal angiomyolipoma with TSC: patient does not require immediate surgery.

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
- Plan Year

### Other Criteria
- Appropriate medical support is readily available when Aldurazyme is administered in the event of anaphylaxis or a severe allergic reaction.

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### Prior Authorization Group
- ALDURAZYME

### Drug Names
- ALDURAZYME

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

### Exclusion Criteria

#### Required Medical Information
- Diagnosis of MPS I was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by DNA testing. Patients with Scheie syndrome must have moderate to severe symptoms of MPS I.

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
- Plan Year

### Other Criteria
- Appropriate medical support is readily available when Aldurazyme is administered in the event of anaphylaxis or a severe allergic reaction.
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>ALPHA1-PROTEINASE INHIBITOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>ARALAST NP, GLASSIA, PROLASTIN-C, ZEMAIRA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Patient has selective IgA deficiency with known antibodies against IgA.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>All patients must have a deficiency of alpha1-proteinase inhibitor (also known as alpha1-antitrypsin) AND clinically evident emphysema. Patients initiating therapy for the first time must also meet the following criteria: 1) Pretreatment serum alpha1-proteinase inhibitor concentration less than 11 micromoles/L, 2) Post-bronchodilation FEV1 between 30% and 65% predicted OR if the FEV1 is greater than 65% predicted, then the patient has experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment.</td>
</tr>
</tbody>
</table>

| Age Restrictions | 18 years of age or older |
| Prescriber Restrictions | Plan Year |

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<thead>
<tr>
<th>Prior Authorization Group</th>
<th>AMPYRA</th>
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<tbody>
<tr>
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<td>AMPYRA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>History of seizures. Creatinine clearance less than or equal to 50 mL/min.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Prior to initiating therapy, patient must demonstrate sustained walking impairment but with the ability to walk 25 feet (with or without assistance). For continuation of therapy, patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting Ampyra. Dose does not exceed 10mg twice daily.</td>
</tr>
</tbody>
</table>

<p>| Age Restrictions | Plan Year |
| Prescriber Restrictions | Plan Year |
| Coverage Duration   | Initial: 1 month. Renewal: Plan Year |
| Other Criteria      | Prior to initiating therapy, patient must demonstrate sustained walking impairment but with the ability to walk 25 feet (with or without assistance). For continuation of therapy, patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting Ampyra. Dose does not exceed 10mg twice daily. |</p>
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<tr>
<th>Prior Authorization Group</th>
<th>ANABOLIC STEROIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>OXANDROLINE</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D, HIV-wasting.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>A. Known or suspected nephrosis (the nephrotic phase of nephritis). B. Known or suspected hypercalcemia. C. Known or suspected carcinoma of the breast in women with hypercalcemia. D. Known or suspected carcinoma of the prostate or breast in male patients. E. Pregnancy.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>A. Patient will be monitored for peliosis hepatis and liver cell tumors. B. If patient has unfavorable blood lipids, therapy will be adjusted.</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
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<tr>
<th>Prior Authorization Group</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>AGRYLIN, ANAGRELIDE HYDROCHLORIDE</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Severe hepatic impairment.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Patient has a diagnosis of thrombocythemia secondary to a myeloproliferative disorder.</td>
</tr>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
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<td>Other Criteria</td>
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<tr>
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<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Concomitant therapy with a serotonin 5HT3 antagonist (e.g., ondansetron).</td>
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<tr>
<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<td>Other Criteria</td>
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<tr>
<td>Prior Authorization Group</td>
<td>APTIOM</td>
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<td>APTIOM</td>
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<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Prior use of oxcarbazepine demonstrated a hypersensitivity reaction.</td>
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<tr>
<td>Required Medical Information</td>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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<tbody>
<tr>
<td>Drug Names</td>
<td>ARANESP ALBUMIN FREE</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D, myelodysplastic syndromes (MDS).</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For all uses: 1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, 2) For reauthorizations (patient received erythropoietin in previous month), an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. Additional requirements for cancer: 1) For initial therapy, at least 2 more months of chemotherapy is expected, 2) For reauthorizations, current Hgb is less than 10 g/dL OR Hgb is greater than or equal to 10 but less than 11 g/dL AND patient has symptoms of anemia. Additional requirements for CKD: 1) For CKD not on dialysis reauthorization, current Hgb is less than or equal to 10 g/dL OR Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose, 2) For CKD on dialysis reauthorization, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, 2) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
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<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Patients will be monitored for thrombotic and cardiac events. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).</td>
</tr>
</tbody>
</table>

Updated 06/01/2014
**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

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**Prior Authorization Group** ARCALYST

**Drug Names** ARCALYST

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

**Exclusion Criteria** Active or chronic infection, combination therapy with another biologic agent.

**Required Medical Information** Patient has a diagnosis of cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS).

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

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

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**Prior Authorization Group** ATYPICAL ANTIPSYCHOTICS ODT

**Drug Names** CLOZAPINE ODT, FAZACLO

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

**Exclusion Criteria** A. If the patient has any of the following contraindications: agranulocytosis, bone marrow suppression, coma, ileus, leukopenia, myocarditis or neutropenia B. If the patient has CNS depression, dementia-related psychosis or uncontrolled epilepsy.

**Required Medical Information** A. The patient is unwilling or unable to take tablets or capsules orally or at high risk for non-compliance AND B. Is not receiving other tablets or capsules indicating that the patient can take non-dissolvable tablets.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria**

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**Prior Authorization Group** AUBAGIO

**Drug Names** AUBAGIO

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

**Exclusion Criteria** Severe hepatic impairment. Pregnancy. Concurrent treatment with leflunomide.

**Required Medical Information** Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** Plan Year

**Other Criteria** For female patients of childbearing potential: must use reliable contraception.
<table>
<thead>
<tr>
<th><strong>Prior Authorization Group</strong></th>
<th>AVONEX</th>
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</thead>
<tbody>
<tr>
<td><strong>Drug Names</strong></td>
<td>AVONEX, AVONEX PEN</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
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<td><strong>Exclusion Criteria</strong></td>
<td>Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease).</td>
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<td><strong>Coverage Duration</strong></td>
<td>Plan Year</td>
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<tr>
<td><strong>Other Criteria</strong></td>
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</tbody>
</table>
Prior Authorization Group

Drug Names

B VS. D

ABELCET, ABRAXANE, ACCUNE, ACETYLHYSTEINE, CYCLOPLAS SODIUM, ADRIAMYCIN, ADRUCIL, ALBUTEROL SULFATE, ALIMTA, ALKERAN, AMBISOME, AMIFOSTINE, AMINOSYN, AMINOSYN 7%/ELECTROLYTES, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 8.5%/ELECTROL, AMINOSYN M, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-PF 7%, AMINOSYN-RF, AMPHOTOCIN B, ARRANOR, ARZERRA, ASTAGRAF XL, ATGAM, AVASTIN, AZACTIDINE, AZASAN, AZATHIOPRINE, BETHKIS, BICNU, BLEOMYCIN SULFATE, BONIVA, BROVANA, BUDENSONIDE, BUSULFEX, CALCITRIOL, CAMPTOSAR, CARBOPLATIN, CARNITOR, CELLCEPT, CELLCEPT INTRAVENOUS, CESAMET, CIPLITIN, CLADRINGE, CLIMINIX 2.75%/DEXTROSE 5, CLIMINIX 4.25%/DEXTROSE 1, CLIMINIX 4.25%/DEXTROSE 2, CLIMINIX 4.25%/DEXTROSE 5, CLIMINIX 5%/DEXTROSE 15%, CLIMINIX 5%/DEXTROSE 20%, CLIMINIX 5%/DEXTROSE 25%, CLIMINIX E 2.75%/DEXTROSE, CLIMINIX E 4.25%/DEXTROSE, CLIMINIX E 5%/DEXTROSE 15, CLIMINIX E 5%/DEXTROSE 20, CLINISOL SF 15%, COLAR, COSMEGEN, CROMOLYN SODIUM, CUBICIN, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE, CYTARABINE AQUEOUS, CYTOVENE, DACARBAMINE, DACOGEN, DAUNORUBICIN HCL, DECAVAC, DECITABINE, DEP-O-PROVERA, DEXRAZOXANE, DILAUDID, DILAUDID-HP, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXERCALCIFEROL, DOXIL, DOXORUBICIN HCL, DOXORUBICIN HCL LIPOSOME, DRONABINOL, DUONEB, DURAMORPH, ELIGARD, ELITEK, ELLENCE, ELOXATIN, EMEND, EMLA, ENGERIX-B, EPIRUBICIN HCL, ERBITUX, ETOPOPHOS, ETOPOSIDE, FASLODEX, FIRMAGON, FLUDARABINE PHOSPHATE, FLUOROURACIL, FREAMINE HBC 6.9%, FREAMINE III, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GEMZAR, GENGRAF, GRANISITRON HCL, GRANISOL, HALAVEN, HECTOROL, HEPARIN SODIUM, HEPATAMINE, HEPATASOL, HERCEPTIN, HUMULIN R U-500 (CONCENTR, HCYCAMTIN, HYDROMORPHONE HCL, IBANDRONATE SODIUM, IDAMICIN PFS, IDARUBICIN HCL, IFEX, IFOSFAMIDE, IMURAN, INFUMORPH 200, INFUMORPH 500, INTRALIPID, INTRON-A, INTRON-A W/DILUENT, IPATROPIUM BROMIDE, IPATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTATAX, IXEMPR KIT, KACLYLA, KEPIVANCE, LEUCCOEVIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVOCARNITINE, LIDOCAINE HCL, LIDOCAINE/PRILOCAINE, LIPOSINE II, LIPOSINE III, MARINOL, MELPHALAN HYDROCHLORIDE, MESNA, MESNEX, METHOTREXATE SODIUM, MIOCALCIN, MITOMYCIN, MITOXANTRO HCL, MORPINE SULFATE, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, MYFORTIC, NEBUPENT, NEORAL, NEPHRAMINE, NIPENT, NULOJIX, ONDANSETRON HCL, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PENTOSTATIN, PERFOROMIST, PREMASOL, PROCALAMINE, PROGRAF, PROLEUKIN, PROSOL, PULMICORT, PULMOZYM, RAPAMUNE,
RECOMBIVAX HB, REMODULIN, ROCACTROL, SANDIMMUNE, SIMULECT, SIROLIMUS, TACROLIMUS, TAXOTERE, TENIVAC, TETANUS TOXOID ADSORBED, TETANUS/DIPHTHERIA TOXOID, THIOTEPA, THYMOCLOBULIN, TOBI, TOBRAMYCIN, TOPOSAR, TOPOTECAN HCL, TORISEL, TPN ELECTROLYTES, TRAVASOL, TREANDA, TREXALL, TRISENOX, TROPHAMINE, TWINRIX, UVADEX, VANCOMYCIN HCL, VECTIBIX, VELCADE, VENTAVIS, VIDAZA, VINBLASTINE SULFATE, VINCASAR PFS, VINORELBINE TARTRATE, XOPENEX, XOPENEX CONCENTRATE, XYLOCAINE, XYLOCAINE-MPF, ZANOSAR, ZEMPLAR, ZINECARD, ZOFRAN, ZOFRAN ODT, ZOLEDRONIC ACID, ZOMETA, ZORTRESS

**Covered Uses**

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

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

N/A

**Prior Authorization Group**

**Drug Names**

BENZODIAZEPINES

CLORAZEPATE DIPOTASSIUM, DIAZEPAM, DIAZEPAM INTENSOL, TRANXENE T, VALIUM

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

**Required Medical Information**

A. If for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the patient has experienced an inadequate treatment response to lorazepam AND B. If the patient is 65 years of age or older, the benefit of therapy with the prescribed medication outweighs the potential risk.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Alcohol Withdwr1mo, Anxiety-3mo, Muscle Spasms-reflex 6mo,motor neuron disorder-Seizures-Plan Year

**Other Criteria**
<table>
<thead>
<tr>
<th><strong>Prior Authorization Group</strong></th>
<th>BETASERON</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug Names</strong></td>
<td>BETASERON</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
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<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Patient must have a diagnosis of CML confirmed by detection of the Philadelphia chromosome and/or BCR-ABL gene AND experienced resistance or intolerance to prior therapy including imatinib, nilotinib or dasatinib.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years of age or older</td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>Plan Year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
### BOTOX

**Drug Names**
- BOTOX

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

**Exclusion Criteria**
- Cosmetic use.

**Required Medical Information**
- For chronic migraine prophylaxis, initial treatment: patient experiences at least 15 headache days per month, and patient had an inadequate response to at least 8 weeks of oral migraine preventative therapy. For chronic migraine prophylaxis, continuation of treatment (after 1 injection cycle): 50% reduction in monthly headache frequency since starting therapy. For primary axillary hyperhidrosis: patient has tried conventional treatments (such as topical aluminum chloride solution or iontophoresis) without adequate relief. For urinary incontinence in a patient with a neurologic condition (e.g., spinal cord injury, multiple sclerosis) or with overactive bladder: patient had an inadequate response to or is intolerant of an anticholinergic medication.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Chronic migraine, initial: 12 wks. Plan Year for all other indications and chronic migraine renewal

### BUPRENORPHINE HCL

**Drug Names**
- BUPRENORPHINE HCL

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

**Exclusion Criteria**
- A. For induction therapy for transition from concurrent opioid use to opioid dependence treatment OR for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone OR if the patient is a pregnant female and receiving buprenorphine for induction and subsequent maintenance therapy for transition from concurrent opioid use to opioid dependence treatment B. The prescriber agrees not to prescribe other opioids while the patient is taking buprenorphine for opioid dependence treatment.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Induction 3 months, Maintenance Plan Year, Pregnancy 10 months.

**Other Criteria**
**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

---

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

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Updated 06/01/2014
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>Drug Names</th>
<th>Covered Uses</th>
<th>Exclusion Criteria</th>
<th>Required Medical Information</th>
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<tbody>
<tr>
<td>Prior Authorization Group</td>
<td>CAPRELSA</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
<td>Long QT syndrome.</td>
<td>Symptomatic or progressive medullary thyroid cancer (MTC) with unresectable locally advanced or metastatic disease.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Other Criteria</td>
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</tbody>
</table>

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

Symptomatic or progressive medullary thyroid cancer (MTC) with unresectable locally advanced or metastatic disease.

### CARBAGLU

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

**Required Medical Information**

Diagnosis of NAGS deficiency was confirmed by enzyme assay demonstrating a deficiency of NAGS enzyme activity or by DNA testing.

### CAYSTON

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

**Required Medical Information**

Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing. Pseudomonas aeruginosa is present in the cultures of the airways.

### Plan Year

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**
**Prior Authorization Group**  
CEREZYME

**Drug Names**  
CEREZYME

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

**Exclusion Criteria**  
Concomitant therapy with miglustat (Zavesca).

**Required Medical Information**  
Diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity. Has Type 1 Gaucher disease. Therapy is initiated for a patient with at least one of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**  
Plan Year

**Other Criteria**

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**Prior Authorization Group**  
CHANTIX

**Drug Names**  
CHANTIX, CHANTIX STARTING MONTH PA

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

**Exclusion Criteria**

**Required Medical Information**  
The patient has been advised to report any changes to the prescriber such as changes in behavior, hostility, agitation, depressed mood, and suicide related events, including ideation, behavior, and attempted suicide, while taking Chantix.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**  
6 months

**Other Criteria**
Prior Authorization Group
CIMZIA

Drug Names
CIMZIA, CIMZIA STARTER KIT

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

Exclusion Criteria
Active infection (including active TB). Combination therapy with another biologic agent.

Required Medical Information
Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Cimzia (or other biologic). For positive latent TB, patient must have completed or is receiving treatment for latent TB infection. For those at risk for hepatitis B virus (HBV) infection, HBV infection has been ruled out or treatment for HBV has been initiated prior to starting Cimzia (or other biologic). For moderately to severely active rheumatoid arthritis (RA), must meet one of the following (new starts only): a) inadequate response to MTX OR b) intolerance or contraindication to MTX and an inadequate response to another nonbiologic DMARD such as leflunomide, hydroxychloroquine, sulfasalazine OR c) intolerance or contraindication to both MTX and at least one other nonbiologic DMARD OR d) inadequate response or intolerance to a prior biologic DMARD OR e) Cimzia will be used as first-line therapy for severely active RA. For moderately to severely active Crohn's disease (new starts only): a) inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine) OR b) intolerance or contraindication to conventional therapy. For active ankylosing spondylitis (new starts only): inadequate response, contraindication or intolerance to at least 2 NSAIDs.

Age Restrictions

Prescriber Restrictions

Coverage Duration
Plan Year

Other Criteria

Prior Authorization Group
COMETRIQ

Drug Names
COMETRIQ

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

Exclusion Criteria
Severe hemorrhage.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration
Plan Year

Other Criteria
Therapy will be discontinued if gastrointestinal perforation or fistula formation occurs.

Updated 06/01/2014
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<thead>
<tr>
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<tbody>
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<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Have relapsing-remitting MS OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease).</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis of MS was confirmed by the presence of diagnostic MRI.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Plan Year</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Plan Year</td>
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<tr>
<td>Coverage Duration</td>
<td>Plan Year</td>
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<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Documented history of hypersensitivity to penicillamine.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Plan Year</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Plan Year</td>
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<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Use for weight loss. Pregnancy. Active malignancy. Disruption of hypothalamic-pituitary axis due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, head irradiation or head trauma.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Patient meets the following criteria: diagnosis of HIV infection, presence of abdominal lipodystrophy and receiving anti-retroviral therapy (ART). For renewal or patients who have received at least 6 months of therapy, patient demonstrated clear clinical improvement from baseline (e.g., decreased waist circumference, CT scan).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>6 months</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>6 months</td>
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<td>Coverage Duration</td>
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<td>Other Criteria</td>
<td>6 months</td>
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</tbody>
</table>
**Prior Authorization Group**

**Drug Names**

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of mucopolysaccharidosis II (Hunter syndrome) is confirmed by an enzyme assay demonstrating a deficiency of iduronate 2-sulfatase enzyme activity or by DNA testing.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**
Appropriate medical support is readily available when Elaprase is administered in the event of anaphylaxis or a severe allergic reaction.

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**Prior Authorization Group**

**Drug Names**

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

**Exclusion Criteria**
Concomitant therapy with miglustat (Zavesca)

**Required Medical Information**
Diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity. Has Type 1 Gaucher disease. Therapy is initiated for a patient with at least one of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly

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

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**
Plan Year
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>EMSAM</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>EMSAM</td>
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<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>A. Pheochromocytoma. B. Concurrent use of the following medications: dextromethorphan or St. John’s Wort.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>A. Patient was not responsive to at least two (2) of the following antidepressants with documented trials of clinically sufficient doses and duration of six weeks each or longer: selective serotonin reuptake inhibitors (SSRIs), serotonin/norepinephrine reuptake inhibitors (SNRIs), bupropion, mirtazapine, or tricyclic/tetracyclic antidepressants. OR B. Patient is unable to take any oral preparations (including commercially available liquid antidepressants).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
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<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Plan Year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>For Emsam dose requests over 6 mg/24 hours, patient will agree to adhere to a tyramine restrictive diet.</td>
</tr>
</tbody>
</table>
**Prior Authorization Group**
- ENBREL

**Drug Names**
- ENBREL, ENBREL SURECLICK

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

**Exclusion Criteria**
- Active infection (including active TB). Combination therapy with another biologic agent.
- Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Enbrel (or other biologic). For positive latent TB, patient must have completed or be receiving treatment for latent TB infection. For those at risk for hepatitis B virus (HBV) infection, HBV infection has been ruled out or treatment for HBV has been initiated prior to starting Enbrel (or other biologic). For moderately to severely active rheumatoid arthritis (RA), must meet one of the following (new starts only): a) inadequate response to MTX OR b) intolerance or contraindication to MTX and an inadequate response to another nonbiologic DMARD such as leflunomide, hydroxychloroquine, sulfasalazine OR c) intolerance or contraindication to both MTX and at least one other nonbiologic DMARD OR d) inadequate response or intolerance to a prior biologic DMARD OR e) Enbrel will be used as first-line therapy for severely active RA. For moderately to severely active juvenile idiopathic arthritis (new starts only): a) inadequate response to MTX OR b) intolerance or contraindication to MTX. For active ankylosing spondylitis (new starts only): a) inadequate response, contraindication or intolerance to at least 2 NSAIDs. For chronic moderate to severe plaque psoriasis (new starts only): a) at least 5% of BSA is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected AND b) inadequate response to either phototherapy (eg, UVB, PUVA) OR a traditional systemic agent (eg, methotrexate, cyclosporine, acitretin), unless patient has contraindication or intolerance to such therapies.

**Required Medical Information**
- For positive latent TB, patient must have completed or be receiving treatment for latent TB infection. For those at risk for hepatitis B virus (HBV) infection, HBV infection has been ruled out or treatment for HBV has been initiated prior to starting Enbrel (or other biologic). For moderately to severely active rheumatoid arthritis (RA), must meet one of the following (new starts only): a) inadequate response to MTX OR b) intolerance or contraindication to MTX and an inadequate response to another nonbiologic DMARD such as leflunomide, hydroxychloroquine, sulfasalazine OR c) intolerance or contraindication to both MTX and at least one other nonbiologic DMARD OR d) inadequate response or intolerance to a prior biologic DMARD OR e) Enbrel will be used as first-line therapy for severely active RA. For moderately to severely active juvenile idiopathic arthritis (new starts only): a) inadequate response to MTX OR b) intolerance or contraindication to MTX. For active ankylosing spondylitis (new starts only): a) inadequate response, contraindication or intolerance to at least 2 NSAIDs. For chronic moderate to severe plaque psoriasis (new starts only): a) at least 5% of BSA is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected AND b) inadequate response to either phototherapy (eg, UVB, PUVA) OR a traditional systemic agent (eg, methotrexate, cyclosporine, acitretin), unless patient has contraindication or intolerance to such therapies.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Plan Year

**Other Criteria**
Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

EPLERENONE

EPLERENONE, INSPIRA

All FDA-approved indications not otherwise excluded from Part D.

A serum potassium level greater than 5.5 mEq/L.

A. Diagnosis of hypertension or post-myocardial infarction with LVEF less than or equal to 40% and clinical evidence of CHF after an acute MI. B. For diagnosis of post MI with LVEF less than or equal to 40% and clinical evidence of CHF after an acute MI, the patient must meet the following requirement: creatinine clearance greater than 30 mL/min. C. For the diagnosis of hypertension, the patient must meet the following requirements: the patient does not have type-2 diabetes with microalbuminuria AND the patient has a creatinine clearance of 50 mL/min or greater.

Plan Year
**Prior Authorization Group**

**Drug Names**

**EPO**, **EPOGEN**, **PROCRIT**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, myelodysplastic syndromes (MDS).

**Exclusion Criteria**


**Required Medical Information**

For all uses except surgery: 1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, 2) For reauthorizations (patient received erythropoietin in previous month), an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. Additional requirements for cancer: 1) For initial therapy, at least 2 more months of chemotherapy is expected, 2) For reauthorizations, current Hgb is less than 10 g/dL OR Hgb is greater than or equal to 10 but less than 11 g/dL AND patient has symptoms of anemia. Additional requirements for CKD: 1) For CKD not on dialysis reauthorization, current Hgb is less than or equal to 10 g/dL OR Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose, 2) For CKD on dialysis reauthorization, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, 2) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for HIV: 1) Concomitant use of zidovudine at a maximum dose of 4200 mg per week, 2) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. For surgery: 1) Patient is at high risk for perioperative blood loss and scheduled for elective, noncardiac, nonvascular surgery, 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.

**Age Restrictions**

**Prescriber Restrictions**

12 weeks

**Coverage Duration**

Patients will be monitored for thrombotic and cardiac events. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).

Updated 06/01/2014
### ERIVEDGE

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

#### Exclusion Criteria
- Patient meets the following criteria: 1) Metastatic BCC, OR 2) Locally advanced BCC that has recurred following surgery or the patient is not a candidate for radiation and not a candidate for surgery.

#### Required Medical Information
- For female patients of childbearing potential, pregnancy status is verified prior to initiation of therapy. Male patients and female patients of childbearing potential are instructed on the importance and proper use of appropriate contraceptive methods.

### EXJADE

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

#### Exclusion Criteria
- CrCl less than 40 mL/min. Platelet count less than 50 million per liter.

#### Required Medical Information
- (1) For chronic iron overload due to blood transfusions, Diagnosis of chronic iron overload due to blood transfusions and current serum ferritin level greater than 1000 mcg/L. (2) For iron overload in patients with NON-transfusion-dependent thalassemia (NTDT), a) Diagnosis of a NON-transfusion thalassemia syndrome and chronic iron overload, b) All liver iron concentrations (LIC) are measured by liver biopsy or by an FDA-cleared or approved method for identifying patients for treatment with deferasirox therapy, c) For initiation of Exjade: i) pretreatment LIC of at least 5 mg per gram of dry weight and ii) pretreatment serum ferritin levels greater than 300 mcg/L on 2 consecutive measurements 1 month apart, and d) For patients currently on Exjade therapy: current LIC is greater than 3 mg per gram of dry weight or Exjade will be withheld until the LIC reaches above 5 mg per gram of dry weight.

#### Age Restrictions
- 2 years of age or older

#### Other Criteria
- Plan Year
### Prior Authorization Group

**Drug Names**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

### Prior Authorization Group

**Drug Names**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

Diagnosis of Fabry disease is confirmed by an enzyme assay showing deficiency of alpha-galactosidase enzyme activity or by DNA testing. Fabrazyme is initiated for patients with clinical signs and symptoms of Fabry disease (e.g., Intermittent paresthesia and acroparesthesia, episodic Fabry crises, angiokeratomas, whorled corneal opacity, gastrointestinal problems, hypohidrosis or anhidrosis, heat, cold, and/or exercise intolerance, renal dysfunction, cardiovascular dysfunction, cerebrovascular complications, pulmonary complications). For female carriers only: Fabrazyme is prescribed for the management of any 1 of the following substantial disease manifestations: renal dysfunction, cardiovascular dysfunction, cerebrovascular complications, pulmonary complications, or neurological or neuropathic dysfunction such as pain.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**
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<tr>
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<th>FENTANYL PATCH</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>DURAGESIC, FENTANYL</td>
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<tr>
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<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>A. The prescriber has considered the risks of opioid/substance abuse/or addiction in this patient while receiving fentanyl patch. B. The patient can be safely started on the requested dose of fentanyl patch based on the patient's current narcotic use or expected tolerance.</td>
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</table>

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

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</tr>
<tr>
<td>Exclusion Criteria</td>
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</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis of transfusional iron overload due to thalassemia syndromes.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Prior Authorization Group</td>
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<td>Drug Names</td>
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<tr>
<td>Covered Uses</td>
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</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Paget's disease of bone, unexplained elevations of alkaline phosphatase, open epiphyses (ie, pediatric or young adult patient), prior radiation therapy involving the skeleton, history of a skeletal malignancy, bone metastases, pre-existing hypercalcemia, metabolic bone disease other than osteoporosis.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Patient meets one of the following criteria (new starts only): 1) Prior fragility fracture OR 2) Had a trial of an oral bisphosphonate unless contraindicated or intolerant to an oral bisphosphonate OR 3) Has more than one risk factors for fracture (e.g., advanced age [postmenopausal women and men 50 years of age and older], low body mass index [less than 19 kg/m2], parental history of hip fracture, current smoker, alcohol intake of 3 or more drinks per day, chronic steroid use [greater than or equal to 5 mg/day prednisone or equivalent for at least 3 months], rheumatoid arthritis, secondary causes of osteoporosis)</td>
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<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Up to a total of 24 months (lifetime)</td>
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<tr>
<td>Exclusion Criteria</td>
<td>The patient and caregivers will be advised to contact the healthcare provider immediately if any serious psychiatric or behavioral reactions are observed.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>12 years of age or older</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Plan Year</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td></td>
</tr>
<tr>
<td>Other Criteria</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>GATTEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>GATTEX</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Diagnosis of short bowel syndrome requiring parenteral support for at least 12 months.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
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<tr>
<td>Coverage Duration</td>
<td>Plan Year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
### GILENYA

**Prior Authorization Group**
- GILENYA

**Drug Names**
- GILENYA

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

**Exclusion Criteria**
- Recent occurrence (within the last 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, class III or IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500ms. Treatment with Class Ia or Class III anti-arrhythmic drugs.

**Required Medical Information**
- Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Plan Year

**Other Criteria**
- For patients previously treated with Tysabri: a minimum 3 month washout period is required after discontinuation of Tysabri.

---

### GILOTRIF

**Prior Authorization Group**
- GILOTRIF

**Drug Names**
- GILOTRIF

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

**Exclusion Criteria**
- Patient has metastatic non-small cell lung cancer. Patient had EGFR mutation testing and is positive for EGFR exon 19 deletions or exon 21 (L858R) substitution mutations.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Plan Year

**Other Criteria**
**Prior Authorization Group**

**Drug Names**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, lymphoblastic lymphoma, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT).

**Exclusion Criteria**

For CML, ALL, and lymphoblastic lymphoma, patient must be positive for the Ph chromosome or BCR-ABL gene. For CML, patient has not progressed on prior treatment with dasatinib or nilotinib. For ALL or lymphoblastic lymphoma, patient meets one of the following: 1) newly diagnosed and Gleevec is used in combination with chemotherapy, or 2) disease is relapsed or refractory. For GIST, patient meets one of the following: 1) unresectable, recurrent, or metastatic GIST, 2) use of Gleevec for adjuvant therapy following resection, or 3) Preoperatively for GIST that is resectable.

Myelodysplastic/myeloproliferative disease is associated with PDGFR gene re-arrangements. For D816V c-Kit mutation, aggressive systemic mastocytosis is negative or unknown. Patient has one of the following diagnoses: hypereosinophilic syndrome, chronic eosinophilic leukemia, desmoid tumor, dermatofibrosarcoma protuberans, PVNS/TGCT.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

Female, prostatic carcinoma or other androgen dependent neoplasm, precocious puberty, anatomical obstruction.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**
<table>
<thead>
<tr>
<th><strong>Prior Authorization Group</strong></th>
<th>GRANIX</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug Names</strong></td>
<td>GRANIX</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D, prophylaxis of chemotherapy-induced febrile neutropenia (FN) or other treatment-compromising neutropenic events in patients with non-myeloid malignancies, treatment of chemotherapy-induced FN, acute lymphocytic leukemia (ALL), leukemic relapse, myelodysplastic syndromes (MDS).</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Use of the requested G-CSF product within 24 hours preceding or following chemotherapy or radiotherapy. For treatment of acute FN, patient received prophylactic Neulasta during the current chemotherapy cycle.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>For prophylaxis of FN (or other treatment-compromising neutropenic event), patient has a non-myeloid cancer and is currently receiving or will be receiving treatment with myelosuppressive anti-cancer drugs. For treatment of chemotherapy-induced FN, patient has a non-myeloid cancer AND is currently receiving OR has received treatment with myelosuppressive anti-cancer drugs. For MDS, patient has symptomatic anemia and the requested G-CSF product will be used in combination with epoetin or darbepoetin OR patient has neutropenia and recurrent or resistant infections.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>6 months</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Prior Authorization Group**

GROWTH HORMONE

**Drug Names**

GENOTROPIN, GENOTROPIN MINIQUICK, HUMATROPE, HUMATROPE COMBO PACK, NORDITROPIN FLEXPRO, NORDITROPIN NORDIFLEX PEN, NUTROPIN, NUTROPIN AQ NUSPIN 5, NUTROPIN AQ PEN, OMNITROPE, SAIZEN, SAIZEN CLICK.EASY, TEV-TROPIN

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D including pediatric growth hormone deficiency (GHD), Turner syndrome (TS), Noonan syndrome (NS), chronic renal insufficiency (CRI), small for gestational age (SGA), Prader-Willi syndrome (PWS), idiopathic short stature (ISS), short stature homeobox-containing gene deficiency (SHOXD), and adult GHD.

**Exclusion Criteria**

Active malignancy, active proliferative or severe non-proliferative diabetic retinopathy, acute critical illness, concurrent use withIncrelex. For pediatric patients only: epiphyseal closure.

**Required Medical Information**

Pediatric GHD, TS, NS, CRI, SGA, PWS, ISS, SHOXD: r/o other causes of growth failure. Pediatric GHD, TS, NS, SHOXD, ISS, CRI, SGA: Younger than 2.5 yrs old, when applicable: pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2.5 yrs old or older: pre-tx 1-year ht velocity more than 2 SD below mean OR pre-tx height more than 2 SD below mean plus 1-year ht velocity more than 1 SD below mean. Pediatric GHD: Delayed bone age AND failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment OR has pituitary or CNS disorder with pre-tx IGF-1/IGFBP3 more than 2 SD below mean. Pediatric GHD in neonate: Random pre-tx GH below 20 ng/mL AND other causes of hypoglycemia r/o and other treatments ineffective. TS: Confirmed by karyotyping. CRI: Not post-kidney transplant AND metabolic, endocrine, nutritional abnormalities treated or stabilized. SGA: Did not manifest catch-up growth by age 2 AND birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA. PWS: r/o upper airway obstruction via appropriate test or examination AND GH will be discontinued if develop severe respiratory impairment. SHOXD: Confirmed by molecular or genetic testing. ISS: Pediatric GHD r/o by appropriate provocative test or examination AND GH will be discontinued if develop severe respiratory impairment. SHOXD: Confirmed by molecular or genetic testing. ISS: Pediatric GHD r/o by appropriate provocative test more than 10 ng/mL AND prior to starting GH tx, ht more than 2.25 SD below mean and adult ht prediction below 5’3” for boys, 4’11” for girls. Adult GHD: Other causes of GHD-like symptoms (e.g., hypothyroidism, malignancy, chronic systemic disease) assessed AND 1 of the following: 1) failed 2 stimulation tests (peak below 5 µg/L) prior to starting tx, 2) 3 or more pituitary hormone deficiencies or panhypopituitarism, 3) childhood-onset GHD with known mutations, embroyopathic lesions, or irreversible structural lesions/damage, or 4) low pre-tx IGF-1 and failed 1 stimulation test (peak below 5 µg/L) prior to starting tx. TS and SGA: 2 years of age or older. NS and SHOXD: 3 years of age or older.

**Age Restrictions**

**Prescriber Restrictions**

Endocrinologist, Pediatric nephrologist

**Coverage Duration**

Plan Year

**Other Criteria**

Renewal for neonatal hypoglycemia: patient is euglycemic or therapy will be adjusted to optimize efficacy. Renewal for pediatric GHD, TS, NS, CRI, SGA, PWS, ISS, or SHOXD: patient is growing more than 2 cm/year. For PWS only: body composition has improved.
Renewal for adult GHD: IGF-1 levels monitored.

### Prior Authorization Group

**Drug Names**

High Risk Medication
- Alora, Amitriptyline HCL, Anafranil, Benztropine Mesylate, Climara, Clo mipramine HCL, CombiPatch, Cyproheptadine HCL, Diabeta, Digoxin, Diphenoxylate/Atropine, Disopyramide Phosphate, Doxepin HCL, Estrace, Estradiol, Glucovance, Glyburide, Glyburide Micronized, Glyburide/Metformin HCL, Glynase, Hydroxyzine HCL, Imipramine HCL, Imipramine Pamoate, Jinteli, Lanoxin, Lomotil, Megace ES, Megace Oral, Megestrol Acetate, Menest, Menostar, Minivelle, Norpace, Norpace CR, Phenobarbital, Phenobarbital Sodium, Surmontil, Thoridazine HCL, Tofranil, Tofranil-PM, Transderm-Scop, Trimipramine Maleate, Vivelle-Dot

### Covered Uses

**Exclusion Criteria**

All FDA-approved indications not otherwise excluded from Part D.

**Required Medical Information**

Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

### Age Restrictions

**Prescriber Restrictions**

### Coverage Duration

Plan Year

**Other Criteria**

**Prior Authorization Group**

HRM-Hypnotics

**Drug Names**

- Ambien, Ambien CR, Edluar, Intermezzo, Lunesta, Sonata, Zaleplon, Zolpidem Tartrate, Zolpidem Tartrate ER, Zolpidem

**Covered Uses**

**Exclusion Criteria**

All FDA-approved indications not otherwise excluded from Part D.

**Required Medical Information**

Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

APPLIES TO GREATER THAN CUMULATIVE ACROSS THE CLASS 90 DAYS OF THERAPY PER YEAR.
**Prior Authorization Group**

**Drug Names**

HUMIRA, HUMIRA PEN, HUMIRA PEN-CROHNS DISEASE, HUMIRA PEN-PSORIASIS STAR

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

Active infection (including active TB). Combination therapy with another biologic agent.

**Required Medical Information**

Latent TB screening with a TB skin test or interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Humira or other biologic. For positive latent TB, patient completed or is receiving treatment for latent TB. For those at risk for hepatitis B virus (HBV) infection, HBV has been ruled out or treatment for HBV has been initiated prior to starting Humira or other biologic. For moderately to severely active RA, must meet 1 of the following (new starts only): a) inadequate response to MTX OR b) intolerance/contraindication to MTX and inadequate response to another nonbiologic DMARD (eg, leflunomide, hydroxychloroquine, sulfasalazine) OR c) intolerance/contraindication to both MTX and at least 1 other nonbiologic DMARD OR d) inadequate response/intolerance to a prior biologic DMARD OR e) Humira will be used first-line for severely active RA. For moderately to severely active JIA (new starts only): inadequate response, intolerance or contraindication to MTX. For active ankylosing spondylitis (new starts only): inadequate response, intolerance or contraindication to at least 2 NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): at least 5% BSA is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected AND inadequate response to either phototherapy or traditional systemic therapy unless intolerance/contraindication. For moderately to severely active Crohn’s disease (new starts only): inadequate response to at least 1 conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine) OR intolerance/contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): a) inadequate response to immunosuppressant therapy (eg, corticosteroids, azathioprine, mercaptopurine) OR intolerance/contraindication to immunosuppressant therapy AND b) patient is naive to TNF inhibitor therapy OR lost response to TNF inhibitor due to antibody formation.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

Updated 06/01/2014
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>ICLUSIG</th>
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</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>ICLUSIG</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Diagnosis of CML or Ph+ ALL was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND CML or Ph+ ALL is positive for the T315I mutation OR treatment with all other tyrosine kinase inhibitors (imatinib, dasatinib, nilotinib, bosutinib) is not indicated.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>18 years of age or older</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Plan Year</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Patient will be monitored for evidence of thromboembolism and vascular occlusion. Cardiac and hepatic functions will be monitored.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>IMBRUVICA</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>IMBRUVICA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>Plan Year</td>
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<tr>
<td>Other Criteria</td>
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</tr>
</tbody>
</table>
**Prior Authorization Group**

INCIVEK

**Drug Names**

INCIVEK

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

Failed previous therapy with a treatment regimen that includes a protease inhibitor (e.g., Incivek, Victrelis). Concomitant administration with a drug that is highly dependent on CYP3A for clearance or a strong inducer of CYP3A (i.e., alfuzosin, dihydroergotamine, ergonovine, ergotamine, methylergonovine, lovastatin, lomitapide, oral midazolam, pimozide, rifampin, simvastatin, St. John's wort, triazolam, Adcirca or Revatio when used for PAH). Concomitant use of any of the following ritonavir-boosted HIV protease inhibitors: lopinavir, darunavir, or fosamprenavir for new starts only.

**Required Medical Information**

Detectable HCV-RNA prior to starting therapy for all patients. HCV Genotype 1. Must be given in combination with pegylated interferon (i.e., Pegasys or PegIntron) and ribavirin. Assess HCV RNA level at weeks 4, 12, and 24 of Incivek triple therapy. HCV-RNA less than or equal to 1,000 IU/mL at week 4 of treatment.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Initial: 6 weeks. Continuation of therapy: Up to 12 weeks.

**Other Criteria**

Patient will be advised to discontinue Incivek, peginterferon, and ribavirin and seek urgent medical care if rash occurs.

**Prior Authorization Group**

INCRELEX

**Drug Names**

INCRELEX

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

Active or suspected neoplasia, history of malignancy in the past 12 months. Concurrent use with GH therapy. Closed epiphyses.

**Required Medical Information**

Must meet all of the following prior to beginning Increlex therapy: 1) height 3 or more standard deviations below the norm for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the norm for children of the same age and gender AND 3) stimulation test showing a normal or elevated growth hormone level AND 4) other causes of IGF-1 deficiency (e.g., hypothyroidism, malignancy, chronic systemic disease, skeletal disorders, malnutrition, celiac disease) have been ruled out.

**Age Restrictions**

**Prescriber Restrictions**

Endocrinologist

**Coverage Duration**

Plan Year

**Other Criteria**

For renewal, patient is growing more than 2 cm/year.
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>INFERGEN</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>INFERGEN</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Decompensated liver disease (e.g., Child-Pugh score greater than 6 [class B and C]). Autoimmune hepatitis. Uncontrolled major depression or severe mental illness.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Detectable HCV-RNA prior to starting therapy for all patients. Patient had a documented adverse reaction (ADR) or is at higher risk for an ADR to a pegylated interferon. If used as monotherapy, must have a contraindication or intolerance to ribavirin.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Allow up to 48 weeks</td>
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<tr>
<td>Other Criteria</td>
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<thead>
<tr>
<th>Prior Authorization Group</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>INLYTA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Patient has a diagnosis of advanced renal cell carcinoma (RCC) that has progressed 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).</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
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<tr>
<td>Age Restrictions</td>
<td></td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>Plan Year</td>
</tr>
<tr>
<td>Other Criteria</td>
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</tr>
</tbody>
</table>
### Prior Authorization Group

**INVEGA SUSTENNA**

### Drug Names

**INVEGA SUSTENNA**

### Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

### Exclusion Criteria

A. Diagnosis of dementia-related psychosis. B. Prior use of risperidone demonstrated a hypersensitivity reaction.

### Required Medical Information

A. Diagnosis of acute and maintenance treatment of schizophrenia. AND B. The patient has a history of noncompliance and/or refuses to utilize oral medication. AND C. The patient has received at least ONE of the following: a. three test doses of oral Risperdal (risperidone) b. three test doses of oral Invega c. previous use of Invega Sustenna.

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration

Plan Year

### Other Criteria

If the dose of Invega Sustenna is being increased, the patient must have a history of two prior injections of Invega Sustenna.

### Prior Authorization Group

**ITRACONAZOLE**

### Drug Names

**ITRACONAZOLE, SPORANOX, SPORANOX PULSEPAK**

### Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

### Exclusion Criteria

A. For onychomycosis, ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF). B. If the patient is currently receiving any of the following medications: cisapride, dofetilide, pimozide, and quinidine.

### Required Medical Information

For onychomycosis, diagnosis has been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy).

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration

12 weeks

### Other Criteria

Criteria apply to capsule dosage form only.
**Prior Authorization Group** | IVIG
---|---
**Drug Names** | CARIMUNE NANOFILTERED, FLEBOGAMMA, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX, GAMUNEX-C, OCTAGAM
**Covered Uses** | All FDA-approved indications not otherwise excluded from Part D, B-cell chronic lymphocytic leukemia (CLL), Kawasaki syndrome, pure red cell aplasia (PRCA).
**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.
**Required Medical Information** | For CLL: serum IgG less than 500 mg/dL or a history of recurrent bacterial infections. For Kawasaki syndrome: IGIV is used in conjunction with high-dose aspirin. PRCA is secondary to parvovirus B19 infection. For all indications, patients with any of the following risk factors for acute renal failure must receive the minimum concentration available of IGIV and the minimum infusion rate practicable: pre-existing renal insufficiency, diabetes mellitus, age over 65 years, volume depletion, sepsis, paraproteinemia, or receiving concomitant nephrotoxic drugs.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** | Plan Year

**Other Criteria** | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

**Prior Authorization Group** | JAKAFI
---|---
**Drug Names** | JAKAFI
**Covered Uses** | All FDA-approved indications not otherwise excluded from Part D.
**Exclusion Criteria** | Patient has intermediate or high-risk myelofibrosis. Patient has been diagnosed with primary myelofibrosis OR secondary myelofibrosis due to polycythemia vera or essential thrombocytemia.
**Required Medical Information** | Patient has intermediate or high-risk myelofibrosis. Patient has been diagnosed with primary myelofibrosis OR secondary myelofibrosis due to polycythemia vera or essential thrombocytemia.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** | Plan Year

**Other Criteria**
Prior Authorization Group: KINERET
Drug Names: KINERET
Covered Uses: All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria: Active infection. Combination therapy with another biologic agent.
Required Medical Information: For rheumatoid arthritis, patient has had an inadequate response or intolerance to a prior biologic DMARD.

Age Restrictions
Prescriber Restrictions
Coverage Duration: Plan Year
Other Criteria

Prior Authorization Group: KUVAN
Drug Names: KUVAN
Covered Uses: All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria: Kuvan will be used in conjunction with a phenylalanine-restricted diet. For patients who have not yet received a therapeutic trial of Kuvan, the following criteria are met: 1) Patients less than or equal to 12 years of age have a baseline blood Phe level greater than 6 mg/dL, 2) Patients greater than 12 years of age have a baseline blood Phe level greater than 10 mg/dL, 3) Blood Phe levels will be checked after 1 week and periodically for up to a month during therapeutic trial with Kuvan to determine responsiveness, and 4) Kuvan will be discontinued if Phe levels do not decrease after one month of treatment. For patients for whom this is the first treatment after a therapeutic trial of Kuvan, patient must have experienced a reduction in blood Phe level of greater than or equal to 30 percent from baseline.

Age Restrictions
Prescriber Restrictions
Coverage Duration: Initial: 1 month. Continuation of treatment: Plan Year.
Other Criteria
Prior Authorization Group: LETAIRIS

Drug Names: LETAIRIS

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

Exclusion Criteria: Pregnancy

Required Medical Information: NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy and will be excluded monthly during therapy, AND 2) Patient will use reliable contraception during treatment and for one month after stopping treatment.

Age Restrictions

Prescriber Restrictions

Coverage Duration: Plan Year

Other Criteria

Prior Authorization Group: LEUKINE

Drug Names: LEUKINE

Covered Uses: All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), myelodysplastic syndromes (MDS), acute lymphocytic leukemia (ALL).

Exclusion Criteria: Use of Leukine less than 24 hours before or after chemotherapy or radiotherapy. For treatment of chemotherapy-induced FN, patient received prophylactic Neulasta during the current chemotherapy cycle.

Required Medical Information: For treatment of chemotherapy-induced FN, patient has a non-myeloid cancer and is currently receiving or has received treatment with myelosuppressive anti-cancer drugs. For MDS, patient has neutropenia and recurrent or resistant infections.

Age Restrictions

Prescriber Restrictions

Coverage Duration: 6 months

Other Criteria
### Prior Authorization Group
**LIDODERM**

### Drug Names
LIDOCAINE, LIDOCAINE

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

### Exclusion Criteria
Patient has sensitivity to local anesthetics of the amide type.

### Required Medical Information
A. The diagnosis is documented as post-herpetic neuralgia. B. The skin where the patch is to be applied is intact. C. Patient demonstrated an inadequate treatment response to a one month trial of the following medications: gabapentin OR Lyrica. D. OR the patient has a contraindication or had a confirmed adverse event with gabapentin or Lyrica.

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
Plan Year

### Other Criteria

### Prior Authorization Group
**LOTRONEX**

### Drug Names
LOTRONEX

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

### Exclusion Criteria
A. Patient is male. B. Patient has a history of any of the following contraindications to Lotronex therapy: chronic or severe constipation or sequelae from constipation, intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions, ischemic colitis, impaired intestinal circulation, thrombophlebitis or hypercoagulable state, Crohn's disease or ulcerative colitis, diverticulitis, severe hepatic impairment.

### Required Medical Information
A. Patient has a diagnosis of severe diarrhea-predominant IBS with chronic IBS symptoms that have lasted for at least 6 months with at least one or more of the following symptoms: a. Frequent and severe abdominal pain/discomfort b. Frequent bowel urgency or fecal incontinence c. Disability or restriction of daily activity due to IBS. AND B. Other anatomical or biochemical abnormalities of the GI tract have been excluded as a cause of the symptoms to be treated by Lotronex AND C. Patient has not responded adequately to conventional therapy for the treatment of IBS.

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
1 month initial, Plan Year on renewal

### Other Criteria
A. The patient will be monitored for Lotronex-related adverse events. B. Upon renewal, patient has received at least 4 weeks of continuous Lotronex therapy within the last 30 days for the diagnosis of severe diarrhea-predominant IBS and the IBS symptoms have been adequately controlled since initiating Lotronex.
Prior Authorization Group: LUMIZYME

Drug Names: LUMIZYME

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

Exclusion Criteria

Required Medical Information: Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of GAA enzyme activity or by DNA testing that identifies mutations in the GAA gene. Patient has late-onset (non-infantile) Pompe disease with no evidence of cardiac hypertrophy.

Age Restrictions: 8 years of age or older

Prescriber Restrictions: Plan Year

Coverage Duration: Appropriate medical support is readily available when Lumizyme is administered in the event of anaphylaxis, severe allergic reaction, or acute cardiorespiratory failure.
**Prior Authorization Group**  
LUPRON

**Drug Names**  
LEUPROLIDE ACETATE, LUPRON Depot, LUPRON Depot-PED

**Covered Uses**  
All FDA-approved indications not otherwise excluded from Part D. Breast cancer (Lupron Depot 3.75mg and Lupron Depot-3 Month 11.25mg only). Ovarian cancer (Lupron Depot 3.75mg and Lupron Depot-3 Month 11.25mg only). Fallopian tube cancer (Lupron Depot 3.75mg only). Primary peritoneal cancer (Lupron Depot 3.75mg only).

**Exclusion Criteria**  
Use as neoadjuvant androgen deprivation therapy (ADT) for radical prostatectomy for clinically localized prostate cancer. Pregnancy for female patients except for children with CPP. Breastfeeding (Lupron Depot 3.75mg and 3 Month 11.25mg only). Undiagnosed abnormal vaginal bleeding (Lupron Depot 3.75mg and 3 Month 11.25mg only).

**Required Medical Information**  
For prostate cancer, must meet one of the following: 1) Locally advanced, recurrent or metastatic disease, OR 2) Use as neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with intermediate or high risk of recurrence. For breast cancer (Lupron Depot 3.75mg and 3 Month 11.25mg only), must meet all of the following: 1) Premenopausal woman with hormone receptor positive disease AND 2) Use with adjuvant therapy OR in combination with endocrine therapy if disease is recurrent or metastatic. For endometriosis: must have at least a 3-month trial and failure of oral contraceptives OR progestins OR danazol. Allow only one-time retreatment AND meet all of the following: 1) recurrence of symptoms 2) receive add-back therapy (e.g., norethindrone) 3) bone mineral density is within normal limits. For uterine leiomyomata: must have anemia (HCT less than or equal to 30% and/or Hgb less than or equal to 10g/dL) AND use Lupron with iron therapy. For ovarian cancer stromal tumor type: must have relapsed stage II-IV granulosa cell tumors. For epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: disease is stable, recurrent, or persistent with primary therapy AND use Lupron (3.75mg only) as a single agent. For CPP: 1) CPP diagnosis was confirmed by a pubertal response to a GnRH agonist test and by assessment of bone age versus chronological age, 2) Onset of sexual characteristics was prior to 8 years of age for female patients or prior to 9 years of age for males, 3) Appropriate diagnostic imaging of the brain has been done to exclude an intracranial tumor, 4) If indicated, adrenal steroid levels have been evaluated to rule out congenital adrenal hyperplasia, 5) If indicated, appropriate diagnostic imaging has been evaluated to rule out steroid secreting tumors, and 6) For males only: if indicated, beta human chorionic gonadotropin levels have been evaluated to rule out a chorionic gonadotropin secreting tumor.

**Age Restrictions**  
For endometriosis/fibroids/ovarian cancer/fallopian tube cancer/primary peritoneal cancer/breast cancer: 18 years of age or older. For CPP: less than 12 years old if female and less than 13 years old if male.

**Prescriber Restrictions**  
Coverage Duration  
Oncology indications: Plan Year. Endometriosis: 6 months. Fibroids: 3 months.

**Updated 06/01/2014**
Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

MEKINIST
MEKINIST
All FDA-approved indications not otherwise excluded from Part D.
As a single agent for the treatment of patients who have received prior BRAF-inhibitor therapy (e.g., Zelboraf, Tafinlar).
Patient has a diagnosis of unresectable or metastatic melanoma AND the tumor is positive for either BRAF V600E or V600K mutation AND patient will use Mekinist as either a single agent or in combination with Tafinlar.

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

MOZOBIL
MOZOBIL
All FDA-approved indications not otherwise excluded from Part D.
Mozobil will be used to mobilize hematopoietic stem cells for collection prior to autologous transplantation and will be used in combination with granulocyte-colony stimulating factor (i.e., filgrastim or pegfilgrastim). Patient has a diagnosis of either non-Hodgkin’s lymphoma or multiple myeloma.

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

MYOZYME
MYOZYME
All FDA-approved indications not otherwise excluded from Part D.
Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of GAA enzyme activity or by DNA testing that identifies mutations in the GAA gene.

Plan Year

Plan Year

Appropriate medical support is readily available when Myozyme is administered in the event of anaphylaxis, severe allergic reaction, or acute cardiorespiratory failure.
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>NAGLAZYME</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>NAGLAZYME</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Diagnosis of mucopolysaccharidosis VI (MPS VI) is confirmed by an enzyme assay demonstrating a deficiency in N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by DNA testing.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For prophylaxis of FN or other treatment-compromising neutropenic events, patient has a non-myeloid cancer and is currently receiving or will be receiving treatment with myelosuppressive anti-cancer drugs.</td>
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<tr>
<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>Plan Year</td>
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<td>Other Criteria</td>
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<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>NEULASTA</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>NEULASTA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D, prophylaxis of chemotherapy-induced febrile neutropenia (FN) or other treatment-compromising neutropenic events in patients with non-myeloid malignancies, mobilization of peripheral blood progenitor cells.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Use of Neulasta less than 14 days before or less than 24 hours after chemotherapy.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For prophylaxis of FN or other treatment-compromising neutropenic events, patient has a non-myeloid cancer and is currently receiving or will be receiving treatment with myelosuppressive anti-cancer drugs.</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>6 months</td>
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<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
Prior Authorization Group: NEUPOGEN

Drug Names: NEUPOGEN

Covered Uses: All FDA-approved indications not otherwise excluded from Part D, prophylaxis of chemotherapy-induced febrile neutropenia (FN) or other treatment-compromising neutropenic events in patients with non-myeloid malignancies, treatment of chemotherapy-induced FN, acute lymphocytic leukemia (ALL), leukemic relapse, myelodysplastic syndromes (MDS)

Exclusion Criteria: Use of Neupogen less than 24 hours before or after chemotherapy or radiotherapy. For treatment of acute FN, patient received prophylactic Neulasta during the current chemotherapy cycle.

Required Medical Information: For prophylaxis of FN (or other treatment-compromising neutropenic event), patient has a non-myeloid cancer and is currently receiving or will be receiving treatment with myelosuppressive anti-cancer drugs. For treatment of chemotherapy-induced FN, patient has a non-myeloid cancer AND is currently receiving OR has received treatment with myelosuppressive anti-cancer drugs. For MDS, patient has symptomatic anemia and Neupogen will be used in combination with epoetin or darbepoetin OR patient has neutropenia and recurrent or resistant infections.

Age Restrictions: 

Prescriber Restrictions: 

Coverage Duration: 6 months

Other Criteria: 

Prior Authorization Group: NEXAVAR

Drug Names: NEXAVAR

Covered Uses: All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), gastrointestinal stromal tumors (GIST), angiosarcoma, desmoid tumors (aggressive fibromatosis).

Exclusion Criteria: For renal cell carcinoma and hepatocellular carcinoma: patient has advanced disease. For follicular, papillary, or Hurthle cell thyroid carcinoma: patient has metastatic disease with nonradioiodine-responsive tumors at sites other than central nervous system. For medullary thyroid carcinoma: patient has metastatic and disseminated symptomatic disease with progression on vandetanib or vandetanib is not appropriate. For GIST: patient has progressive disease AND tried and had an inadequate response to imatinib or sunitinib. Patient has angiosarcoma or desmoid tumors (aggressive fibromatosis).

Age Restrictions: 

Prescriber Restrictions: 

Coverage Duration: Plan Year

Other Criteria: 

Updated 06/01/2014
**Prior Authorization Group**
NITROFURANTOIN

**Drug Names**
FURADANTIN, MACROBID, MACRODANTIN, NITROFURANTOIN, NITROFURANTOIN MACROCRYST, NITROFURANTOIN MONOHYDRAT

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

**Exclusion Criteria**
Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
Plan Year

**Other Criteria**
APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR

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**Prior Authorization Group**
NUDEXTA

**Drug Names**
NUDEXTA

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

**Exclusion Criteria**
A. Patient is currently taking drugs containing quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong the QT interval and are metabolized by CYP2D6. B. Patient has a prolonged QT interval or congenital long QT syndrome (LQTS), or heart failure or a history suggestive of torsades de pointes (TdP). C. Patient has complete atrioventricular (AV) block without an implanted pacemaker or is at high risk of complete AV block.

**Required Medical Information**
Nuedexita is being requested for the treatment of pseudobulbar affect (PBA).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
Plan Year

**Other Criteria**

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**Prior Authorization Group**
NUVIGIL

**Drug Names**
NUVIGIL

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

**Exclusion Criteria**
A. Diagnosis is narcolepsy confirmed by sleep lab evaluation. OR B. Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography. OR C. Diagnosis is shift work disorder (SWD).

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
Plan Year

**Other Criteria**
Prior Authorization Group
OCTREOTIDE

Drug Names
OCTREOTIDE ACETATE, SANDOSTATIN

Covered Uses
All FDA-approved indications not otherwise excluded from Part D, neuroendocrine tumors (NET), meningioma, thymic carcinoma.

Exclusion Criteria
For acromegaly, the patient meets all of the following: 1) clinical evidence of acromegaly AND 2) high pre-treatment IGF-1 level for age/gender AND 3) inadequate or partial response to surgery and/or radiotherapy unless there is a clinical reason for why the patient has not had surgery or radiotherapy. For recurrent meningioma: tumors are surgically unresectable. For thymic carcinoma: 1) patient has locally advanced, unresectable disease AND 2) octreotide is used following radiation treatment. For NET: 1) patient has poorly differentiated NET/small cell tumors and octreotide will be used in combination with chemotherapy OR 2) patient has any one of the following pancreatic endocrine tumors (Islet cell tumors): VIPoma, gastrinoma, or glucagonoma, OR 3) patient has carcinoid tumors and one of the following: a) metastatic, unresectable disease, b) carcinoid syndrome, c) clinically significant tumor burden, d) clinically significant progressive disease, or e) patient has atypical lung carcinoids and will be used in combination with chemotherapy, OR 4) patient has lung NET with positive octreotide scan, OR 5) patient has MEN type 1 tumors and insulinoma or pituitary adenoma.

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria
Plan Year

Prior Authorization Group
OLYSIO (Criteria Under Review)

Drug Names
OLYSIO

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria
Prior Authorization Group: ONFI

Drug Names: ONFI

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

Exclusion Criteria: Patient has types of seizures associated with Lennox-Gastaut Syndrome (e.g., tonic, atonic, absence or myoclonic seizures).

Required Medical Information: Neurologist or affiliated with a neurology practice

Age Restrictions: Plan Year

Prescriber Restrictions: Neurologist or affiliated with a neurology practice

Coverage Duration: Plan Year

Other Criteria: 

Prior Authorization Group: ONMEL

Drug Names: ONMEL

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

Exclusion Criteria: A. The patient is currently receiving any of the following medications: cisapride, doxylamine, dihydroergotamine, ergotamine, ergometrine, methylergonovine, felodipine, levacetylmethadol, lovastatin, methadone, oral midazolam, nisoldipine, pimozide, quinidine, simvastatin, or triazolam. B. The patient has evidence of ventricular dysfunction such as congestive heart failure (CHF) or history of congestive heart failure (CHF).

Required Medical Information: Diagnosis of onychomycosis has been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy).

Age Restrictions: 

Prescriber Restrictions: 

Coverage Duration: 12 weeks

Other Criteria: Criteria apply to tablet dosage form only.

Prior Authorization Group: OPSUMIT

Drug Names: OPSUMIT

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

Exclusion Criteria: PAH (WHO Group 1) was confirmed by right heart catheterization. NYHA Functional Class II or III symptoms.

Required Medical Information: 

Age Restrictions: 

Prescriber Restrictions: 

Coverage Duration: Plan Year

Other Criteria: 

Updated 06/01/2014
**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**ORAL TESTOSTERONES**

**ANDROXY**

All FDA-approved indications not otherwise excluded from Part D.

Male patients who have carcinoma of the breast or known or suspected prostate cancer.

A. For female patients being treated for inoperable metastatic breast cancer who are 1 to 5 years postmenopausal (naturally or surgically) and who have had an incomplete response to other therapy for metastatic breast cancer. B. For male patients being treated for hypogonadism (primary: e.g. testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchidectomy OR hypogonadotropic: e.g. idiopathic gonadotropin or LHRH deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation), 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. C. For male patients being treated for delayed puberty, bone development will be checked at least every 6 months.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Plan Year**

**Other Criteria**

Patients have tried and failed or unable to tolerate non-oral forms of testosterone supplementation.

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**ORAL-INTRANASAL FENTANYL**

**ABSTRAL, ACTIQ, FENTANYL CITRATE ORAL TRA, FENTORA, LAZANDA, SUBSYS**

All FDA-approved indications not otherwise excluded from Part D.

A. The oral/intranasal fentanyl product will be used to manage breakthrough pain due to a current cancer condition or cancer related complication AND B. A long-acting opioid is being prescribed for around-the-clock treatment of the cancer pain AND C. The patient can be safely started on the requested dose based on current narcotic use history.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

6 months

**Other Criteria**
### Prior Authorization Group
ORENCEIA

### Drug Names
ORENCEIA

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

### Exclusion Criteria
Active infection (including active TB). Combination therapy with another biologic agent.

### Required Medical Information
Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Orencia (or other biologic). For positive latent TB, patient must have completed or be receiving treatment for latent TB infection prior to initiating Orencia (or other biologic). For those at risk for hepatitis B virus (HBV) infection, HBV infection has been ruled out or treatment has been initiated. For rheumatoid arthritis, patient must meet one of the following: a) inadequate response to MTX OR b) inadequate response to another nonbiologic DMARD such as leflunomide, hydroxychloroquine, sulfasalazine if patient has intolerance or contraindication to MTX OR c) intolerance or contraindication to at least 2 nonbiologic DMARDs OR d) patient has had an inadequate response or intolerance to a prior biologic DMARD. For juvenile idiopathic arthritis (active polyarticular disease and systemic arthritis with active arthritis): a) inadequate response to TNF inhibitor OR b) intolerance or contraindication to TNF inhibitor.

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
Plan Year

### Other Criteria

### Prior Authorization Group
ORFADIN

### Drug Names
ORFADIN

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

### Exclusion Criteria
Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) and appropriate clinical picture of the patient, or 2) DNA testing (mutation analysis). Orfadin is used in conjunction with dietary restriction of tyrosine and phenylalanine.

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
Plan Year

### Other Criteria
Prior Authorization Group: PEGASYS (Criteria Under Review)
Drug Names: PEGASYS, PEGASYS PROCLICK

Covered Uses
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria
Prior Authorization Group
PEGINTRON
Drug Names
PEG-INTRON, PEG-INTRON REDIPEN
Covered Uses
All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia.
Exclusion Criteria
Decompensated liver disease (e.g., Child-Pugh score greater than 6 [class B and C]). Autoimmune hepatitis. Uncontrolled major depression or severe mental illness.
Required Medical Information
For Chronic Hepatitis C: 1) HCV genotype (G) and detectable HCV-RNA prior to starting treatment(Tx) for all patients, 2) for G 2 and 3: allow up to a total of 24 weeks (wks), 3) for monoTx (all genotypes): a) patient must have a contraindication or intolerance to ribavirin Tx, b) allow up to 24-wk assessment if detectable HCV-RNA at wk 12, c) allow up to a total of 48 wks if undetectable HCV-RNA at wk 12 or 24, 4) for dual Tx with ribavirin (for G 1 and 4): allow up to 24-wk assessment if detectable HCV-RNA at wk 12 and allow up to a total of 48 wks if undetectable HCV-RNA at wk 12 or 24, 5) for Tx-naive and retreatment (re-Tx) with Peglntron, ribavirin and Victrelis (G 1 only): a) must receive 4 wks of Peglntron and ribavirin prior to starting Victrelis, b) HCV-RNA levels assessed at wks 4, 8, 12, and 24, c) HCV-RNA less than 100 IU/mL at wk 12, d) undetectable HCV-RNA at wk 24, e) allow up to a total of 28 wks for Tx-naive patients with undetectable HCV-RNA at wk 8, f) allow up to a total of 36 wks for re-Tx patients with undetectable HCV-RNA at wk 8, and g) allow up to a total of 48 wks for patients with cirrhosis, poorly IFN-responsive patients (less than 1.0-log10 drop in HCV-RNA at wk 4 of Tx), null responders with prior Tx (less than 2-log10 drop in HCV-RNA at wk 12 of prior Tx), and patients with detectable HCV-RNA at wk 8, 6) for Tx-naive and re-Tx with Peglntron, ribavirin and Incivek (G 1 only): a) HCV-RNA levels assessed at wks 4, 12, and 24 of Tx, b) HCV-RNA less than or equal to 1,000 IU/mL at wks 4 and 12 of Tx, c) undetectable HCV-RNA at wk 24 of Tx, d) allow up to a total of 24 wks for Tx-naive or relapers with undetectable HCV-RNA at wks 4 and 12, and e) allow up to a total of 48 wks for patients with cirrhosis (Tx-naive or relapers), patients with detectable HCV-RNA at wks 4 and/or 12 of Tx (Tx-naive or relapers), and prior nonresponders (including partial and null response).
Age Restrictions
Prescriber Restrictions
Coverage Duration
HCV: 12 to 48 weeks for dual and monoTx, 6 to 48 wks for triple Tx. CML: 48 weeks.
Other Criteria
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>POMALYST</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>POMALYST</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>For multiple myeloma: 1) Patient received prior therapy with Velcade (bortezomib) AND Revlimid (lenalidomide), 2) disease has progressed during or within 60 days of completion of last therapy.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For CLL: serum IgG less than 500 mg/dL or a history of recurrent bacterial infections. For Kawasaki syndrome: IGIV is used in conjunction with high-dose aspirin. PRCA is secondary to parvovirus B19 infection. For all indications, patients with any of the following risk factors for acute renal failure must receive the minimum concentration available of IGIV and the minimum infusion rate practicable: pre-existing renal insufficiency, diabetes mellitus, age over 65 years, volume depletion, sepsis, paraproteinemia, or receiving concomitant nephrotoxic drugs.</td>
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<tr>
<td>Age Restrictions</td>
<td>Plan Year</td>
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<td>Prescriber Restrictions</td>
<td>Plan Year</td>
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<tr>
<td>Coverage Duration</td>
<td>Plan Year</td>
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<tr>
<td>Other Criteria</td>
<td>Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.</td>
</tr>
<tr>
<td>Prior Authorization Group</td>
<td>PROCYSBI</td>
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<tr>
<td>Drug Names</td>
<td>PROCYSBI</td>
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<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Documented history of hypersensitivity to penicillamine</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing. Patient has tried and experienced intolerance to prior Cystagon therapy.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>6 years of age or older</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Plan Year</td>
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<td>Coverage Duration</td>
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<thead>
<tr>
<th>Prior Authorization Group</th>
<th>PROMACTA</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>PROMACTA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>1) Pt has chronic or persistent ITP and meets the following criteria: For new starts: a) Pt has been evaluated for other causes of thrombocytopenia, b) Pt has had an insufficient response or intolerance to corticosteroids, immunoglobulins, or splenectomy, c) Plt count at time of diagnosis is: less than 30,000/mcL OR less than or equal to 50,000/mcL with significant mucous membrane bleeding or risk factors for bleeding. For continuation of therapy: a) Plt count response to Promacta: plt count increased to at least 50,000/mcL OR plt count increased to a level sufficient to avoid clinically important bleeding after at least 4 weeks of Promacta at a maximal dose, b) If plt counts rise above 200,000/mcL with Promacta, therapy will be adjusted to maintain the minimal plt count needed to reduce the patient's risk for bleeding. 2) Pt has thrombocytopenia associated with chronic hep C and meets the following criteria: a) Promacta is used for initiation and maintenance of interferon-based therapy, b) Plt count at time of diagnosis is less than 75,000/mcL.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
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<tr>
<td>Prescriber Restrictions</td>
<td>ITP: 6 mos ini, renewal: plan yr if adq plt response, 3 mos w/o plt response. Hep C: 6 mos.</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td></td>
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<tr>
<td>Other Criteria</td>
<td>Alanine aminotransferase levels must not be greater than or equal to 3 times the upper limit of normal or greater than or equal to 3 times baseline in a patient with pre-treatment elevations in transaminases with any of the following characteristics: progressive, persistent, accompanied by increased bilirubin or symptoms of liver injury or evidence of hepatic decompensation. Liver function must be assessed pretreatment and regularly throughout therapy.</td>
</tr>
</tbody>
</table>
**Prior Authorization Group**
- PROVIGIL

**Drug Names**
- MODAFINIL, PROVIGIL

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

**Exclusion Criteria**

**Required Medical Information**
- A. Diagnosis is narcolepsy confirmed by sleep lab evaluation. OR B. Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography. OR C. Diagnosis is shift work disorder (SWD).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Plan Year

**Other Criteria**

---

**Prior Authorization Group**
- RANEXA

**Drug Names**
- RANEXA

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

**Exclusion Criteria**

**Required Medical Information**
- The patient has tried, failed and/or been intolerant (continues to have angina) to a trial of therapy with a nitrate plus a beta-blocker or calcium channel blocker.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Plan Year

**Other Criteria**

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**Prior Authorization Group**
- REBIF

**Drug Names**
- REBIF, REBIF TITRATION PACK

**Covered Uses**
- All FDA-approved indications not otherwise excluded from Part D, clinically isolated syndrome (first clinical episode of MS).

**Exclusion Criteria**

**Required Medical Information**
- Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Plan Year

**Other Criteria**
Prior Authorization Group: REGRANEX

Drug Names: REGRANEX

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

Exclusion Criteria: Neoplasm(s) at site(s) of application

Required Medical Information:
- A. Treatment of lower-extremity diabetic ulcers that extend into the subcutaneous tissue or beyond AND
- B. The ulcer has adequate blood supply AND
- C. Good ulcer care practices including ALL of the following: a. initial sharp debridement b. pressure relief c. infection control will be performed concurrently with Regranex gel.

Age Restrictions
Prescriber Restrictions
Coverage Duration: 20 weeks
Other Criteria

Prior Authorization Group: RELISTOR

Drug Names: RELISTOR

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

Exclusion Criteria: Known or suspected mechanical gastrointestinal obstruction.

Required Medical Information: requested for the treatment of opioid-induced constipation in a patient with advanced illness who is receiving palliative care.

Age Restrictions
Prescriber Restrictions
Coverage Duration: 4 months
Other Criteria:
- A. patient demonstrated an inadequate treatment response or intolerance to a drug regimen of polyethylene glycol 3350 (PEG 3350) OR
- B. patient has a documented contraindication to polyethylene glycol 3350 (PEG 3350).
Prior Authorization Group

REMICADE

Drug Names

REMICADE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Active infection (including active TB), unstable moderate to severe heart failure, combination therapy with another biologic agent.

Required Medical Information

Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Remicade or other biologic. For positive latent TB, patient completed or is receiving treatment for latent TB. For those at risk for hepatitis B virus (HBV) infection, HBV infection has been ruled out or treatment for HBV has been initiated prior to starting Remicade or other biologic. For moderately to severely active rheumatoid arthritis (new starts only): a) Remicade will be used in combination with MTX or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND b) patient had an inadequate response to a self-injectable TNF inhibitor (e.g., Cimzia, Enbrel, Humira or Simponi) OR patient has intolerance/contraindication to a self-injectable TNF inhibitor. For moderately to severely active Crohn's disease (new starts only): patient has fistulizing disease OR inadequate response to a self-injectable TNF inhibitor (e.g., Cimzia or Humira) OR intolerance/contraindication to a self-injectable TNF inhibitor. For moderately to severely active ulcerative colitis (new starts only): inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine) OR intolerance/contraindication to conventional therapy. For active ankylosing spondylitis (new starts only): inadequate response, intolerance, or contraindication to a self-injectable TNF inhibitor (e.g., Enbrel, Humira or Simponi). For chronic moderate to severe plaque psoriasis (new starts only): a) at least 5% BSA is affected or crucial body areas (e.g., feet, hands, face, neck and/or groin) are affected AND b) inadequate response, intolerance or contraindication to a self-injectable TNF inhibitor (e.g., Enbrel or Humira).

Age Restrictions

Prescriber Restrictions

Coverage Duration

Plan Year

Other Criteria
<table>
<thead>
<tr>
<th><strong>Prior Authorization Group</strong></th>
<th>REVATIO</th>
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</thead>
<tbody>
<tr>
<td><strong>Drug Names</strong></td>
<td>REVATIO, SILDENAFIL CITRATE</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Patient requires nitrate therapy on a regular or intermittent basis.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
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<td><strong>Coverage Duration</strong></td>
<td>Plan Year</td>
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<tr>
<td><strong>Other Criteria</strong></td>
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</tbody>
</table>
**Prior Authorization Group**

**Drug Names**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, chronic lymphocytic leukemia (CLL), myelodysplastic syndromes (MDS) without the deletion 5q, progressive solitary plasmacytoma (PSP), systemic light chain amyloidosis, and the following other subtypes of non-Hodgkin's lymphomas (NHL): AIDS-related diffuse large B-cell lymphoma (DLBCL), AIDS-related lymphoma associated with Castleman's disease, AIDS-related primary effusion lymphoma, DLBCL, follicular lymphoma (FL), gastric mucosa associated lymphoid tissue (MALT) lymphoma, mantle cell lymphoma (MCL), nodal marginal zone lymphoma, nongastric MALT lymphoma, primary cutaneous B-cell lymphoma (PCBCL), and splenic marginal zone lymphoma.

**Exclusion Criteria**

**Required Medical Information**

1) For Myeloma or PSP: a) Revlimid is used as primary therapy in combination with dexamethasone OR melphalan and prednisone, b) Revlimid is used as maintenance monotherapy, c) Revlimid is used as salvage therapy. 2) For low or intermediate-1 risk MDS with a 5q deletion: pt has a transfusion-dependent anemia (i.e., greater than or equal to 2 units of red blood cells in the previous 8 weeks) OR symptomatic anemia. 3) For low or intermediate-1 risk MDS without a 5q deletion: a) pt has symptomatic anemia AND b) pretreatment serum erythropoietin level greater than 500 mU/mL OR pretreatment serum erythropoietin level less than or equal to 500 mU/mL AND a failed a trial of epoetin or darbepoetin. 4) For CLL: Revlimid is used in relapsed or refractory disease. 5) For NHL subtypes (AIDS-related DLBCL, AIDS-related lymphoma associated with Castleman's disease, AIDS-related primary effusion lymphoma, DLBCL, FL, gastric MALT lymphoma, MCL, nodal marginal zone lymphoma, nongastric MALT lymphoma, PCBCL, splenic marginal zone lymphoma: a) disease is recurrent, relapsed or progressive AND, b) Revlimid is used as monotherapy OR in combination with rituximab. 6) For systemic light chain amyloidosis: Revlimid is used in combination with dexamethasone.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**
### Prior Authorization Group
- **RIBAVIRIN (Criteria Under Review)**

### Drug Names
- COPEGUS, MODERIBA, REBETOL, RIBAPAK, RIBASPHERE, RIBAVIRIN

### Covered Uses

### Exclusion Criteria

### Required Medical Information

#### Age Restrictions

#### Prescriber Restrictions

#### Coverage Duration

#### Other Criteria

### Prior Authorization Group
- **RISPERDAL CONSTA**

### Drug Names
- RISPERDAL CONSTA

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

### Exclusion Criteria
- Dementia-related psychosis.

### Required Medical Information
- A. The patient has a history of non-compliance and/or refuses to utilize oral medications.
- B. The patient must have a history of 3 test doses of oral Risperdal (risperidone).
- C. If the patient is increasing the dose of Risperdal Consta they must have a history of two prior injections of Risperdal Consta.

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
- Plan Year

### Other Criteria
Prior Authorization Group  
**RITUXAN**

Drug Names  
**RITUXAN**

Covered Uses  

Exclusion Criteria  
Severe, active infection. Concomitant use of another biologic agent. History of severe skin or infusion reactions with prior Rituxan use that cannot be appropriately managed.

Required Medical Information  
Prior to initiating therapy, patient has been screened for hepatitis B virus (HBV) infection. For moderately to severely active rheumatoid arthritis (new starts only): Rituxan will be used in combination with methotrexate AND patient had an inadequate response to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., Cimzia, Enbrel, Humira, or Simponi) OR intolerance or contraindication to a self-injectable TNF inhibitor. For Wegener’s granulomatosis and microscopic polyangiitis, Rituxan is used in combination with glucocorticoids. Hematologic malignancies must be CD20-positive. For diffuse large B cell lymphoma (DLBCL), patient meets one of the following: a) previously untreated DLBCL in combination with chemotherapy OR b) previously treated DLBCL in combination with chemotherapy for a patient who is a candidate for autologous stem cell transplant OR c) previously treated DLBCL in a patient who is not a candidate for autologous stem cell transplant.

Age Restrictions  

Prescriber Restrictions  

Coverage Duration  
Plan Year

Other Criteria  
Patient monitored for pulmonary toxicity. For continuation of therapy for RA: improvement in clinical symptoms is required from the last treatment course, which was at least 16 weeks earlier.
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>SABRIL</th>
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</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>SABRIL</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>For infantile spasms: Sabril is used as monotherapy. For complex partial seizures (CPS): patient had an inadequate response to 2 alternative therapies (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine) for CPS and Sabril is used as adjunctive therapy.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Initial treatment infantile spasms, 1 month to 2 years. CPS, 16 years of age or older</td>
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<td>Age Restrictions</td>
<td>Plan Year</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
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<tbody>
<tr>
<td>Drug Names</td>
<td>SAMSCA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Patient is unable to sense and appropriately respond to thirst. Patient is anuric. Concomitant treatment with a strong CYP 3A inhibitor (e.g., clarithromycin, itraconazole, ketoconazole, ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, telithromycin). Underlying liver disease.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Samsca therapy was initiated (or re-initiated) in the hospital. The dose of Samsca will be limited so that the maximum rate of hyponatremia correction is less than or equal to 12 mEq/L per 24 hours.</td>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td>30 days</td>
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<tr>
<td>Other Criteria</td>
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</tbody>
</table>
Prior Authorization Group: SANDOSTATIN LAR

Drug Names: SANDOSTATIN LAR DEPOT

Covered Uses: All FDA-approved indications not otherwise excluded from Part D, neuroendocrine tumors (NET), thymic carcinoma.

Exclusion Criteria

Required Medical Information

For patients who are prescribed Sandostatin LAR Depot, patient must have received at least 2 weeks of initial treatment with Sandostatin Injection (not the Depot formulation), and treatment with Sandostatin Injection was effective and tolerable. For acromegaly, the patient meets all of the following: 1) clinical evidence of acromegaly AND 2) high pre-treatment IGF-1 level for age/gender AND 3) inadequate or partial response to surgery and/or radiotherapy unless there is a clinical reason for why the patient has not had surgery or radiotherapy. For thymic carcinoma: 1) patient has locally advanced, unresectable disease AND 2) octreotide is used following radiation treatment. For NET: 1) patient has poorly differentiated NET/small cell tumors and octreotide will be used in combination with chemotherapy, OR 2) patient has any one of the following pancreatic endocrine tumors (Islet cell tumors): VIPoma, gastrinoma, or glucagonoma, OR 3) patient has carcinoid tumors and one of the following: a) metastatic, unresectable disease, b) carcinoid syndrome, c) clinically significant tumor burden, d) clinically significant progressive disease, or e) patient has atypical lung carcinoids and will be used in combination with chemotherapy, OR 4) patient has MEN type 1 tumors and insulinoma or pituitary adenoma.

Age Restrictions

Prescriber Restrictions

Coverage Duration: Plan Year

Other Criteria

For acromegaly continuation of therapy: the IGF-1 level decreased or normalized.
### Prior Authorization Group
- **SEROSTIM**

### Drug Names
- SEROSTIM

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

### Exclusion Criteria
- Acute critical illness OR active malignancy OR diabetic retinopathy.

### Required Medical Information
- Patient has a diagnosis of cachexia or wasting syndrome associated with HIV infection. Serostim is used in combination with antiretroviral therapy. BMI is less than 27 kg/m2. Alternative causes of wasting (e.g., testosterone deficiency, peripheral growth hormone resistance, diarrhea, inadequate caloric intake, malignancies or opportunistic infections) have been ruled out or treated appropriately. Prior to somatropin, (1) patient had a suboptimal response to at least 1 other therapy for wasting or cachexia (e.g., megestrol, dronabinol, cyproheptadine, or testosterone therapy if hypogonadal) or (2) patient has contraindication or intolerance to alternative therapies. For initial approval, patient must have experienced (1) diarrhea, fever, or weakness lasting 30 days or longer and (2) unintentional weight loss greater than 10% of body weight over 12 months. For continuation of therapy, patients must have demonstrated a response to therapy with Serostim (i.e., body mass index has improved or stabilized).

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
- 12 weeks

### Other Criteria

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### Prior Authorization Group
- SIGNIFOR

### Drug Names
- SIGNIFOR

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

### Exclusion Criteria
- Patient had pituitary surgery that was not curative unless surgery is not an option. Patient must have controlled blood glucose levels or receiving optimized antidiabetic therapy.

### Required Medical Information
- Fasting plasma glucose and/or hemoglobin A1c levels must be obtained at baseline. For continuation of therapy, patient must show a clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease.

### Age Restrictions

### Prescriber Restrictions
- Endocrinologist

### Coverage Duration
- Plan Year

### Other Criteria
**Prior Authorization Group**

**Drug Names**  
SIMPONI, SIMPONI ARIA

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

**Exclusion Criteria**  
Active infection (including active TB). Combination therapy with another biologic agent.

**Required Medical Information**  
Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Simponi (or other biologic). For positive latent TB, patient must have completed or be receiving treatment for latent TB infection prior to initiating Simponi (or other biologic). For those at risk for Hepatitis B (HBV) infection, HBV has been ruled out or treatment has been initiated. For rheumatoid arthritis (RA), patient must meet one of the following: a) inadequate response to MTX OR b) inadequate response to another nonbiologic DMARD such as leflunomide, hydroxychloroquine, sulfasalazine if contraindicated or intolerant to MTX OR c) intolerance or contraindication to at least 2 nonbiologic DMARDs OR d) patient has had an inadequate response or intolerance to a prior biologic DMARD OR e) Simponi will be used as first-line therapy for severely active RA. For ankylosing spondylitis, patient had an inadequate response or intolerance/contraindication to at least 2 non-steroidal ant-inflammatory drugs. For moderately to severely active ulcerative colitis (new starts only): patient has corticosteroid dependence OR had an inadequate response to conventional therapy (e.g., oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine) OR has intolerance or a contraindication to conventional therapy.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**  
Plan Year

**Other Criteria**  
For rheumatoid arthritis, Simponi is used in combination with MTX unless MTX is contraindicated or was not tolerated.

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**Prior Authorization Group**

**Drug Names**  
SIRTURO

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

**Exclusion Criteria**  
Sirturo being requested for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis (e.g., central nervous system), or infection caused by the non-tuberculous mycobacteria (NTM).

**Required Medical Information**  
A. Sirturo is being requested as part of combination therapy in a patient with pulmonary multi-drug resistant tuberculosis (MDR-TB) B. Another effective treatment regimen cannot be used instead of Sirturo.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**  
6 Months

**Other Criteria**
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<tr>
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<th>SOLARAZE</th>
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<tbody>
<tr>
<td><strong>Drug Names</strong></td>
<td>DICLOFENAC SODIUM, SOLARAZE</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
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<tr>
<td><strong>Exclusion Criteria</strong></td>
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<tr>
<td><strong>Required Medical Information</strong></td>
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<tr>
<th>Prior Authorization Group</th>
<th>SOMATULINE DEPOT</th>
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<tbody>
<tr>
<td><strong>Drug Names</strong></td>
<td>SOMATULINE DEPOT</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
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<td><strong>Exclusion Criteria</strong></td>
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<td><strong>Required Medical Information</strong></td>
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<td><strong>Prescriber Restrictions</strong></td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>Plan Year</td>
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<tr>
<td><strong>Other Criteria</strong></td>
<td>For continuation of therapy, the IGF-1 level decreased or normalized.</td>
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<thead>
<tr>
<th>Prior Authorization Group</th>
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<td><strong>Drug Names</strong></td>
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<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
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<tr>
<td><strong>Exclusion Criteria</strong></td>
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<td><strong>Required Medical Information</strong></td>
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<td>For continuation of therapy, the IGF-1 level decreased or normalized.</td>
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</tbody>
</table>
**Prior Authorization Group**  
SORIATANE

**Drug Names**  
ACITRETIN, SORIATANE

**Covered Uses**  
All FDA-approved indications not otherwise excluded from Part D, prevention of non-melanoma skin cancers in high risk individuals.

**Exclusion Criteria**  
A. Severely impaired liver function. B. Severely impaired kidney function. C. Chronically abnormally elevated blood lipid values. D. Patient currently taking methotrexate or tetracycline.

**Required Medical Information**  
A. If the patient is female and able to bear children (e.g., no hysterectomy, not reached menopause, has achieved menses). AND B. The patient is unresponsive to other therapies for the covered diagnoses OR the other therapies for the treatment of the covered diagnoses are contraindicated due to the clinical condition of the patient. AND C. Pregnancy has been excluded as confirmed by 2 negative urine or serum pregnancy tests with a sensitivity of at least 25 mIU/mL. AND D. the patient has chosen to use any of the following methods of contraception: one primary form (e.g., tubal ligation, partner's vasectomy, intrauterine devices, birth control pills, injectable/implantable/insertable/topical hormonal birth control products) plus one secondary form (e.g., diaphragms, latex condoms, cervical caps) used in combination with a spermicide OR absolute abstinence. AND E. The patient has agreed to use her chosen form of contraception for at least 1 month before initiation of Soriatane therapy, during Soriatane therapy, and for at least 3 years after discontinuation of therapy. AND F. The patient has been advised that ethanol must not be ingested by female patients during Soriatane treatment and for 2 months following therapy. AND G. The patient will have a negative pregnancy test on a monthly basis.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

Female patient or guardian signed a Patient Agreement/Informed Consent.

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**Prior Authorization Group**  
SOVALDI (Criteria Under Review)

**Drug Names**  
SOVALDI

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**
<table>
<thead>
<tr>
<th><strong>Prior Authorization Group</strong></th>
<th>SPRYCEL</th>
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<tbody>
<tr>
<td><strong>Drug Names</strong></td>
<td>SPRYCEL</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D, gastrointestinal stromal tumor (GIST).</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>For ALL and newly diagnosed CML, patient must be positive for the Ph chromosome or BCR-ABL gene. For ALL, patient meets one of the following: 1) ALL is newly diagnosed and Sprycel is used in combination with chemotherapy, OR 2) resistance or intolerance to prior therapy. For CML, patient meets one of the following: 1) newly diagnosed in chronic phase, 2) resistance or intolerance/toxicity to imatinib or nilotinib, 3) after hematopoietic stem cell transplant or 4) advanced phase (accelerated or blast phase). GIST in patients with disease progression on imatinib or sunitinib.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>For ALL, patient meets one of the following: 1) ALL is newly diagnosed and Sprycel is used in combination with chemotherapy, OR 2) resistance or intolerance to prior therapy. For CML, patient meets one of the following: 1) newly diagnosed in chronic phase, 2) resistance or intolerance/toxicity to imatinib or nilotinib, 3) after hematopoietic stem cell transplant or 4) advanced phase (accelerated or blast phase). GIST in patients with disease progression on imatinib or sunitinib.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years of age or older</td>
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<td><strong>Prescriber Restrictions</strong></td>
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<td><strong>Coverage Duration</strong></td>
<td>Plan Year</td>
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<tr>
<th><strong>Prior Authorization Group</strong></th>
<th>STELARA</th>
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<td><strong>Drug Names</strong></td>
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<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Active infection (including active TB). Combination therapy with another biologic agent.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Stelara (or other biologic). For positive latent TB, patient must have completed or is receiving treatment for latent TB infection. For moderate to severe plaque psoriasis (new starts only): a) at least 5% of BSA is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected AND b) inadequate response to either phototherapy (eg, UVB, PUVA) OR a traditional systemic agent (eg, methotrexate, cyclosporine, acitretin), unless patient has contraindication or intolerance to such therapies.</td>
</tr>
<tr>
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<td><strong>Prior Authorization Group</strong></td>
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<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Patient with mCRC must have been previously treated with the following: fluoropyrimidine-, oxaliplatin- and irinotecan-based regimen, an anti-VEGF agent, and an anti-EGFR agent if KRAS wild type. Patient with GIST must have been previously treated with imatinib or sunitinib.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>Clinical manifestations of congestive heart failure (CHF).</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Plan Year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Liver function test monitoring at initiation of therapy and throughout treatment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Prior Authorization Group</strong></th>
<th>SUTENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug Names</strong></td>
<td>SUTENT</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), lung neuroendocrine tumors (LNETs), angiosarcoma, solitary fibrous tumor or hemangiopericytoma.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>For renal cell carcinoma: patient has advanced disease. For gastrointestinal stromal tumor: patient had disease progression on imatinib or was intolerant to imatinib. For pancreatic neuroendocrine tumors: patient has well differentiated tumors and progressive unresectable locally advanced or metastatic disease. For LNETs: tumors are low or intermediate grade (typical or atypical carcinoid) and patient has unresectable or advanced disease (stage IIIb-IV). For follicular, papillary, or Hurthle cell thyroid carcinoma: patient has metastatic disease with nonradioiodine-responsive tumors at sites other than central nervous system. For medullary thyroid carcinoma: patient has metastatic and disseminated symptomatic disease with progression on vandetanib or vandetanib is not appropriate. Patient has solitary fibrous tumor, hemangiopericytoma, OR angiosarcoma.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Plan Year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Prior Authorization Group** | SYLATRON
---|---
**Drug Names** | SYLATRON
**Covered Uses** | All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia (CML), giant cell tumor of the bone.

**Exclusion Criteria** | Autoimmune hepatitis. Decompensated hepatic disease. Uncontrolled major depression or severe mental illness.

**Required Medical Information** | For melanoma: must have microscopic or gross nodal involvement AND had a surgical resection of the tumor including complete lymphadenectomy. For CML: patient is unable to tolerate a tyrosine kinase inhibitor (e.g., imatinib, dasatinib, nilotinib, bosutinib) OR post-transplant patient without remission or with relapse.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** | Plan Year

**Other Criteria** | For melanoma, Sylatron must be requested within 84 days (12 weeks) of the surgical resection.

---

**Prior Authorization Group** | SYMLIN
---|---
**Drug Names** | SYMLINPEN 120, SYMLINPEN 60
**Covered Uses** | All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria** | A. Recurrent severe hypoglycemia that required assistance during the past 6 months. B. Gastroparesis. C. Patient requires drug therapy to stimulate gastrointestinal motility. D. Hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia). E. HbA1c level greater than 9 percent.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** | Plan Year

**Other Criteria** | A. If patient received Symlin in previous 3 months, patient demonstrated an expected reduction in HbA1c since starting Symlin therapy. OR B. The patient has inadequate glycemic control (HbA1c greater than 7 percent). AND C. Patient is currently receiving optimal mealtime insulin therapy.
**Prior Authorization Group**
TAFINLAR

**Drug Names**
TAFINLAR

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

**Exclusion Criteria**
For monotherapy, patient must have a diagnosis of unresectable or metastatic melanoma AND the tumor must be positive for BRAF V600E mutation. For combination with Mekinist, patient must have a diagnosis of unresectable or metastatic melanoma AND the tumor must be positive for either BRAF V600E or V600K mutation.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
Plan Year

**Other Criteria**

---

**Prior Authorization Group**
TARCEVA

**Drug Names**
TARCEVA

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D, NSCLC with known active EGFR mutation or gene amplification.

**Exclusion Criteria**
For non-small cell lung cancer (NSCLC), Tarceva is used as monotherapy AND is used for locally advanced or metastatic disease. For NSCLC, Tarceva can be used for: 1) first line treatment of NSCLC when patient has a known active epidermal growth factor receptor (EGFR) mutation or amplification of the EGFR gene, AND 2) second or third line treatment of NSCLC, AND 3) maintenance treatment of NSCLC when the patient responded to or remains stable after four cycles of platinum-based chemotherapy. For pancreatic cancer, the following criteria are met: 1) pancreatic cancer is locally advanced, unresectable or metastatic, AND 2) Tarceva is used as first line treatment, AND 3) Tarceva is used in combination with gemcitabine.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
Plan Year

**Other Criteria**
<table>
<thead>
<tr>
<th><strong>Prior Authorization Group</strong></th>
<th>TARGRETIN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drug Names</strong></td>
<td>TARGRETIN</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome (Capsules only), adult T-cell leukemia/lymphoma (Gel only), primary cutaneous B-cell lymphoma (Gel only).</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Pregnancy</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>ECG monitored at baseline, 7 days after initiation, and periodically during treatment. For ALL and newly diagnosed CML, patient must be positive for the Ph chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) newly diagnosed CML and Tasigna is used for first line treatment, OR 2) resistance to imatinib or dasatinib, OR 3) intolerance to imatinib or dasatinib, OR 4) after hematopoietic stem cell transplant. For ALL, patient has relapsed or refractory ALL. For GIST, disease has progressed on imatinib or sunitinib.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years of age or older</td>
</tr>
<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Plan Year</td>
</tr>
<tr>
<td><strong>Coverage Duration</strong></td>
<td>Plan Year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Patient has been instructed to take Tasigna 1 hour before or 2 hours after a meal. Drugs known to prolong the QT interval or any strong CYP 3A4 inhibitors should be avoided. If patient has hepatic impairment, a lower starting dose will be considered.</td>
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<thead>
<tr>
<th><strong>Prior Authorization Group</strong></th>
<th>TASIGNA</th>
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<tbody>
<tr>
<td><strong>Drug Names</strong></td>
<td>TASIGNA</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D, acute lymphoblastic leukemia (ALL), gastrointestinal stromal tumor (GIST).</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>Uncorrected hypokalemia or hypomagnesemia, long QT syndrome.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>ECG monitored at baseline, 7 days after initiation, and periodically during treatment. For ALL and newly diagnosed CML, patient must be positive for the Ph chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) newly diagnosed CML and Tasigna is used for first line treatment, OR 2) resistance to imatinib or dasatinib, OR 3) intolerance to imatinib or dasatinib, OR 4) after hematopoietic stem cell transplant. For ALL, patient has relapsed or refractory ALL. For GIST, disease has progressed on imatinib or sunitinib.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
<td>18 years of age or older</td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Plan Year</td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>Plan Year</td>
</tr>
<tr>
<td><strong>Other Criteria</strong></td>
<td>Patient has been instructed to take Tasigna 1 hour before or 2 hours after a meal. Drugs known to prolong the QT interval or any strong CYP 3A4 inhibitors should be avoided. If patient has hepatic impairment, a lower starting dose will be considered.</td>
</tr>
</tbody>
</table>
### Prior Authorization Group
- **TAZORAC**

### Drug Names
- **TAZORAC**

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

### Exclusion Criteria

#### Required Medical Information
- A. For patients being treated for plaque psoriasis Tazorac will be applied to less than 20 percent of the body surface area. B. For female patients who are able to bear children (no hysterectomy, not reached menopause, has achieved menses), a negative pregnancy test (sensitivity down to at least 50 mIU/mL for hCG) has been obtained within 2 weeks prior to Tazorac therapy, beginning during a normal menstrual period. C. Physician has discussed with the patient the potential risks of fetal harm and importance of birth control while using Tazorac.

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
- Plan Year

### Other Criteria
- A. For patients being treated for plaque psoriasis a trial of at least two topical corticosteroids (patient may still be using a corticosteroid product in addition to Tazorac) OR B. patient has a contraindication to topical corticosteroids.

---

### Prior Authorization Group
- **TECFIDERA**

### Drug Names
- **TECFIDERA**
  - **TECFIDERA STARTER PACK**

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

### Exclusion Criteria

#### Required Medical Information
- Have a relapsing form of MS (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses).

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
- Plan Year

### Other Criteria
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>THALOMID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>THALOMID</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D, myelofibrosis with myeloid metaplasia, progressive solitary plasmacytoma, systemic light chain amyloidosis, and Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>1) For myeloma or progressive solitary plasmacytoma: a) Thalomid is used as primary therapy in combination with dexamethasone OR melphalan and prednisone, b) Thalomid is used as maintenance monotherapy, c) Thalomid is used for salvage therapy. 2) For systemic light chain amyloidosis: Thalomid is used in combination with dexamethasone. 3) For Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma: Thalomid is used a monotherapy or in combination with rituximab.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For CrCl between 20 to 60 mL/min: Tikosyn is administered at a reduced dose (less than 500mcg twice daily).</td>
</tr>
<tr>
<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
<td>Plan Year</td>
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<tr>
<td>Other Criteria</td>
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<tr>
<td>Prior Authorization Group</td>
<td>TIKOSYN</td>
</tr>
<tr>
<td>Drug Names</td>
<td>TIKOSYN</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D, ventricular tachyarrhythmia, paroxysmal supraventricular tachycardia.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Calculated creatinine clearance (CrCl) less than 20mL/min. Concomitant therapy with any of the following drugs: cimetidine, hydrochlorothiazide, ketoconazole, megestrol, prochlorperazine, trimethoprim, verapamil.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For CrCl between 20 to 60 mL/min: Tikosyn is administered at a reduced dose (less than 500mcg twice daily).</td>
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<tr>
<td>Age Restrictions</td>
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<td>Coverage Duration</td>
<td>Plan Year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
</tbody>
</table>
**Prior Authorization Group**

TOBI

**Drug Names**

TOBI PODHALER

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

1) Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
2) Pseudomonas aeruginosa is present in the cultures of the airways OR patient has a history of infection or colonization of Pseudomonas aeruginosa in the airways.

**Required Medical Information**

1) Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.  
2) Pseudomonas aeruginosa is present in the cultures of the airways OR patient has a history of infection or colonization of Pseudomonas aeruginosa in the airways.

**Age Restrictions**

Prescriber Restrictions

Coverage Duration

Plan Year

**Other Criteria**

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**Prior Authorization Group**

TOPICAL IMMUNOSUPPRESSANT

**Drug Names**

ELIDEL, PROTOPIC

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

A. For Elidel, the diagnosis of mild to moderate atopic dermatitis (eczema). For Protopic, the diagnosis of moderate to severe atopic dermatitis (eczema). B. Patient completed a documented trial and failure of at least one medium or higher potency topical steroid or has a documented intolerance or unresponsiveness to medium or higher potency topical steroids. C. Patients have been advised that Elidel and Protopic should only be used to treat the immediate problem and then should be stopped when the condition improves.

**Required Medical Information**

A. For Elidel, the diagnosis of mild to moderate atopic dermatitis (eczema). For Protopic, the diagnosis of moderate to severe atopic dermatitis (eczema). B. Patient completed a documented trial and failure of at least one medium or higher potency topical steroid or has a documented intolerance or unresponsiveness to medium or higher potency topical steroids. C. Patients have been advised that Elidel and Protopic should only be used to treat the immediate problem and then should be stopped when the condition improves.

**Age Restrictions**

2 years of age or older, unless Protopic 0.1% 16 years of age or older

Prescriber Restrictions

Coverage Duration

Plan Year

**Other Criteria**

---

**Prior Authorization Group**

TOPICAL TESTOSTERONES

**Drug Names**

ANDRODERM, ANDROGEL, ANDROGEL PUMP, AXIRON, FORTESTA, STRIANT, TESTIM

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

Female.

**Required Medical Information**

The patient had or currently has a confirmed low testosterone level (according to standard lab reference values).

**Age Restrictions**

Prescriber Restrictions

Coverage Duration

Plan Year

**Other Criteria**

---
Prior Authorization Group  TRACLEER
Drug Names  TRACLEER
Covered Uses  All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria  Pregnancy. Concomitant use with cyclosporine or glyburide. For initial therapy: alanine
aminotransferase (ALT)/aspartate aminotransferase (AST) level greater than 3 times the upper limit of normal (ULN).
Required Medical Information  NYHA Functional Class II to IV symptoms. PAH (WHO Group 1) was confirmed by right
heart catheterization. For female patients of childbearing potential: 1) Pregnancy was
excluded prior to initiation of therapy and will be excluded monthly during therapy, and 2) Patient will use reliable contraception during treatment and for one month after stopping treatment.
Age Restrictions
Prescriber Restrictions
Coverage Duration  Plan Year
Other Criteria

Prior Authorization Group  TRELSTAR
Drug Names  TRELSTAR DEPOT MIXJECT, TRELSTAR LA MIXJECT, TRELSTAR MIXJECT
Covered Uses  All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria  Use as neoadjuvant androgen deprivation therapy (ADT) for radical prostatectomy for clinically localized disease.
Required Medical Information  For prostate cancer, patient must meet one of the following: 1) Locally advanced,
recurrent or metastatic disease OR 2) Use as neoadjuvant/concurrent/adjuvant ADT in combination with radiation therapy for clinically localized disease with intermediate or high risk of recurrence.
Age Restrictions
Prescriber Restrictions
Coverage Duration  Plan Year
Other Criteria
## Prior Authorization Group
**TYKERB**

## Drug Names
**TYKERB**

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

## Exclusion Criteria
Patient has recurrent or metastatic, HER2 positive breast cancer. Tykerb must be used in combination with 1) capecitabine or trastuzumab (without cytotoxic therapy) for patients who have received prior trastuzumab-containing regimen, OR 2) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) for postmenopausal women with hormone receptor positive disease. Liver function tests must be monitored at baseline and every four to six weeks during therapy and as clinically indicated. In patients with severe hepatic impairment, Tykerb is used at a reduced dose.

## Required Medical Information
Prescriber Restrictions

**Plan Year**

## Coverage Duration
Plan Year

## Other Criteria

## Prior Authorization Group
**TYSABRI**

## Drug Names
**TYSABRI**

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

## Exclusion Criteria
Use as monotherapy. For CD, patient must have an inadequate response or intolerance to conventional therapy and a TNF inhibitor for CD (e.g., oral steroids, 5-ASA compounds, immunosuppressant drugs, TNF-inhibitors such as Remicade, Humira, or Cimzia).

## Required Medical Information

## Age Restrictions

## Prescriber Restrictions

## Coverage Duration
MS = Plan Year. CD = 3 months for initial and Plan Year for renewal

## Other Criteria
Patients must be monitored for any new sign or symptom that may be suggestive of PML. Tysabri dose will be withheld at the first sign or symptom suggestive of PML. Upon renewal for CD, patient's condition must have improved or stabilized with Tysabri treatment.
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>VALCHLOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>VALCHLOR</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Failed previous therapy with a treatment regimen that includes a protease inhibitor (e.g., Incivek, Victrelis). Concomitant administration with a drug that is highly dependent on CYP3A4/5 for clearance or is a potent CYP3A4/5 inducer (i.e., alfuzosin, carbamazepine, drosipirenone, dihydroergotamine, ergonovine, ergotamine, methylergonovine, lovastatin, lomitapide, oral midazolam, phenobarbital, phenytoin, pimozide, rifampin, simvastatin, St. John’s wort, triazolam, Adcirca or Revatio when used for PAH). Concomitant use of any of the following ritonavir-boosted HIV protease inhibitors: atazanavir, lopinavir, or darunavir for new starts only.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Detectable HCV-RNA prior to starting therapy for all patients. HCV Genotype 1. Must be given in combination with pegylated interferon (i.e., Pegasys or PegIntron) and ribavirin. Patient will receive 4 weeks of PEG-IFN and ribavirin prior to starting Victrelis. Assess HCV RNA level at weeks 4, 8, 12, and 24 of Victrelis triple therapy. HCV-RNA less than 100 IU/mL at week 12. Undetectable HCV-RNA at week 24. Allow up to a total of 24 weeks for treatment naive patients with undetectable HCV-RNA at week 8. Allow up to a total of 32 weeks for treatment naive patients with detectable HCV-RNA at week 8. Allow up to a total of 32 weeks for retreatment patients with detectable or undetectable HCV-RNA at week 8. Allow up to a total of 44 weeks for patients with cirrhosis, poorly IFN-responsive patients (less than 1.0-log10 drop in HCV-RNA at week 4 of treatment), and null responders with prior therapy (less than 2-log10 drop in HCV-RNA at week 12 of prior treatment).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>Plan Year</td>
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<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Initial: 10 weeks of Victrelis. Continuation: 20 wks to 44 wks of Victrelis therapy.</td>
</tr>
</tbody>
</table>
**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

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**VOTRIENT**

All FDA-approved indications not otherwise excluded from Part D.

Alanine transaminase (ALT) greater than 3 times the upper limit of normal (ULN) and bilirubin greater than 2 times the ULN OR total bilirubin greater than 3 times the ULN.

For advanced soft tissue sarcoma (STS), patient does not have gastrointestinal stromal tumor or adipocytic STS AND patient has received a prior chemotherapy (e.g., doxorubicin, ifosfamide, epirubicin or dacarbazine). For renal cell carcinoma, patient has advanced disease.

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**VPRIV**

All FDA-approved indications not otherwise excluded from Part D.

Concomitant therapy with miglustat (Zavesca).

diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity. Has Type 1 Gaucher disease. Therapy is initiated for a patient with at least one of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.

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**XALKORI**

All FDA-approved indications not otherwise excluded from Part D, inflammatory myofibroblastic tumor (IMT).

**Exclusion Criteria**

**Required Medical Information**

For NSCLC and IMT: the tumor is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test.

NSCLC is locally advanced or metastatic.

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Updated 06/01/2014
**Prior Authorization Group**
XELJANZ

**Drug Names**
XELJANZ

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

**Exclusion Criteria**
Active infection (including active TB). Combination therapy with a biologic DMARD or a potent immunosuppressant such as azathioprine or cyclosporine.

**Required Medical Information**
Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Xeljanz or previous biologic DMARD. For positive latent TB, patient must have completed or is receiving treatment for latent TB. For those at risk for hepatitis B virus (HBV) infection, HBV infection has been ruled out or treatment for HBV has been initiated prior to starting Xeljanz or previous biologic DMARD. Patient has a diagnosis of moderately to severely active rheumatoid arthritis AND a) inadequate response to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., Cimzia, Enbrel, Humira or Simponi) OR b) intolerance or contraindication to a self-injectable TNF inhibitor (step applies to new starts only).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
Plan Year

**Other Criteria**

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**Prior Authorization Group**
XENAZINE

**Drug Names**
XENAZINE

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

**Exclusion Criteria**
Patients who are actively suicidal or have untreated or inadequately treated depression. Impaired hepatic function. Use of Xenazine in combination with a monoamine oxidase inhibitor (MAOI) or it has been less than 14 days since the MAOI was discontinued. Use of Xenazine in combination with reserpine or it has been less than 20 days since reserpine was discontinued.

**Required Medical Information**
Patient has chorea associated with Huntington's disease.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
Plan Year

**Other Criteria**

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Updated 06/01/2014
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>XEOMIN</th>
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</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>XEOMIN</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Cosmetic use.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
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<tr>
<td>Age Restrictions</td>
<td></td>
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<tr>
<td>Prescriber Restrictions</td>
<td></td>
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<tr>
<td>Coverage Duration</td>
<td></td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Prior Authorization Group</th>
<th>XGEVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>XGEVA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Patient has bone metastases from a solid tumor OR giant cell tumor of the bone. For giant cell tumor of the bone, patient has unresectable disease or surgical resection is likely to result in severe morbidity.</td>
</tr>
<tr>
<td>Required Medical Information</td>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
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<tr>
<td>Coverage Duration</td>
<td></td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Patient will receive calcium and vitamin D supplementation as needed to treat or prevent hypocalcemia. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Prior Authorization Group</th>
<th>XIFAXAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>XIFAXAN</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>18 years of age or older</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>18 years of age or older</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Hepatic encephalopathy - 6 months</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>The recommended dose of two 550 mg tablets daily will not be exceeded.</td>
</tr>
</tbody>
</table>
**Prior Authorization Group**  
XOLAIR

**Drug Names**  
XOLAIR

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

**Exclusion Criteria**

**Required Medical Information**

For allergic asthma: Xolair will be used in combination with other medications for long-term control of asthma, and patient will have a rapid-acting beta2-agonist available for rescue therapy. For initial therapy for allergic asthma: 1) Patient has a diagnosis of moderate to severe persistent asthma, 2) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 3) Patient has baseline IgE level at or above 30 IU/mL, 4) Asthma is inadequately controlled despite use of inhaled corticosteroid at the optimal dose, and 5) Patient is using a long-acting inhaled beta2-agonist, leukotriene modifier, or theophylline at the optimal dose. For continuation of therapy for allergic asthma: patient must have improved asthma control while on Xolair. For chronic idiopathic urticaria initial therapy: 1) Patient has been evaluated for other causes of urticaria, 2) Patient has had itchy hives for at least 6 weeks, 3) Patient has remained symptomatic despite H1-antihistamine treatment, and 4) The dose of antihistamine has been optimized. For continuation of therapy for chronic idiopathic urticaria: patient's symptom has been improved with Xolair treatment.

**Age Restrictions**

12 years of age or older

**Prescriber Restrictions**

Plan Year

**Coverage Duration**

Plan Year

**Other Criteria**

Xolair will be administered in a controlled healthcare setting with access to emergency medications (e.g., anaphylaxis kit) and appropriate observation following administration. Patient will be provided with a prescription for an epinephrine self-injection pen for use in the event of a delayed allergic/anaphylactic reaction outside of a controlled healthcare setting.

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**Prior Authorization Group**  
XTANDI

**Drug Names**  
XTANDI

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

**Exclusion Criteria**

**Required Medical Information**

Patient must have metastatic, castration-resistant prostate cancer. Patient must have previously received docetaxel.

**Age Restrictions**

12 years of age or older

**Prescriber Restrictions**

Plan Year

**Coverage Duration**

Plan Year

**Other Criteria**

Patient must have metastatic, castration-resistant prostate cancer. Patient must have previously received docetaxel.
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>ZAVESCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>ZAVESCA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Pregnancy (currently pregnant or planning a pregnancy).</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Patient has mild to moderate type 1 Gaucher disease. Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity. Enzyme replacement therapy is not a therapeutic option (e.g., due to constraints such as allergy, hypersensitivity, or poor venous access).</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>18 years of age or older</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Plan Year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Patient will use adequate contraception throughout therapy and for 3 months thereafter.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>ZELBORAF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>ZELBORAF</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D, melanoma with BRAF V600K mutation.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Patient has a diagnosis of unresectable, recurrent, or metastatic melanoma AND the tumor is positive for either BRAF V600E or V600K mutation as detected by an FDA-approved test.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Plan Year</td>
</tr>
<tr>
<td>Other Criteria</td>
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<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>ZOLINZA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>ZOLINZA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, multiple myeloma.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td></td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>For multiple myeloma: Zolinza will be used as salvage therapy in combination with bortezomib.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
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<tr>
<td>Coverage Duration</td>
<td>Plan Year</td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
<tr>
<td>Prior Authorization Group</td>
<td>ZORBTIVE</td>
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<tr>
<td>--------------------------</td>
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</tr>
<tr>
<td>Drug Names</td>
<td>ZORBTIVE</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Active malignancy (either newly diagnosed or recurrent). Acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma, or acute respiratory failure. Patient has received more than 8 weeks of Zorbtive therapy.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>Gastroenterologist or nutritional support specialist</td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>Maximum 8 weeks total.</td>
</tr>
<tr>
<td>Other Criteria</td>
<td>Zorbtive will be used in conjunction with optimal management of short bowel syndrome. Patient must be receiving specialized nutritional support.</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Prior Authorization Group</th>
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<tr>
<td>Drug Names</td>
<td>ZYTIGA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Patient must have metastatic, castration-resistant prostate cancer. Zytiga will be used in combination with prednisone.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
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<tr>
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