**PA Criteria**

**Prior Authorization Group**
ACTEMRA

**Drug Names**
ACTEMRA

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

**Exclusion Criteria**
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 Actemra (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., Cimzia, Enbrel, Humira or Simponi) OR 2) Intolerance or contraindication to a self-injectable TNF inhibitor OR 3) History of demyelinating disorder, heart failure, hepatitis B, or autoantibody formation/lupus like syndrome. For active systemic juvenile idiopathic arthritis (new starts only): 1) Inadequate response to corticosteroids OR 2) Intolerance or contraindication to corticosteroids. For active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response to TNF inhibitor OR 2) Intolerance or contraindication to TNF inhibitor.

**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.

Updated 01/01/2015
<table>
<thead>
<tr>
<th><strong>Other Criteria</strong></th>
<th>For infantile spasms: for continuation of therapy, patient must show substantial clinical benefit from therapy.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior Authorization Group</strong></td>
<td>ACTIMMUNE</td>
</tr>
<tr>
<td><strong>Drug Names</strong></td>
<td>ACTIMMUNE</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, atopic dermatitis.</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>For atopic dermatitis, the condition is resistant to conservative treatments (eg, topical medications, phototherapy).</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td></td>
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<tr>
<td><strong>Age Restrictions</strong></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>
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<tr>
<td><strong>Other Criteria</strong></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><strong>Prior Authorization Group</strong></td>
<td>ADAGEN</td>
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<tr>
<td><strong>Drug Names</strong></td>
<td>ADAGEN</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>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.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
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<tr>
<td><strong>Age Restrictions</strong></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>
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<tr>
<td><strong>Other Criteria</strong></td>
<td></td>
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<tr>
<td><strong>Prior Authorization Group</strong></td>
<td>ADCIRCA</td>
</tr>
<tr>
<td><strong>Drug Names</strong></td>
<td>ADCIRCA</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>
<td></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
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<td><strong>Coverage Duration</strong></td>
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<tr>
<td><strong>Other Criteria</strong></td>
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<tr>
<td><strong>Prior Authorization Group</strong></td>
<td>ADEMPAS</td>
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<tr>
<td><strong>Drug Names</strong></td>
<td>ADEMPAS</td>
</tr>
<tr>
<td><strong>Covered Uses</strong></td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
</tbody>
</table>
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 b. Inoperable CTEPH, AND c. 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

Prior Authorization Group

AFINITOR

Drug Names

AFINITOR, AFINITOR DISPERZ

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, lung neuroendocrine tumors, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma with following histologic subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangioleiomyomatosis.

Exclusion Criteria

Required Medical Information

For advanced RCC, patient failed previous treatment with Sutent (sunitinib), Nexavar (sorafenib), or Votrient (pazopanib). For PNETs, patient has unresectable, locally advanced or metastatic disease. For breast cancer, all of the following criteria are met: 1) patient has advanced hormone receptor positive, HER2-negative disease, 2) patient was previously treated with letrozole or anastrozole and 3) Afinitor will be used in combination with exemestane. For SEGA with TSC, patient is not a candidate for curative surgical resection. For renal angiomyolipoma with TSC, patient does not require immediate surgery. For soft tissue sarcoma, patient has one of the following histologic subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, or lymphangioleiomyomatosis. OR patient has a diagnosis of either Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma or lung neuroendocrine tumors.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Plan Year

Other Criteria

Prior Authorization Group

ALDURAZYME

Drug Names

ALDURAZYME

Covered Uses

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

### Prior Authorization Group
ALPHA1-PROTEINASE INHIBITOR

### Drug Names
ARALAST NP, GLASSIA, PROLASTIN-C, ZEMAIRA

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

### Exclusion Criteria
Patient has selective IgA deficiency with known antibodies against IgA.

### Required Medical Information
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 have pretreatment serum alpha1-proteinase inhibitor concentration less than 11 micromoles/L (80 mg/dL) AND post-bronchodilation FEV1 between 25 percent and 80 percent predicted. 18 years of age or older.

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
Plan Year

### Other Criteria

### Prior Authorization Group
AMPYRA

### Drug Names
AMPYRA

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

### Exclusion Criteria
History of seizures. Creatinine clearance 50 mL/min or less.

### Required Medical Information

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
Initial: 1 month. Renewal: Plan Year

### Other Criteria
Prior to initiating therapy, patient must demonstrate sustained walking impairment and 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.

### Prior Authorization Group
ANABOLIC STEROIDS

### Drug Names
OXANDROLONE

### Covered Uses
All FDA-approved indications not otherwise excluded from Part D, HIV-wasting syndrome or cachexia due to chronic disease, Turner's syndrome.
Exclusion Criteria

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

Required Medical Information

Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes.

Age Restrictions

Prescriber Restrictions

Coverage Duration

6 months

Other Criteria

Prior Authorization Group

APOKYN

Drug Names

APOKYN

Covered Uses

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

Exclusion Criteria

Concomitant treatment with a serotonin 5HT3 antagonist (eg, ondansetron).

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Plan Year

Other Criteria

Prior Authorization Group

ARANESP

Drug Names

ARANESP ALBUMIN FREE

Covered Uses

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

Exclusion Criteria

Patients receiving chemotherapy with curative intent. Patients with myeloid cancer. For all uses: 1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 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 anemia due to myelosuppressive cancer chemotherapy: 1) For initial therapy, at least 2 more months of chemotherapy is expected, AND 2) For reauthorizations, current Hgb is less than 11 g/dL. Additional requirements 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. Additional requirements for MDS: 1) Patient has symptomatic anemia, AND 2) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, AND 3) 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.

Age Restrictions

Prescriber Restrictions

Coverage Duration

12 weeks
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 (eg, 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).

Prior Authorization Group
ARCALYST

Drug Names
ARCALYST

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

Exclusion Criteria
Patient has a diagnosis of cryopyrin-associated periodic syndromes (CAPS), including familial cold auto-inflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS) 12 years of age or older.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration
Plan Year

Other Criteria

Prior Authorization Group
AUBAGIO

Drug Names
AUBAGIO

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
For female patients of childbearing potential: must use reliable contraception.

Prior Authorization Group
B VS. D
Drug Names

ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ADRUCIL, ALBUTEROL SULFATE, ALIMTA, 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, AMPHOTEC, AMPHOTERICIN B, ARRANON, ARZERRA, ASTAGRAF XL, ATGAM, AVASTIN, AZACITIDINE, AZASAN, AZATHIOPRINE, BETHKIS, BICNU, BLEOMYCIN SULFATE, BROVANA, BUDESONIDE, BUSULFEX, CALCITRIOL, CAMPTOSAR, CARBOPLATIN, CELLCEPT, CELLCEPT INTRAVENOUS, CESAMET, CISPLATIN, CLADRIBINE, CLINIMIX 2.75%/DEXTROSE 5, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 2, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 5%/DEXTROSE 25%, CLINIMIX E 2.75%/DEXTROSE, CLINIMIX E 4.25%/DEXTROSE, CLINIMIX E 5%/DEXTROSE 15, CLINIMIX E 5%/DEXTROSE 20, CLINIMIX E 5%/DEXTROSE 25, CLINISOL SF 15%, CLOLAR, CROMOLYN SODIUM, CUBICIN, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE, CYTARABINE AQUEOUS, DACARBAZINE, DAUNORUBICIN HCL, DECITABINE, DEPO-MEDROL, DEPO-PROVERA, DEXRAZOXANE, DILAUDID-HP, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXERCALCIFEROL, DOXORUBICIN HCL, DOXORUBICIN HCL LIPOSOME, DRONABINOL, DURAMORPH, ELIGARD, ELITEK, ELOXATIN, EMEND, ENGERIX-B, EPIRUBICIN HCL, ERBITUX, ETOPOPHOS, ETOPOSIDE, FASLODEX, FIRMAGON, FLO-PRED, FLUDARABINE PHOSPHATE, FLUOROURACIL, FREAMINE HBC 6.9%, FREAMINE III, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, GRANISOL, HALAVEN, HEPARIN SODIUM, HEPATAMINE, HEPATASOL, HERCEPTIN, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, IBANDRONATE SODIUM, IDARUBICIN HCL, IFEX, IFOSFAMIDE, INFUMORPH 200, INFUMORPH 500, INTRALIPID, INTRON-A, INTRON-A W/DILUENT, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTODAX, IXEMPRA KIT, KADCYLA, KEPIVANCE, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVOCARNITINE, LIDOCAINE HCL, LIDOCAINE/PRilocaine, LIPOSYN III, MEDROL, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE SODIUM, METHYPREDNISOLONE, METHYLDPREDNISOLONE ACETAT, METHYLDPREDNISOLONE DOSE P, METHYLDPREDNISOLONE SODIUM, MIACALCIN, MILLIPRED, MITOMYCIN, MITOXANTRONE HCL, MORPHINE SULFATE, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEBUPENT, NEORAL, NEPHRAMINE, NULOJIX, ONDANSETRON HCL, ONDANSETRON ODT, ORAPRED ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL,
Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Prior Authorization Group
BANZEL

Drug Names
BANZEL

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

Exclusion Criteria
The patient is diagnosed with familial short QT Syndrome.

Required Medical Information
The patient is diagnosed with Lennox-Gastaut Syndrome.

Age Restrictions

Prescriber Restrictions

Coverage Duration
Plan Year

Other Criteria

Prior Authorization Group
BETASERON

Drug Names
BETASERON

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

Exclusion Criteria
Have a relapsing form of MS (eg, 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 (ie, multifocal white matter disease).

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration
Plan Year

Other Criteria

Updated 01/01/2015
**Prior Authorization Group**

**Drug Names**

**Covered Uses**

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

**Exclusion Criteria**

Patient must be positive for the Philadelphia chromosome or BCR-ABL gene AND patient meets one of the following: 1) experienced resistance or intolerance/toxicity to alternative tyrosine kinase inhibitor (imatinib, dasatinib, nilotinib, ponatinib), or 2) post hematopoietic stem cell transplant.

**Age Restrictions**

18 years of age or older.

**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, excessive salivation secondary to advanced Parkinson's disease, hemifacial spasm.

**Exclusion Criteria**

Cosmetic use.

**Required Medical Information**

For chronic migraine prophylaxis, 1) 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, 2) continuation of treatment (after 1 injection cycle): 50% reduction in monthly headache frequency since starting therapy. For urinary incontinence in a patient with a neurologic condition (eg, 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.

**Other Criteria**

---

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

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

**Exclusion Criteria**

1) For induction therapy for transition from 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 being prescribed buprenorphine for induction and subsequent maintenance therapy for transition from opioid use to opioid dependence treatment AND 2) The prescriber agrees not to prescribe other opioids while the patient is taking buprenorphine.

**Age Restrictions**

Updated 01/01/2015
<table>
<thead>
<tr>
<th>Prescriber Restrictions</th>
<th>Induction 3 months, Maintenance Plan Year, Pregnancy 10 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Duration</td>
<td></td>
</tr>
<tr>
<td>Other Criteria</td>
<td></td>
</tr>
<tr>
<td><strong>Prior Authorization Group</strong></td>
<td>BUPRENORPHINE-NALOXONE</td>
</tr>
<tr>
<td><strong>Drug Names</strong></td>
<td>BUPRENORPHINE HCL/NALOXON, SUBOXONE, ZUBSOLV</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></td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>The prescriber agrees not to prescribe other opioids while the patient is taking the requested drug for opioid dependence treatment.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Plan Year</td>
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<tr>
<td><strong>Prior Authorization Group</strong></td>
<td>BYDUREON</td>
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<tr>
<td><strong>Drug Names</strong></td>
<td>BYDUREON</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>Personal or family history of medullary thyroid carcinoma (MTC). Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). History of pancreatitis. Severe renal impairment (creatinine clearance less than 30mL per minute). End stage renal disease.</td>
</tr>
<tr>
<td><strong>Required Medical Information</strong></td>
<td>1) Diagnosis of type 2 diabetes mellitus AND 2) The patient has an HbA1c level above 7 percent and has demonstrated an inadequate treatment response, contraindication or intolerance to metformin OR a sulfonylurea OR a thiazolidinedione.</td>
</tr>
<tr>
<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
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<tr>
<td><strong>Coverage Duration</strong></td>
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<tr>
<td><strong>Other Criteria</strong></td>
<td>If the patient has been receiving GLP-1 Agonist therapy for at least 3 months, the patient demonstrated an expected reduction in HbA1c since starting GLP-1 Agonist therapy (examples of GLP-1 Agonists are Bydureon, Byetta, Victoza).</td>
</tr>
<tr>
<td><strong>Prior Authorization Group</strong></td>
<td>CAPRELSA</td>
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<tr>
<td><strong>Drug Names</strong></td>
<td>CAPRELSA</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></td>
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<tr>
<td><strong>Required Medical Information</strong></td>
<td>Medullary thyroid cancer is symptomatic or progressive AND patient has unresectable locally advanced or metastatic disease.</td>
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<tr>
<td><strong>Age Restrictions</strong></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
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<tr>
<td><strong>Other Criteria</strong></td>
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</tbody>
</table>
**Drug Names** | CARBAGLU
---|---
**Covered Uses** | All FDA-approved indications not otherwise excluded from Part D, methylmalonic acidemia, propionic acidemia.

**Exclusion Criteria**

**Required Medical Information** | Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
---|---
**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** | Plan Year
---|---

**Other Criteria**

**Prior Authorization Group** | CAYSTON

**Drug Names** | CAYSTON
---|---
**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 airway.
---|---
**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** | Plan Year
---|---

**Other Criteria**

**Prior Authorization Group** | CEREZYME

**Drug Names** | CEREZYME
---|---
**Covered Uses** | All FDA-approved indications not otherwise excluded from Part D, Type 3 Gaucher disease.

**Exclusion Criteria**

**Required Medical Information** | Concomitant therapy with miglustat (Zavesca). Diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity. Patient has Type 1 or Type 3 Gaucher disease. Patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.
---|---
**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration** | Plan Year
---|---

**Other Criteria**

**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**

Updated 01/01/2015
### 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. Axial spondyloarthritis.

### Exclusion Criteria
- 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 moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance, or contraindication to MTX, OR 2) Inadequate response or intolerance to a prior biologic DMARD, OR 3) Cimzia will be used as first-line therapy for severely active RA. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For active ankylosing spondylitis and axial spondyloarthritis (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
- CINRYZE

### Drug Names
- CINRYZE

### Covered Uses
All FDA-approved indications not otherwise excluded from Part D, treatment of hereditary angioedema attacks.

### Exclusion Criteria
- Diagnosis of HAE confirmed by laboratory tests (e.g., C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels)

### Age Restrictions

#### Prescriber Restrictions

#### Coverage Duration
Plan Year

#### Other Criteria

### Prior Authorization Group
- CLORAZEPATE

### Drug Names
- CLORAZEPATE DIPOTASSIUM

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

1) 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 OR for adjunctive therapy in the management of partial seizures OR symptomatic relief in acute alcohol withdrawal AND 2) If the patient is 65 years of age or older, the benefit of therapy with the prescribed medication outweighs the potential risk. (The prescribed medication is considered a "high risk medication" that is considered either ineffective in most patients 65 years of age or older or that poses an unnecessarily high risk when safer alternative therapy may be available.)

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Anxiety-6 mo, Other diagnoses-Plan Year

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria

CLOZAPINE ODT
CLOZAPINE ODT, FAZACLO
All FDA-approved indications not otherwise excluded from Part D.
History of clozapine-induced agranulocytosis or severe granulocytopenia. Dementia-related psychosis.

Required Medical Information

The patient is unwilling or unable to take tablets or capsules orally or is at high risk for non-compliance.

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Plan Year

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria

COMETRIQ
COMETRIQ
All FDA-approved indications not otherwise excluded from Part D.
Severe hemorrhage.
Medullary thyroid cancer is symptomatic, progressive, or metastatic.

Required Medical Information

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Plan Year
Therapy will be discontinued if gastrointestinal perforation or fistula formation occurs.

Prior Authorization Group
Drug Names
Covered Uses

COPAXONE
COPAXONE
All FDA-approved indications not otherwise excluded from Part D, first clinical episode of MS.
### CYSTAGON

**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**
- Plan Year

**Prescriber Restrictions**

**Coverage Duration**
- Plan Year

**Other Criteria**

**Prior Authorization Group**
- CYSTAGON

**Drug Names**
- CYSTAGON

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

**Exclusion Criteria**
- Documented history of hypersensitivity to penicillamine.

**Required Medical Information**
Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing.

### DIAZEPAM

**Required Medical Information**
1) 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 OR for symptomatic relief in acute alcohol withdrawal OR for use as an adjunct for the relief of skeletal muscle spasms OR for adjunctive therapy in the treatment of convulsive disorders AND 2) If the patient is 65 years of age or older, the benefit of therapy with the prescribed medication outweighs the potential risk. (The prescribed medication is considered a "high risk medication" that is considered either ineffective in most patients 65 years of age or older or that poses an unnecessarily high risk when safer alternative therapy may be available.)

**Age Restrictions**
- Anxiety-6 mo, Other diagnoses-Plan Year

**Prescriber Restrictions**

**Coverage Duration**
- Anxiety-6 mo, Other diagnoses-Plan Year

**Other Criteria**

**Prior Authorization Group**
- DIAZEPAM

**Drug Names**
- DIAZEPAM, DIAZEPAM INTENSOL

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

**Exclusion Criteria**

**Required Medical Information**

**EGRIFTA**

**Required Medical Information**
Use for weight loss.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Anxiety-6 mo, Other diagnoses-Plan Year

**Other Criteria**

**Prior Authorization Group**
- EGRIFTA

**Drug Names**
- EGRIFTA

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

**Exclusion Criteria**

**Updated 01/01/2015**
**Required Medical Information**

Egrifta is requested to reduce excess abdominal fat in an HIV-infected patient with lipodystrophy. Patient has a diagnosis of HIV infection and is receiving anti-retroviral therapy (ART). For patients who have received at least 6 months of Egrifta therapy: patient has demonstrated clear clinical improvement from baseline that is supported by a waist circumference or CT scan.

**Age Restrictions**

### Prescriber Restrictions

**Coverage Duration**

6 months

**Other Criteria**

### Prior Authorization Group

**Drug Names**

ELAPRASE

**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**

Plan Year

**Other Criteria**

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

### Prior Authorization Group

**Drug Names**

ELELYSO

**Covered Uses**

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

**Exclusion Criteria**

Diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity. Patient has Type 1 Gaucher disease. Patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. 18 years of age or older.

**Age Restrictions**

### Prescriber Restrictions

**Coverage Duration**

Plan Year

**Other Criteria**

### Prior Authorization Group

**Drug Names**

ELIDEL

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, Psoriasis on the eyelid or genital areas.
### Required Medical Information
1) Diagnosis of mild to moderate atopic dermatitis (eczema) AND 2) Patient completed a documented trial and failure of at least one medium or higher potency topical steroid or has a documented intolerance or contraindication to medium or higher potency topical steroids OR 3) Diagnosis of psoriasis on the genital or eyelid areas.

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

### Prescriber Restrictions

### Coverage Duration
Plan Year

### Other Criteria

<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>EMSAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>EMSAM</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>Pheochromocytoma. Concurrent use with carbamazepine, oxcarbazepine, dextromethorphan, cyclobenzaprine, sympathomimetic agents such as amphetamines, meperidine, analgesic agents such as tramadol and methadone, St. John's Wort, other antidepressants.</td>
</tr>
</tbody>
</table>

### Required Medical Information
1) Patient experienced an inadequate treatment response to each of any two antidepressants: selective serotonin reuptake inhibitors (SSRIs) (e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline), serotonin/norepinephrine reuptake inhibitors (SNRIs) (e.g., venlafaxine), bupropion, mirtazapine, trazodone, tricyclic/tetracyclic antidepressants (e.g., amitriptyline, nortriptyline) OR 2) Patient is unable to swallow oral formulations.

### Age Restrictions

### Prescriber Restrictions

### Coverage Duration
Plan Year

### Other Criteria

<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>EPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>EPOGEN, PROCRIT</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D, anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa).</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Patients receiving chemotherapy with curative intent. Patients with myeloid cancer. Use to facilitate preoperative autologous blood donation.</td>
</tr>
</tbody>
</table>
**Required Medical Information**

For all uses except surgery: 1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 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 anemia due to myelosuppressive cancer chemotherapy: 1) For initial therapy, at least 2 more months of chemotherapy is expected, AND 2) For reauthorizations, current Hgb is less than 11 g/dL. Additional requirements 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. Additional requirements for MDS: 1) Patient has symptomatic anemia, AND 2) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, AND 3) 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, AND 2) For initial therapy, pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, AND 3) 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 anemia due to CHF, RA, hepatitis C treatment, or patients whose religious beliefs forbid blood transfusions: 1) 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 scheduled for elective, noncardiac, nonvascular surgery, AND 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

12 weeks

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). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions.

**Prior Authorization Group**

**Drug Names**

ERIVEDGE

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

Patient meets one of the following criteria: 1) patient has metastatic BCC, OR 2) patient has undergone surgery or radiation therapy for BCC and has residual or recurrent disease following surgery or radiation, OR 3) both surgery and radiation are contraindicated or not appropriate for the patient.
**Plan Year**

**Prior Authorization Group**

**EXJADE**

**Drug Names**

**EXJADE**

**Covered Uses**

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

**Exclusion Criteria**

For chronic iron overload due to blood transfusions: Diagnosis of chronic iron overload due to blood transfusions AND Pretreatment serum ferritin level greater than 1000 mcg/L. For iron overload in patients with NON-transfusion dependent thalassemia (NTDT): 1) Diagnosis of a NON-transfusion dependent thalassemia syndrome and chronic iron overload, 2) 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, 3) For initiation of Exjade: Pretreatment LIC of at least 5 mg per gram of dry weight AND Pretreatment serum ferritin levels greater than 300 mcg/L on 2 consecutive measurements 1 month apart, 4) 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.

**Required Medical Information**

- Two years of age or older.
Required Medical Information: Diagnosis of Fabry disease is confirmed by an enzyme assay showing deficiency of alpha-galactosidase enzyme activity or by DNA testing. Patient has clinical signs and symptoms of Fabry disease.

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Prior Authorization Group: FENTANYL PATCH
Drug Names: FENTANYL
Covered Uses: All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria: Significant respiratory depression. Known or suspected paralytic ileus.
Required Medical Information: 1) The prescriber has considered the risks of opioid/substance abuse/or addiction in this patient while receiving fentanyl patch AND 2) The patient can be safely started on the requested dose of fentanyl patch based on the patient's current narcotic use or expected tolerance.

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Prior Authorization Group: FERRIPROX
Drug Names: FERRIPROX
Covered Uses: All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria: Diagnosis of transfusional iron overload due to thalassemia syndromes.
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Prior Authorization Group: FIRAZYR
Drug Names: FIRAZYR
Covered Uses: All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria: Diagnosis of HAE confirmed by laboratory tests (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels)
Required Medical Information: 18 years of age or older
Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Prior Authorization Group: FORTEO
**Drug Names**

FORTEO

**Covered Uses**

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

**Exclusion Criteria**

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.

**Required Medical Information**

Patient meets one of the following criteria (new starts only): 1) Prior fragility fracture OR 2) Had at least a 1-year trial of an oral bisphosphonate unless contraindicated or intolerant to an oral bisphosphonate OR 3) Has more than one risk factors for fracture (eg, 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).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

24 months (lifetime)

**Other Criteria**

**Prior Authorization Group**

FYCOMPA

**Drug Names**

FYCOMPA

**Covered Uses**

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

**Required Medical Information**

The patient and caregivers will be advised to contact the healthcare provider immediately if any serious psychiatric or behavioral reactions are observed.

**Age Restrictions**

**Prescriber Restrictions**

12 years of age or older.

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group**

GATTEX

**Drug Names**

GATTEX

**Covered Uses**

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

**Required Medical Information**

Diagnosis of short bowel syndrome requiring parenteral support for at least 12 months.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**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. Treatment with Class Ia or Class III anti-arrhythmic drugs. |
| **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** | |

| **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** | GLEEVEC |
| **Drug Names** | GLEEVEC |
| **Covered Uses** | All FDA-approved indications not otherwise excluded from Part D, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, and melanoma. |

| **Exclusion Criteria** | For chronic myeloid leukemia (CML) and acute lymphoblastic leukemia, patient must be positive for the Ph chromosome or BCR-ABL gene. For CML, patient did not fail prior therapy with a tyrosine kinase inhibitor (dasatinib, nilotinib, bosutinib, ponatinib). For myelodysplastic/ myeloproliferative disease, disease is associated with PDGFR gene re-arrangements. For aggressive systemic mastocytosis, D816V c-Kit mutation is negative or unknown. For melanoma, c-Kit mutation is positive. Patient has one of the following diagnoses: gastrointestinal stromal tumor, hypereosinophilic syndrome, chronic eosinophilic leukemia, desmoid tumor, dermatofibrosarcoma protuberans, PVNS/TGCT, or chordoma. |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Plan Year |
| **Other Criteria** | |
**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

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**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

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**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

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**Prior Authorization Group**

**Drug Names**
**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 kidney disease (CKD), 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. Pediatric patients with closed epiphyses (except in patients with PWS).

**Required Medical Information**

Pediatric GHD, TS, CKD, SHOXD, NS: 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: Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment (tx) OR Pre-tx IGF-1/IGFBP3 more than 2 SD below mean. TS: Confirmed by karyotyping. CKD: Not post-kidney transplant. 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: Confirmed by one of the following: 1) deletion of the paternally inherited chromosomal 15q11.2-q13 region, 2) maternal uniparental disomy in chromosome 15, or 3) imprinting defects or translocations involving chromosome 15. SHOXD: Confirmed by molecular or genetic testing. ISS: Pediatric GHD ruled out 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: Patient meets ANY of the following: 1) Failed 2 stimulation tests (peak below 5 mcg/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 mcg/L) prior to starting tx.

**Age Restrictions**

TS and SGA: 2 years of age or older. NS and SHOXD: 3 years of age or older.

**Prescriber Restrictions**

Endocrinologist, Pediatric nephrologist

**Coverage Duration**

Plan year

Renewal for pediatric GHD, TS, NS, CKD, SGA, PWS patients with open epiphyses, ISS, or SHOXD: patient is growing more than 2 cm/year. For PWS only: 1) body composition and psychomotor function have improved. Renewal for PWS patients with closed epiphyses and adult GHD patients: Current IGF-1 level is normal for age and gender.

**Prior Authorization Group**

HIGH RISK MEDICATION

**Drug Names**

ALORA, COMBIPATCH, CYCLOBENZAPRINE HCL, DIGOXIN, DISOPYRAMIDE PHOSPHATE, ESTRADIOL, LANOXIN, MEGESTROL ACETATE, MENOSTAR, MINIVELLE, NORPACE CR, TRANSDERM-SCOP, VIVELLE-DOT
### 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
This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug. AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

### Prior Authorization Group
HRM-ANTICONVULSANTS

### Drug Names
PHENOBARBITAL, PHENOBARBITAL SODIUM

### 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
This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (carbamazepine, lamotrigine, topiramate) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (carbamazepine, lamotrigine, topiramate) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patients 65 years of age or older.

### Prior Authorization Group
HRM-ANTIDEPRESSANTS TCA

### Drug Names
AMITRIPTYLINE HCL, DOXEPIN HCL, IMIPRAMINE HCL, IMIPRAMINE PAMOATE, SURMONTIL

### 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

This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (citalopram, duloxetine, escitalopram, fluoxetine, sertraline, venlafaxine, venlafaxine ER) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (citalopram, duloxetine, escitalopram, fluoxetine, sertraline, venlafaxine, venlafaxine ER) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group
HRM-ANTIPARKINSON

Drug Names
BENZTROPINE MESYLATE

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

Prior Authorization Group
HRM-ANTIPSYCHOTICS

Drug Names
THIORIDAZINE HCL

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

This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (olanzapine, quetiapine, risperidone, ziprasidone) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (olanzapine, quetiapine, risperidone, ziprasidone) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group
HRM-CLOMIPRAMINE

Drug Names
CLOMIPRAMINE HCL

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

This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (fluoxetine, fluvoxamine) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (fluoxetine, fluvoxamine) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group
HRM-HYDROXYZINE HCL

Drug Names
HYDROXYZINE HCL

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
This Prior Authorization requirement only applies to patients 65 years of age or older. For pruritus 1) A non-HRM formulary drug (levocetirizine) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (levocetirizine) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. For anxiety 1) A non-HRM formulary drug (duloxetine, escitalopram, venlafaxine ER) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (duloxetine, escitalopram, venlafaxine ER) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group
HRM-HYPNOTICS

Drug Names
ZOLPIDEM TARTRATE

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

Required Medical Information
Plan Year
This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (temazepam 7.5mg, temazepam 15mg, Silenor 3mg, Silenor 6mg) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (temazepam 7.5mg, temazepam 15mg, Silenor 3mg, Silenor 6mg) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

Prior Authorization Group
HRM-NITROFURANTOIN

Drug Names
MACRODANTIN, NITROFURANTOIN, NITROFURANTOIN MACROCRYST, NITROFURANTOIN MONOHYDRAT

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

Plan Year

This Prior Authorization requirement only applies to patients 65 years of age or older. 1) A non-HRM formulary drug (ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, trimethoprim) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, trimethoprim) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

Prior Authorization Group

HRM-PROMETHAZINE

Drug Names

PROMETHAZINE HCL

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

This Prior Authorization requirement only applies to patients 65 years of age or older. For nausea/vomiting 1) A non-HRM formulary drug (ondansetron) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (ondansetron) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. For allergic rhinitis 1) A non-HRM formulary drug (levocetirizine, fluticasone nasal) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (levocetirizine, fluticasone nasal) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. For urticaria 1) A non-HRM formulary drug (levocetirizine) is not an acceptable alternative for the drug being prescribed. (In most patients 65 years of age or older, the prescribed medication is considered a "high risk medication" that poses an unnecessarily high risk when safer alternative therapy may be available.) AND 2) The patient experienced an inadequate treatment response, intolerance or contraindication to a non-HRM alternative formulary drug (levocetirizine) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group

HUMIRA

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, axial spondyloarthritis.

Exclusion Criteria
Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Humira (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance, or contraindication to MTX, OR 2) Inadequate response or intolerance to a prior biologic DMARD, OR 3) Humira will be used as first-line therapy for severely active RA. For moderately to severely active juvenile idiopathic arthritis (new starts only): 1) Inadequate response to MTX, OR 2) Intolerance or contraindication to MTX. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response, contraindication or intolerance to at least 2 NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected, AND 2) Inadequate response to either phototherapy (eg, UVB, PUVA) or a traditional systemic agent (eg, methotrexate, cyclosporine, acitretin), unless contraindicated or intolerant to such therapies. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (eg, corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to immunosuppressant therapy (eg, corticosteroids, azathioprine, mercaptopurine) OR intolerance/contraindication to immunosuppressant therapy, AND 2) Patient is naive to TNF inhibitor therapy OR patient lost response to previous TNF inhibitor therapy due to antibody formation.

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.

18 years of age or older.

Patient will be monitored for evidence of thromboembolism and vascular occlusion. Cardiac and hepatic function will be monitored.
<table>
<thead>
<tr>
<th>Drug Names</th>
<th>IMBRUVICA</th>
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<tbody>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>The patient has received at least one prior therapy.</td>
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<tr>
<td>Required Medical Information</td>
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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
<td>Plan Year</td>
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<td>Other Criteria</td>
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<tr>
<td>Prior Authorization Group</td>
<td>INCRELEX</td>
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<tr>
<td>Drug Names</td>
<td>INCRELEX</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>Closed epiphyses.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Must meet all of the following prior to beginning Increlex therapy (new starts only): 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. For renewal, patient is growing more than 2 cm/year AND the current IGF-1 level is normal for age and gender.</td>
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<td>Age Restrictions</td>
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<tr>
<td>Prescriber Restrictions</td>
<td>Endocrinologist</td>
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<td>Coverage Duration</td>
<td>Plan Year</td>
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<td>Other Criteria</td>
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<tr>
<td>Prior Authorization Group</td>
<td>INLYTA</td>
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<td>Drug Names</td>
<td>INLYTA</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>Patient has a diagnosis of advanced renal cell carcinoma (RCC) and the cancer has progressed after at least 1 prior systemic therapy for RCC. Examples of prior systemic therapies for RCC include bevacizumab, pazopanib, sorafenib, sunitinib, temsirolimus, and cytokines (interferon alpha or interleukin-2).</td>
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<td>Required Medical Information</td>
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<td>Age Restrictions</td>
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<tr>
<td>Prior Authorization Group</td>
<td>ITRACONAZOLE</td>
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<tr>
<td>Drug Names</td>
<td>ITRACONAZOLE</td>
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</tbody>
</table>
**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D, Coccidioidomycosis, Cryptococcosis, Sporotrichosis, Penicilliosis, Microsporidiosis, Onychomycosis-immunocompromised, Pityriasis versicolor/Tinea versicolor - extensive superficial infections or in immunocompromised patients, Tinea corporis/Tinea cruris, Tinea manuum/Tinea pedis.

**Exclusion Criteria**
Evidence of ventricular dysfunction, such as congestive heart failure (CHF). Current use of certain drugs metabolized by CYP3A4.

**Required Medical Information**
1) If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed with a fungal diagnostic test OR 2) Extensive superficial infection of Pityriasis versicolor or Tinea versicolor or the patient is immunocompromised OR 3) If for the treatment of tinea corporis, tinea cruris, tinea manuum, tinea pedis, the patient has experienced either an inadequate treatment response, adverse event, intolerance, or contraindication to griseofulvin OR 4) Diagnosis of blastomycosis, histoplasmosis, aspergillosis, coccidioidomycosis, cryptococcosis, sporotrichosis, penicilliosis, microsporidiosis.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
Onychomycosis, Versicolor, Tinea-3mo, Systemic infection-6mo

**Other Criteria**
Criteria apply to capsule dosage form only.

**Prior Authorization Group**
IVIG

**Drug Names**
BIVIGAM, CARIMUNE NANOFILTERED, FLEBOGAMMA, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D, B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT), chronic inflammatory demyelinating polyneuropathy, dermatomyositis, fetal/neonatal alloimmune thrombocytopenia, Guillain-Barré syndrome (GBS), idiopathic thrombocytopenic purpura, Kawasaki syndrome, Lambert-Eaton myasthenic syndrome, myasthenia gravis, multifocal motor neuropathy, pediatric HIV infection, polymyositis, pure red cell aplasia (PRCA), relapsing-remitting multiple sclerosis (RRMS).

**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 BMT/HSCT: serum IgG less than 400mg/dL. For dermatomyositis and polymyositis: standard 1st line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For RRMS: standard 1st line treatments (interferon or glatiramer) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For pediatric HIV infection: serum IgG less than 400 mg/dL OR a history of recurrent bacterial infections. 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 dose or concentration available of IVIG 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. For all indications: patients with any of the following risk factors for thrombosis must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: age 45 years or older, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling central vascular catheters, hyperviscosity, or cardiovascular risk factors.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

Patient has been diagnosed with primary myelofibrosis OR myelofibrosis due to polycythemia vera OR myelofibrosis due to essential thrombocythemia. Myelofibrosis is intermediate or high-risk.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

**Prior Authorization Group**

**Drug Names**

**Updated 01/01/2015**
Covered Uses
- All FDA-approved indications not otherwise excluded from Part D, Cushing's syndrome.

Exclusion Criteria
- Acute or chronic liver disease.
- Current use with dofetilide, quinidine, pimozide, cisapride, eplerenone, nisoldipine, alprazolam, oral midazolam, oral triazolam, ergot alkaloids, statins.

Required Medical Information
- Patient's liver status will be assessed prior to therapy and as needed during therapy.

Age Restrictions
- 6 months

Prescriber Restrictions
- 1) For blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, and paracoccidioidomycosis, other antifungal therapies are ineffective, unavailable, or not tolerated [Note: other antifungal therapy examples are itraconazole or fluconazole].
- 2) For Cushing's syndrome, patient cannot tolerate surgery or surgery has not been curative.

Prior Authorization Group
- KINERET

Drug Names
- KINERET

Covered Uses
- All FDA-approved indications not otherwise excluded from Part D, systemic juvenile idiopathic arthritis, adult-onset Still's disease.

Exclusion Criteria
- For moderately to severely active rheumatoid arthritis, patient has had an inadequate response or intolerance to a prior biologic DMARD. For adult onset Still's disease (new starts only), patient has had an inadequate response, contraindication, or intolerance to methotrexate. For systemic juvenile idiopathic arthritis (new starts only), patient has had an inadequate response, contraindication, or intolerance to corticosteroids.

Age Restrictions
- Plan Year

Prescriber Restrictions
- KUVAN

Coverage Duration
- Plan Year

Other Criteria
- Kuvan will be used in conjunction with a phenylalanine-restricted diet. For patients who have not yet received a therapeutic trial of Kuvan: 1) Patients less than or equal to 12 years of age have a baseline blood Phe level greater than 6 mg/dL, OR 2) Patients greater than 12 years of age have a baseline blood Phe level greater than 10 mg/dL.
- 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.
<table>
<thead>
<tr>
<th>Coverage Duration</th>
<th>Initial: 1 month. Continuation of treatment: Plan Year.</th>
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<tbody>
<tr>
<td>Other Criteria</td>
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<tr>
<td>Prior Authorization Group</td>
<td>LETAIRIS</td>
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<tr>
<td>Drug Names</td>
<td>LETAIRIS</td>
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<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
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<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization.</td>
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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
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<td>Prior Authorization Group</td>
<td>LEUKINE</td>
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<tr>
<td>Drug Names</td>
<td>LEUKINE</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D, chemotherapy-induced febrile neutropenia (FN), myelodysplastic syndromes (MDS), acute lymphocytic leukemia (ALL).</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Use of Leukine within 24 hours preceding or following chemotherapy or radiotherapy. For prophylaxis of chemotherapy-induced FN, 1) Patient has a non-myeloid cancer AND 2) is currently receiving or will be receiving treatment with myelosuppressive anti-cancer drugs. For treatment of chemotherapy-induced FN, 1) Patient has a non-myeloid cancer AND 2) is currently receiving or has received treatment with myelosuppressive anti-cancer drugs. For MDS, patient has neutropenia and recurrent or resistant infections.</td>
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<tr>
<td>Required Medical Information</td>
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<td>Age Restrictions</td>
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<td>Prescriber Restrictions</td>
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<td>Other Criteria</td>
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<tr>
<td>Prior Authorization Group</td>
<td>LIDODERM</td>
</tr>
<tr>
<td>Drug Names</td>
<td>LIDOCAINE</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>Patient has a sensitivity to local anesthetics of the amide type. 1) The diagnosis is post-herpetic neuralgia AND 2) The skin where the patch is to be applied is intact AND 3) Patient has demonstrated an inadequate treatment response to a one month trial of gabapentin OR Lyrica OR 4) The patient has a contraindication or had a confirmed adverse event with gabapentin OR Lyrica.</td>
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<tr>
<td>Required Medical Information</td>
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<td>Age Restrictions</td>
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<td>Coverage Duration</td>
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<td>Other Criteria</td>
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</table>
**Prior Authorization Group**

**LOTRONEX**

**Drug Names**

LOTRONEX

**Covered Uses**

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

**Exclusion Criteria**

Patient has a history of any of the following conditions: 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**

1) Lotronex is being requested for a woman with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) chronic IBS symptoms lasting for at least 6 months AND 3) gastrointestinal tract abnormalities have been ruled out AND 4) inadequate response to conventional therapy.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group**

**LUMIZYME**

**Drug Names**

LUMIZYME

**Covered Uses**

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

**Exclusion Criteria**

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.

**Required Medical Information**

8 years of age or older.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

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**

**LUPANETA**

**Drug Names**

LUPANETA PACK

**Covered Uses**

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

**Exclusion Criteria**


**Required Medical Information**

For retreatment patient must meet all of the following (one-time retreatment course allowed): 1) Patient has had a recurrence of symptoms, AND 2) Bone mineral density is within normal limits.

**Age Restrictions**

18 years of age or older

**Prescriber Restrictions**

**Coverage Duration**

6 months

**Other Criteria**
Prior Authorization Group

Drug Names

Covered Uses

LUPRON

LEUPROLIDE ACETATE, LUPRON DEPOT, LUPRON DEPOT-PED

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 stromal tumors (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg only), epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer (Lupron Depot 3.75mg only), in combination with growth hormone for children with growth failure and advancing puberty (leuprolide acetate only).

Exclusion Criteria

For prostate cancer, use as neoadjuvant androgen deprivation therapy (ADT) for radical prostatectomy for clinically localized disease. Pregnancy for female patients except for children with CPP. Breastfeeding (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg). Undiagnosed abnormal vaginal bleeding (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg).

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. For endometriosis retreatment, patient must meet all of the following: 1) Patient has had a recurrence of symptoms AND 2) Patient will be receiving add-back therapy (eg, norethindrone) AND 3) Bone mineral density is within normal limits. For uterine fibroids, patient must meet all of the following: 1) Diagnosis of anemia (ie, hematocrit less than or equal to 30% and/or hemoglobin less than or equal to 10g/dL) AND 2) Lupron Depot will be use in conjunction with iron therapy. For uterine fibroids retreatment, bone mineral density is within normal limits. For epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: Lupron (3.75mg only) will be used as a single agent. For breast cancer (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg), patient must meet both of the following: 1) Premenopausal woman AND 2) Hormone receptor positive disease. For CPP (Lupron Depot-PED), patients not currently receiving therapy must meet all of the following: 1) Diagnosis of CPP confirmed by a) A pubertal response to a GnRH agonist OR a basal 3rd generation LH level AND b) Assessment of bone age versus chronological age AND c) Appropriate diagnostic imaging of the brain has been done to exclude an intracranial tumor, AND 2) The onset of sexual characteristics occurred prior to eight years of age for female patients OR prior to nine years of age for male patients.

Age Restrictions

For endometriosis, fibroids, breast cancer, ovarian stromal tumors, epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: 18 years of age or older. CPP: Patient must be less than 12 years old if female and less than 13 years old if male.

Prescriber Restrictions

Coverage Duration


Other Criteria

Updated 01/01/2015
<table>
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<th>Prior Authorization Group</th>
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<td>Drug Names</td>
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</tr>
<tr>
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</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Pregnancy</td>
</tr>
<tr>
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<td></td>
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<tr>
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<td></td>
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<td>Plan Year</td>
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<thead>
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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>As a single agent for the treatment of patients who have received prior BRAF-inhibitor therapy (eg, Zelboraf, Tafinlar).</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>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.</td>
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<td>Drug Names</td>
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<td>Covered Uses</td>
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</tr>
<tr>
<td>Exclusion Criteria</td>
<td>1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography OR 3) Diagnosis is shift work disorder (SWD).</td>
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<td>Required Medical Information</td>
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<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>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).</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
<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></td>
</tr>
</tbody>
</table>
Prescriber Restrictions
Coverage Duration 6 months

Prior Authorization Group MYOZYME
Drug Names MYOZYME
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.

Age Restrictions
Prescriber Restrictions
Coverage Duration Plan Year
Other Criteria Appropriate medical support is readily available when Myozyme is administered in the event of anaphylaxis, severe allergic reaction, or acute cardiorespiratory failure.

Prior Authorization Group NAGLAZYME
Drug Names NAGLAZYME
Covered Uses All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria
Required Medical Information 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.

Age Restrictions
Prescriber Restrictions
Coverage Duration Plan Year
Other Criteria

Prior Authorization Group NAMENDA
Drug Names NAMENDA, NAMENDA XR, NAMENDA XR TITRATION PACK
Covered Uses All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria
Required Medical Information The drug is being prescribed for the treatment of moderate to severe dementia of the Alzheimer's type.

Age Restrictions
Prescriber Restrictions
Coverage Duration Plan Year
Other Criteria This edit only applies to patients less than 30 years of age.

Prior Authorization Group NEULASTA
Drug Names NEULASTA
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D, mobilization of peripheral blood progenitor cells prior to autologous transplantation. |
| Exclusion Criteria | Use of Neulasta within 14 days before or 24 hours after chemotherapy. |
| Required Medical Information | For prophylaxis of chemotherapy-induced FN, patient has a non-myeloid cancer AND is currently receiving or will be receiving treatment with myelosuppressive anti-cancer drugs. |

| 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, angiosarcoma, desmoid tumors (aggressive fibromatosis), osteosarcoma. |
| Exclusion Criteria | For RCC and HCC, patient has advanced disease. For follicular, papillary, or Hürthle cell thyroid carcinoma, patient has tumors at sites other than the central nervous system that were not responsive to radioiodine therapy. For medullary thyroid carcinoma, patient has experienced progression on vandetanib or cabozantinib OR vandetanib or cabozantinib is not an appropriate option. For GIST, patient has experienced progression on imatinib or sunitinib. For osteosarcoma, patient has relapsed/refractory or metastatic disease. |
| Required Medical Information |  |

| Age Restrictions |  |
| Prescriber Restrictions |  |
| Coverage Duration | Plan Year |
| Other Criteria |  |

| Prior Authorization Group | NUEDEXTA |
| Drug Names | NUEDEXTA |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. Patient is currently using quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong the QT interval and are metabolized by CYP2D6 (examples: thioridazine and pimozide). Patient has a prolonged QT interval or congenital long QT syndrome (LQTS), or heart failure or a history suggestive of torsades de pointes (Tdp). Patient has complete atrioventricular (AV) block without an implanted pacemaker or is at high risk of complete AV block. |
| Exclusion Criteria | Nuedexta is being requested for the treatment of pseudobulbar affect (PBA). |
| Required Medical Information |  |

| Age Restrictions |  |
| Prescriber Restrictions |  |
| Coverage Duration | Plan Year |
| Other Criteria |  |
### Other Criteria

**Prior Authorization Group**
- NUVIGIL

**Drug Names**
- NUVIGIL

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

**Exclusion Criteria**
- 1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR
2) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography OR
3) 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

**Covered Uses**
- All FDA-approved indications not otherwise covered under Part D, poorly differentiated (high-grade) neuroendocrine tumor (NET)/large or small cell, pancreatic endocrine tumors (Islet cell tumors), carcinoid tumors, lung NET, unresectable and recurrent meningiomas, thymic carcinomas.

**Exclusion Criteria**
- For Acromegaly, must meet all of the following: 1) Clinical evidence of acromegaly, AND 2) Pre-treatment high IGF-1 level for age/gender, AND 3) Patient had an inadequate or partial response to surgery and/or radiotherapy or there is a clinical reason for why the patient has not had surgery or radiotherapy.

**Required Medical Information**

### 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**
- OLYSIO

**Drug Names**
- OLYSIO

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

**Exclusion Criteria**
- Failed previous treatment with a HCV protease inhibitor (e.g., Incivek, Olysio, Victrelis) despite adequate dosing and duration of therapy.
**Required Medical Information**

Diagnosis of chronic hepatitis C infection has been confirmed by presence of HCV RNA in serum prior to starting therapy. For treatment (tx) with pegylated interferon (PegIFN) and RBV: 1) must have HCV genotype 1 (Genotype 1a or genotype 1b) or genotype 4 infection, 2) For genotype 1a infection, absence of NS3 Q80K polymorphism must be confirmed by a laboratory testing prior to starting therapy, 3) Allow a total of 12 weeks for patients with Genotype 1 infection or Genotype 4 infection who are treatment-naïve or prior relapers to PegIFN and RBV. For tx with Sovaldi with or without RBV: 1) must have Genotype 1 infection, 2) total 24 weeks for recurrent HCV infection post liver transplantation, 3) total 12 weeks for patients who had nonresponse to prior PegIFN and RBV therapy, 4) total 12 weeks for treatment naïve patients and relapers to prior PegIFN and RBV therapy with documented intolerance or ineligibility to receive IFN.

**Age Restrictions**

12 to 24 weeks depending on genotype, treatment regimen and transplantation status. Ineligibility to receive IFN is defined as having one or more of the following: autoimmune hepatitis and other autoimmune disorders, hypersensitivity to PEG or any of its components, decompensated liver disease (eg, Child-Pugh score 7 or above [class B and C]), history of depression, or clinical features consistent with depression, history of pre-existing cardiac disease, a baseline neutrophil count less than 1,500/uL, a baseline platelet count less than 90,000/uL, or baseline hemoglobin less than 10 g/dL.

**Prescriber Restrictions**

*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).

**Prior Authorization Group**

ONFI

**Drug Names**

ONFI

**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**

Evidence of ventricular dysfunction, such as congestive heart failure (CHF). Current use of certain drugs metabolized by CYP3A4.

**Required Medical Information**

Treatment of onychomycosis of the toenail due to Trichophyton that has been confirmed by a fungal diagnostic test.

**Age Restrictions**

**Prescriber Restrictions**
<p>| Coverage Duration | 3 months |
| 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 |  |
| Required Medical Information | PAH (WHO Group 1) was confirmed by right heart catheterization. NYHA Functional Class II or III symptoms. |
| Age Restrictions |  |
| Prescriber Restrictions |  |
| Coverage Duration | Plan Year |
| Other Criteria |  |
| Prior Authorization Group | ORAL TESTOSTERONES |
| Drug Names | ANDROXY |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria |  |
| Required Medical Information | 1) Drug is being prescribed for female patients with inoperable metastatic breast cancer who are 1 to 5 years postmenopausal and who have had an incomplete response to other therapy for metastatic breast cancer OR 2) Drug is being prescribed for hypogonadism for patients who had or currently has a confirmed low testosterone level (according to standard lab reference values) OR 3) Drug is being prescribed for delayed puberty. |
| Age Restrictions |  |
| Prescriber Restrictions |  |
| Coverage Duration | Plan Year |
| Other Criteria | Patients have tried and failed or unable to tolerate one non-oral form of testosterone supplementation. |
| Prior Authorization Group | ORAL-INTRANASAL FENTANYL |
| Drug Names | ABSTRAL, FENTANYL CITRATE ORAL TRA, FENTORA, LAZANDA, SUBSYS |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria |  |
| Required Medical Information | 1) The oral/intranasal fentanyl product will be used to manage breakthrough pain due to a current cancer condition or cancer related complication AND 2) A long-acting opioid is being prescribed for around-the-clock treatment of the cancer pain AND 3) 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 |  |</p>
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>ORENCIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>ORENCIA</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>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 moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance, or contraindication to MTX, OR 2) Patient has had an inadequate response or intolerance to a prior biologic DMARD. For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response to TNF inhibitor, OR 2) Intolerance or contraindication to TNF inhibitor.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization.</td>
</tr>
</tbody>
</table>

| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Plan Year |
| Other Criteria | |

<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>ORENITRAM</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 (Child Pugh Class C)</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization.</td>
</tr>
</tbody>
</table>

| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Plan Year |
| Other Criteria | |

<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>ORFADIN</th>
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</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>ORFADIN</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 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.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td></td>
</tr>
</tbody>
</table>

| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Plan Year |
| Other Criteria | |

<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>OTEZLA</th>
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</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>OTEZLA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D.</td>
</tr>
</tbody>
</table>

Updated 01/01/2015
<table>
<thead>
<tr>
<th>Exclusion Criteria</th>
<th>Inadequate response, contraindication, or intolerance to at least two disease-modifying antirheumatic drugs (DMARDs).</th>
</tr>
</thead>
<tbody>
<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>
<td></td>
</tr>
<tr>
<td>Prior Authorization Group</td>
<td>PEGASYS, PEGASYS PROCLICK</td>
</tr>
<tr>
<td>Drug Names</td>
<td>All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia (CML), giant cell tumor of the bone (GCTB).</td>
</tr>
<tr>
<td>Covered Uses</td>
<td></td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>For Chronic Hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment (tx). For mono-tx OR dual tx w/ ribavirin (RBV), Allow a total 48 weeks (wks). For tx w/ Victrelis and RBV 1) Genotype 1 [G1] only, 2) Allow a total 48 wks. For tx w/ Incivek and RBV 1) G1 only, 2) Allow a total 48 wks. For tx w/ Olysio and RBV (G1 and G4), 1) Allow a total 24 wks for tx naïve or relapers w/ G1, 2) HCV-RNA less than 25 IU/mL at wk 24, a) Allow a total 48 wks for G4 tx naïve or relapers, b) Allow a total 48 wks for G1 nonresponders to prior PegIFN and RBV tx. For tx w/ Sovaldi and RBV, 1) For recurrent G1 infection post liver transplantation, allow total 24 wks, 2) G1 thru G6 pts w/ nonresponse to prior PegIFN and RBV tx (w/ or w/o a protease inhibitor), Allow total 12 wks of tx. 3) For pts w/ G1, 3, 4, 5, or 6 who are tx naïve and relapser to prior PegIFN and RBV tx, Allow total 12 wks of tx.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td>HCV=12 to 48 wks depending on treatment regimen and genotype. HBV=48 wks. CML and GCTB = Plan Year.</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td></td>
</tr>
<tr>
<td>Coverage Duration</td>
<td>For Chronic Hepatitis B, 1) For pt with cirrhosis, Pt must have been HBsAg positive for at least 6 months AND must have serum HBV-DNA greater than or equal to 10,000 copies/mL or greater than or equal to 2,000 IU/mL regardless of HBeAg status. 2) For pts without cirrhosis, Pt must have been HBsAg positive for at least 6 months. If HBeAg positive, pt must have serum HBV-DNA greater than 100,000 copies/mL or greater than 20,000 IU/mL. If HBeAg negative, pt must have serum HBV-DNA greater than 10,000 copies/mL or greater than 2,000 IU/mL. Must have persistent or intermittently elevated ALT greater than 2 times the upper limit of normal OR liver biopsy showing chronic hepatitis with moderate to severe necroinflammation.</td>
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<tr>
<td>Other Criteria</td>
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</tr>
<tr>
<td>Prior Authorization Group</td>
<td>PEGINTRON</td>
</tr>
<tr>
<td>Drug Names</td>
<td>PEG-INTRON, PEG-INTRON REDIPEN</td>
</tr>
</tbody>
</table>
**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia.

**Exclusion Criteria**

Decompensated liver disease (e.g. Child-Pugh class B or C).

**Required Medical Information**

For Chronic Hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment (tx). For mono-tx OR dual tx w/ ribavirin (RBV), Allow a total 48 weeks (wks). For tx w/ Victrelis and RBV 1) Genotype 1 [G1] only, 2) Allow a total 48 wks. For tx w/ Incivek and RBV 1) G1 only, 2) Allow a total 48 wks. For tx w/ Olysio and RBV (G1 and G4), 1) Allow a total 24 wks for tx naïve or relapsers w/ G1, 2) HCV-RNA less than 25 IU/mL at wk 24, a) Allow a total 48 wks for G4 tx naïve or relapsers, b) Allow a total 48 wks for G1 nonresponders to prior PegIFN and RBV tx.

For tx w/ Sovaldi and RBV, 1) For recurrent G1 infection post liver transplantation, allow total 24 wks, 2) G1 thru G6 pts w/ nonresponse to prior PegIFN and RBV tx (w/ or w/o a protease inhibitor), Allow total 12 wks of tx. 3) For pts w/ G1, 3, 4, 5, or 6 who are tx naïve and relapser to prior PegIFN and RBV tx, Allow total 12 wks of tx.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

HCV=12 to 48 weeks depending on tx regimen and genotype. CML=Plan Year.

**Other Criteria**

**Prior Authorization Group**

POMALYST

**Drug Names**

POMALYST

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis.

**Exclusion Criteria**

For multiple myeloma: 1) patient received prior therapy with Velcade (bortezomib) AND with either Revlimid (lenalidomide) OR Thalomid (thalidomide), AND 2) disease has progressed during or within 60 days of completion of last therapy. For systemic light chain amyloidosis: Pomalyst is used in combination with dexamethasone.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group**

PRIVIGEN

**Drug Names**

PRIVIGEN
**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D, B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT), chronic inflammatory demyelinating polyneuropathy, dermatomyositis, fetal/neonatal alloimmune thrombocytopenia, Guillain-Barré syndrome (GBS), Kawasaki syndrome, Lambert-Eaton myasthenic syndrome, myasthenia gravis, multifocal motor neuropathy, pediatric HIV infection, polymyositis, pure red cell aplasia (PRCA), relapsing-remitting multiple sclerosis (RRMS).

**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. Hyperprolinemia.

**Required Medical Information**
For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections.
For BMT/HSCT: serum IgG less than 400mg/dL. For dermatomyositis and polymyositis: standard 1st line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For RRMS: standard 1st line treatments (interferon or glatiramer) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For pediatric HIV infection: serum IgG less than 400 mg/dL OR a history of recurrent bacterial infections. 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 dose or concentration available of IVIG 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. For all indications: patients with any of the following risk factors for thrombosis must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: age 45 years or older, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling central vascular catheters, hyperviscosity, or cardiovascular risk factors.

**Age Restrictions**
For pediatric HIV infection: age 12 years or younger.

**Prescriber Restrictions**

**Coverage Duration**
Plan Year
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**
PROCYSBI

**Drug Names**
PROCYSBI

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

Updated 01/01/2015
**Exclusion Criteria**

Documented history of hypersensitivity to penicillamine.

**Required Medical Information**

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.

**Age Restrictions**

6 years of age or older.

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group**

PROMACTA

**Drug Names**

PROMACTA

**Covered Uses**

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

**Exclusion Criteria**

For patients with chronic or persistent ITP, the following criteria are met: 1) New starts: a) Patient has had an inadequate response or is intolerant to corticosteroids, immunoglobulins or splenectomy AND 2) platelet count at time of diagnosis is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) Continuation of therapy: platelet count response to Promacta - a) Current platelet count is 50,000-200,000/mcL, b) Current platelet count is less than 50,000/mcL and sufficient to avoid clinically important bleeding, c) Current platelet count is less than 50,000/mcL and patient has not received a maximal dose of Promacta for at least 4 weeks, OR d) Current platelet count is greater than 200,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding. For patients with thrombocytopenia associated with chronic hepatitis C, the following criteria are met: 1) New starts: Promacta is used for initiation and maintenance of interferon-based therapy AND platelet count at time of diagnosis is less than 75,000/mcL, 2) Continuation of therapy: patient is receiving interferon-based therapy.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Hep C:6mo. ITP: init=6mo, reauth w/ adq plt response=Plan yr, reauth inadequate plt response=3mo.

**Other Criteria**

Liver function will be measured at baseline and regularly throughout treatment AND Alanine aminotransferase (ALT) levels must not be equal to or greater than 3x the upper limit of normal in patients with normal liver function or equal to or greater than 3x baseline in a patient with pre-treatment elevations in transaminases AND have any of the following characteristics: progressive, persistent for equal to or greater than 4 weeks, accompanied by increased direct bilirubin or symptoms of liver injury or evidence of hepatic decompensation.

**Prior Authorization Group**

PROTOPIC

**Drug Names**

PROTOPIC

Updated 01/01/2015
Covered Uses
All FDA-approved indications not otherwise excluded from Part D, Psoriasis on the eyelid or genital areas.

Exclusion Criteria
1) Diagnosis of moderate to severe atopic dermatitis (eczema) AND 2) Patient completed a documented trial and failure of at least one medium or higher potency topical steroid or has a documented intolerance or contraindication to medium or higher potency topical steroids OR 3) Diagnosis of psoriasis on the genital or eyelid areas.

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
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).

Exclusion Criteria
Have a relapsing form of MS (eg, 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 (ie, 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
1) For the treatment of lower extremity diabetic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply AND 2) Good ulcer care practices including initial sharp debridement, pressure relief, and infection control will be performed.

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**

For the treatment of opioid-induced constipation in a patient with advanced illness who is receiving palliative care.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan year

**Other Criteria**

The patient's response to laxative therapy has been insufficient.

**Prior Authorization Group**

**Drug Names**

REMICADE

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis, Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.

**Exclusion Criteria**

Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Remicade (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): 1) Remicade will be used in combination with MTX or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide, AND 2) Inadequate response to a self-inj ectable tumor necrosis factor (TNF) inhibitor (e.g., Cimzia, Enbrel, Humira or Simponi), OR 3) Intolerance or contraindication to a self-injectable TNF inhibitor. For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease, OR 2) Inadequate response to a self-injectable TNF inhibitor (eg, Cimzia or Humira), OR 3) Intolerance or contraindication to a self-injectable TNF inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (eg, corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to a self-injectable TNF inhibitor (eg, Enbrel, Humira or Simponi), OR 2) Intolerance or contraindication to a self-injectable TNF inhibitor. For chronic moderate to severe plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected, AND 2) Inadequate response, intolerance or contraindication to a self-injectable TNF inhibitor (eg, Enbrel or Humira). For juvenile idiopathic arthritis: (new starts only): 1) Inadequate response to MTX, OR 2) Intolerance or contraindication to MTX.
**Prior Authorization Group**

**Drug Names**

**Covered Uses**

Prior Authorization Group

RELVIMID

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

**Exclusion Criteria**

**Required Medical Information**

1) For myeloma or PSP: a) Revlimid is used as primary therapy in combination with dexamethasone OR with melphalan AND prednisone, OR b) Revlimid is used as maintenance monotherapy, OR c) Revlimid is used as salvage therapy. 2) For low or intermediate-1 risk MDS with 5q deletion: pt has a transfusion-dependent anemia (ie, 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 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 failed to respond to epoetin or darbepoetin. 4) For mantle cell lymphoma: disease is recurrent, relapsed or progressive. 5) For other NHL subtypes (AIDS-related DLBCL, AIDS-related primary effusion lymphoma, AIDS-related lymphoma associated with Castleman’s disease, DLBCL, FL, gastric/nongastric MALT lymphoma, nodal/splenic marginal zone lymphoma, or PCBCL: 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**

**Drug Names**

**Covered Uses**

Prior Authorization Group

RIBAVIRIN

MODERIBA, MODERIBA 1200 DOSE PACK, MODERIBA 800 DOSE PACK, REBETOL, RIBAVIRE, RIBAVIRE RIBAPAK, RIBAVIRIN

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

Updated 01/01/2015
Required Medical Information

CHC infection confirmed by presence of HCV-RNA in serum prior to starting treatment (tx). For tx w/ PegIFN/IFN, allow total 48 wks. For tx w/ PegIFN and BOC (G1 only), allow total 48 wks. For tx w/ PegIFN and TPV (G1 only), allow total 48 wks. For tx w/ PegIFN and SMP (G1,4), 1) TN or relapers w/ G1: total 24 wks, 2) VL less than 25 IU/mL at wk 24, a)TN or relapers w/ G4: total 48 wks, b)G1 pts w/ nonresponse to prior PegIFN and ribavirin tx: total 48 wks. For tx w/ SOV and SMP, 1) G1, 2) TN pts and relapers to PegIFN and RBV w/ documented IFN intolerance or ineligibility: total 12 wks, 3) recurrent HCV infection post LT: total 24 wks, 4) Nonresponse to prior PegIFN and RBV therapy, total 12 wks. For tx w/ SOV and PegIFN, 1)Recurrent G1 infection post LT: total 24 wks, 2)G1-6 w/ nonresponse to prior PegIFN and RBV tx (w/ or w/o a protease inhibitor [PI]): total 12 wks, 3)G1/G3-6 pts who are TN or relaper to prior tx: total 12 wks. For tx w/ SOV, 1)Decompensated liver disease, allow total 48 wks, 2)HCC pts awaiting LT who meet MILAN criteria: total 48 wks/until LT, whichever occurs first, 3)Recurrent infection post LT w/ G1-3: total 24 wks, 4)G1/G4 pts w/ documented intolerance or ineligibility to receive IFN: total 24 wks, 5)G3: total 24 wks, 6)G2: total 12 wks, unless pt is nonresponder to prior PegIFN and RBV tx (w/ or w/o a PI) w/ cirrhosis: total 16 wks.

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

HCV= 12 to 48 wks total depending on tx regimen, genotype, and LT status.
Abbreviations: Treatment (tx), detectable (det), undetectable (undet), genotype (G), treatment-naïve (TN), peginterferon (PegIFN), interferon (IFN), HCV-RNA (VL), Incivek (TPV), Victrelis (BOC), Olysio (SMP), Sovaldi (SOV), patients (pts), liver transplantation (LT), hepatocellular carcinoma (HCC). Poor IFN-response is defined as having less than 1.0-log10 drop in VL at wk 4. Null response is defined as less than 2-log10 drop in VL at wk 12. MILAN criteria defined as the presence of a tumor 5cm or less in diameter in pts with single hepatocellular carcinomas, and no more than 3 tumor nodules, each 3cm or less in diameter in pts with multiple tumors and no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor. Ineligibility to receive IFN is defined as having autoimmune hepatitis and other autoimmune disorders, hypersensitivity to PEG or any of its components, decompensated liver disease (Child-Pugh score 7 or above [class B or C]), history of depression, or clinical features consistent with depression, a baseline neutrophil count less than 1,500/uL, baseline platelet count less than 90,000/uL, or baseline hemoglobin less than 10g/dL or history of pre-existing cardiac disease. Decompensated liver disease is defined as Child-Pugh score 7 or above (class B or C).

Prior Authorization Group
Drug Names

RITUXAN

Updated 01/01/2015
**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, primary CNS lymphoma, leptomeningeal metastases, Hodgkin's lymphoma (lymphocyte-predominant), non-Hodgkin's lymphoma subtypes [marginal zone lymphomas (splenic, MALT), diffuse large B-cell lymphoma (DLBCL), Mantle cell lymphoma, Burkitt lymphoma, AIDS-related B-cell lymphoma, Hairy cell leukemia, small lymphocytic lymphoma (SLL), post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma], acute lymphoblastic leukemia, acquired blood factor VIII deficiency, autoimmune hemolytic anemia, chronic graft-versus-host disease (GVHD), multicentric Castleman's disease with HIV, refractory immune or idiopathic thrombocytopenic purpura (ITP), Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma, Sjögren syndrome, and prevention of Epstein-Barr virus (EBV)-related PTLD.

**Exclusion Criteria**

Prior to initiating therapy, patient has been screened for hepatitis B virus (HBV) infection. For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response to a self-injectable tumor necrosis factor (TNF) inhibitor (eg, Cimzia, Enbrel, Humira or Simponi), OR 2) Intolerance or contraindication to a self-injectable TNF inhibitor. Hematologic malignancies must be CD20-positive. For ALL and Burkitt lymphoma, Rituxan is used as a component of a chemotherapy regimen. For DLBCL, patient meets one of the following: 1) previously untreated DLBCL in combination with chemotherapy, OR 2) previously treated DLBCL in combination with chemotherapy for a patient who is a candidate for autologous stem cell transplant, OR 3) previously treated DLBCL in a patient who is not a candidate for high-dose therapy with autologous stem cell transplant.

**Age Restrictions**

Prescriber Restrictions

Coverage Duration

Other Criteria

For rheumatoid arthritis, Rituxan is used in combination with MTX unless MTX is contraindicated or was not tolerated.

**Prior Authorization Group**

SABRIL

**Drug Names**

SABRIL

**Covered Uses**

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

**Exclusion Criteria**

For infantile spasms: Sabril is used as monotherapy. For complex partial seizures (CPS): 1) patient had an inadequate response to 2 alternative therapies (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine) for CPS AND 2) Sabril is used as adjunctive therapy. Initial treatment infantile spasms: 1 month to 2 years. CPS: none.

**Age Restrictions**

Prescriber Restrictions

Coverage Duration

Plan Year
### Other Criteria

<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>SAMSCA</th>
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</thead>
<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>Underlying liver disease.</td>
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<tr>
<td>Required Medical Information</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>30 days</td>
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<tr>
<td>Other Criteria</td>
<td>Samsca therapy was initiated (or re-initiated) in the hospital.</td>
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<thead>
<tr>
<th>Prior Authorization Group</th>
<th>SANDOSTATIN LAR</th>
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</thead>
<tbody>
<tr>
<td>Drug Names</td>
<td>SANDOSTATIN LAR DEPOT</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise covered under Part D, poorly differentiated (high-grade) neuroendocrine tumor (NET)/large or small cell, pancreatic endocrine tumors (Islet cell tumors), carcinoid tumors, multiple endocrine neoplasia (MEN) type 1, unresectable and recurrent meningiomas, thymic carcinomas.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>For Acromegaly, must meet all of the following: 1) Clinical evidence of acromegaly, AND 2) Pre-treatment high IGF-1 level for age/gender, AND 3) Patient had an inadequate or partial response to surgery and/or radiotherapy or there is a clinical reason for why the patient has not had surgery or radiotherapy.</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>
<td></td>
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<tr>
<td>Coverage Duration</td>
<td>Plan Year</td>
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<tr>
<td>Other Criteria</td>
<td>For acromegaly continuation of therapy: the IGF-1 level decreased or normalized.</td>
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<thead>
<tr>
<th>Prior Authorization Group</th>
<th>SEROSTIM</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>SEROSTIM</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.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Patient has a diagnosis of cachexia or wasting syndrome associated with HIV infection. Serostim is used in combination with antiretroviral therapy. Patient has had a suboptimal response to at least 1 other therapy for wasting or cachexia (eg, megestrol, dronabinol, cyproheptadine, or testosterone therapy if hypogonadal) OR patient has contraindication or intolerance to alternative therapies. For initial approval, patient must have a body mass index (BMI) less than 18.5 kg/m2 AND have experienced unintentional weight loss greater than 5% of body weight in the previous 6 months. For continuation of therapy, patient must have demonstrated a response to therapy with Serostim (ie, BMI has improved or stabilized) AND have BMI less than 27 kg/m2.</td>
</tr>
<tr>
<td>Age Restrictions</td>
<td></td>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
<td>Infectious disease specialist</td>
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<tr>
<td><strong>Coverage Duration</strong></td>
<td>12 weeks</td>
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<tr>
<td><strong>Other Criteria</strong></td>
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</tbody>
</table>

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

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<th><strong>Age Restrictions</strong></th>
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<tr>
<td><strong>Prescriber Restrictions</strong></td>
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<tr>
<td><strong>Coverage Duration</strong></td>
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<tr>
<td><strong>Other Criteria</strong></td>
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</tbody>
</table>

| **Prior Authorization Group** | SILDENAFIL |
| **Drug Names**               | SILDENAFIL |
| **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**         | 18 years of age or older. |
| **Prescriber Restrictions** | Endocrinologist |
| **Coverage Duration**       | Plan Year |
| **Other Criteria**          | |

| **Prior Authorization Group** | SIMPONI |
| **Drug Names**               | SIMPONI, SIMPONI ARIA |
| **Covered Uses**             | All FDA-approved indications not otherwise excluded from Part D. Axial spondyloarthritis (Simponi only). |
| **Exclusion Criteria**       | |
### 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/Simponi Aria (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance, or contraindication to MTX, OR 2) Patient has had an inadequate response or intolerance to a prior biologic DMARD, OR 3) Simponi/Simponi Aria will be used as first-line therapy for severely active RA. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response, intolerance, or contraindication to at least 2 non-steroidal anti-inflammatory drugs. For moderately to severely active ulcerative colitis (new starts only): 1) Patient has corticosteroid dependence, OR 2) Patient had an inadequate response to conventional therapy (eg, oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopyrrole), OR 3) Patient has intolerance or a contraindication to conventional therapy.

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<tr>
<th>Age Restrictions</th>
<th>Prescriber Restrictions</th>
<th>Coverage Duration</th>
<th>Other Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Plan year</td>
<td>For rheumatoid arthritis, Simponi/Simponi Aria is used in combination with MTX unless MTX is contraindicated or was not tolerated.</td>
</tr>
</tbody>
</table>

### 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). 1) Sirturo is being requested as part of combination therapy in a patient with pulmonary multi-drug resistant tuberculosis (MDR-TB) AND 2) Another effective treatment regimen cannot be used instead of Sirturo.

### Required Medical Information

1) Sirturo is being requested as part of combination therapy in a patient with pulmonary multi-drug resistant tuberculosis (MDR-TB) AND 2) Another effective treatment regimen cannot be used instead of Sirturo.

### Prior Authorization Group

**Drug Names**

- SOLARAZE
- DICLOFENAC SODIUM

**Covered Uses**

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

**Exclusion Criteria**

Plan Year
<table>
<thead>
<tr>
<th>Prior Authorization Group</th>
<th>SOMATULINE DEPOT</th>
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<tr>
<td>Drug Names</td>
<td>SOMATULINE DEPOT</td>
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<tr>
<td>Covered Uses</td>
<td>All FDA-Approved indications not otherwise excluded from Part D, poorly differentiated (high-grade) neuroendocrine tumors (NET)/large or small cell, pancreatic endocrine tumors (Islet cell tumors), carcinoid tumors, multiple endocrine neoplasia (MEN) type 1.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
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<tr>
<td>Required Medical Information</td>
<td>For Acromegaly, must meet all of the following: 1) Clinical evidence of acromegaly, AND 2) Pre-treatment high IGF-1 level for age/gender, AND 3) Patient had an inadequate or partial response to surgery and/or radiotherapy or there is a clinical reason for why the patient has not had surgery or radiotherapy.</td>
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<tr>
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<td>Plan Year</td>
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<tr>
<td>Coverage Duration</td>
<td>For acromegaly continuation of therapy: the IGF-1 level decreased or normalized.</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>Patient must meet all of the following: Clinical evidence of acromegaly, AND Pre-treatment high IGF-1 level for age/gender, AND Patient had an 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, AND Patient had an inadequate response to octreotide or lanreotide unless patient is intolerant or has a contraindication to octreotide or lanreotide.</td>
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<tr>
<td>Required Medical Information</td>
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<tr>
<td>Age Restrictions</td>
<td>Plan Year</td>
</tr>
<tr>
<td>Prescriber Restrictions</td>
<td>For renewal, the IGF-1 level decreased or normalized.</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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<thead>
<tr>
<th>Prior Authorization Group</th>
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<tbody>
<tr>
<td>Drug Names</td>
<td>ACITRETIN</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D, prevention of non-melanoma skin cancers in high risk individuals.</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Severely impaired liver function or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracycline.</td>
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<tr>
<td>Required Medical Information</td>
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<td>Age Restrictions</td>
<td>Plan Year</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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</tbody>
</table>
Other Criteria
If the patient is female and able to bear children, female patient and/or guardian signed a Patient Agreement/Informed Consent (e.g., Do Your P.A.R.T) which includes confirmation of 2 negative pregnancy tests.

Prior Authorization Group
SOVALDI

Drug Names
SOVALDI

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

Exclusion Criteria
Chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to starting therapy. For treatment (tx) with peginterferon (PegIFN) and RBV: 1) total 24 weeks (wks) for recurrent HCV infection post liver transplantation with Genotype (G) 1, 2) total 12 wks for G1 to 6 patients who had nonresponse to prior HCV therapy to PegIFN and RBV (with or without a protease inhibitor), 3) total 12 wks for G 1, 3, 4, 5, or 6 patients who are tx-naïve and relapers to prior HCV therapy. For tx with Olysio with or without RBV: 1) has G1 infection, 2) total 24 wks for recurrent HCV infection post liver transplantation, 3) total 12 wks for patients with nonresponse to prior PegIFN and RBV therapy, 4) total 12 wks for tx-naïve patients and relapers to prior PegIFN and RBV with documented intolerance or ineligibility to receive IFN. For tx with RBV: 1) total 48 wks for patients with decompensated liver disease (e.g., Child-Pugh Class B or C), 2) total 48 wks or until liver transplantation, whichever occurs first for patients with hepatocellular carcinoma awaiting for liver transplantation meeting MILAN criteria, 3) total 24 wks for recurrent HCV infection post liver transplantation with G 1, 2, or 3 infection, 4) total 24 wks for G1 or 4 with documented intolerance or ineligibility to receive IFN, 5) total 24 wks for G3, 6) for G2, total 16 wks if patient is nonresponder to prior HCV therapy with PegIFN and RBV (with or without a protease inhibitor) AND has cirrhosis. Otherwise total 12 wks.

Age Restrictions
Prescriber Restrictions
Coverage Duration
12-48 wks depending on tx regimen, genotype, liver transplantation status and decompensation

Other Criteria
Ineligibility to receive IFN is defined as having one or more of the following: autoimmune hepatitis and other autoimmune disorders, hypersensitivity to PEG or any of its components, decompensated liver disease (eg, Child-Pugh score 7 or above [class B and C]), history of depression, or clinical features consistent with depression, history of pre-existing cardiac disease, a baseline neutrophil count less than 1,500/µL, baseline platelet count less than 90,000/µL, or baseline hemoglobin less than 10 g/dL. MILAN criteria is defined as the presence of a tumor 5cm or less in diameter in patients with single hepatocellular carcinomas, and no more than 3 tumor nodules, each 3cm or less in diameter in patients with multiple tumors and no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor.
Prior Authorization Group: SPRYCEL
Drug Names: SPRYCEL
Covered Uses: All FDA-approved indications not otherwise excluded from Part D, gastrointestinal stromal tumor (GIST).

Exclusion Criteria
Required Medical Information: For chronic myeloid leukemia (CML) and acute lymphoblastic leukemia (ALL), patient must be positive for the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) using Sprycel as first line treatment, 2) experienced resistance or intolerance/toxicity to alternative tyrosine kinase inhibitor (imatinib, nilotinib, bosutinib, ponatinib), or 3) post hematopoietic stem cell transplant. For GIST, patient must have progressed on imatinib or sunitinib.

Age Restrictions
Prescriber Restrictions
Coverage Duration: Plan Year
Other Criteria

Prior Authorization Group: STELARA
Drug Names: STELARA
Covered Uses: All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria
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 Stelara (or other biologic). For moderate to severe plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected, AND 2) Inadequate response to either phototherapy (eg, UVB, PUVA) or a traditional systemic agent (eg, methotrexate, cyclosporine, acitretin), unless contraindicated or intolerant to such therapies.

Age Restrictions
Prescriber Restrictions
Coverage Duration: Plan year
Other Criteria

Prior Authorization Group: STIVARGA
Drug Names: STIVARGA
Covered Uses: All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria
Required Medical Information: Patient with metastatic colorectal cancer must have been previously treated with the following: fluoropyrimidine-, oxaliplatin- and irinotecan-based regimen, and an anti-EGFR agent if KRAS mutation-negative (wild-type). Patient with locally advanced, unresectable or metastatic gastrointestinal stromal tumor must have been previously treated with imatinib or sunitinib.

Age Restrictions
**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group** SUTENT

**Drug Names** SUTENT

**Covered Uses** All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), lung neuroendocrine tumors, angiosarcoma, solitary fibrous tumor or hemangiopericytoma, chordoma (bone cancer).

**Exclusion Criteria**

**Required Medical Information**

For RCC, patient has advanced disease. For GIST, patient experienced disease progression on imatinib or was intolerant to imatinib. For PNETs, patient has well differentiated tumors and progressive unresectable locally advanced or metastatic disease. For follicular, papillary, or Hürthle cell thyroid carcinoma, patient has tumors at sites other than the central nervous system that were not responsive to radioiodine therapy. For medullary thyroid carcinoma, patient experienced progression on vandetanib or cabozantinib OR vandetanib or cabozantinib is not an appropriate option. For bone cancer, patient has chordoma subtype and has recurrent disease.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group** SYLATRON

**Drug Names** SYLATRON

**Covered Uses** All FDA-approved indications not otherwise excluded from Part D, giant cell tumor of the bone.

**Exclusion Criteria**

**Required Medical Information**

For Melanoma: must have microscopic or gross nodal involvement AND had a surgical resection of the tumor and complete lymphadenectomy

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

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**
- Plan Year

1) If patient received Symlin in previous 3 months, patient demonstrated an expected reduction in HbA1c since starting Symlin therapy OR 2) The patient has inadequate glycemic control (HbA1c greater than 7 percent) and is currently receiving optimal mealtime insulin therapy.

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

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**

**Other Criteria**
- Plan Year

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

For non-small cell lung cancer, Tarceva is used for locally advanced, recurrent, or metastatic disease, and one of the following: a) First-line treatment in a patient who has had EGFR mutation testing AND is positive for EGFR exon 19 deletion or exon 21 (L858R) substitution mutation, OR b) maintenance treatment in a patient who responded to or remained stable after first-line chemotherapy AND Tarceva is being used as monotherapy, OR c) second- or third-line treatment AND Tarceva is being used as monotherapy. For pancreatic cancer: a) Pancreatic cancer is locally advanced, unresectable or metastatic, AND b) Tarceva is used in combination with gemcitabine. For chordoma: a) Patient has recurrent disease, AND b) Tarceva will be used as monotherapy or in combination with cetuximab.

**Age Restrictions**

**Prescriber Restrictions**

Updated 01/01/2015
<table>
<thead>
<tr>
<th>Coverage Duration</th>
<th>Plan Year</th>
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</thead>
<tbody>
<tr>
<td>Prior Authorization Group</td>
<td>TARGRETIN</td>
</tr>
<tr>
<td>Drug Names</td>
<td>TARGRETIN</td>
</tr>
<tr>
<td>Covered Uses</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), and primary cutaneous B-cell lymphoma (Gel only).</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>Pregnancy</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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<td>Coverage Duration</td>
<td>Plan Year</td>
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<tr>
<td>Prior Authorization Group</td>
<td>TASIGNA</td>
</tr>
<tr>
<td>Drug Names</td>
<td>TASIGNA</td>
</tr>
<tr>
<td>Covered Uses</td>
<td>All FDA-approved indications not otherwise excluded from Part D, acute lymphoblastic leukemia (ALL), gastrointestinal stromal tumor (GIST).</td>
</tr>
<tr>
<td>Exclusion Criteria</td>
<td>For chronic myeloid leukemia (CML) and acute lymphoblastic leukemia (ALL), patient must be positive for the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) using Tasigna as first line treatment, 2) experienced resistance or intolerance/toxicity to alternative tyrosine kinase inhibitor (imatinib, dasatinib, bosutinib, ponatinib), or 3) post hematopoietic stem cell transplant. For ALL, patient has relapsed or refractory ALL. For GIST, patient must have progressed on imatinib or sunitinib.</td>
</tr>
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<td>Required Medical Information</td>
<td>For chronic myeloid leukemia (CML) and acute lymphoblastic leukemia (ALL), patient must be positive for the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) using Tasigna as first line treatment, 2) experienced resistance or intolerance/toxicity to alternative tyrosine kinase inhibitor (imatinib, dasatinib, bosutinib, ponatinib), or 3) post hematopoietic stem cell transplant. For ALL, patient has relapsed or refractory ALL. For GIST, patient must have progressed on imatinib or sunitinib.</td>
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<tr>
<td>Age Restrictions</td>
<td>18 years of age or older.</td>
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<td>Prescriber Restrictions</td>
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<td>Coverage Duration</td>
<td>Plan Year</td>
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<tr>
<td>Prior Authorization Group</td>
<td>TAZORAC</td>
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<tr>
<td>Drug Names</td>
<td>TAZORAC</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) Diagnosis of plaque psoriasis with 20 percent body surface area involvement or less OR 2) Diagnosis of acne vulgaris AND 3) For female patients who are able to bear children, the pregnancy status of the patient has been evaluated.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>1) Diagnosis of plaque psoriasis with 20 percent body surface area involvement or less OR 2) Diagnosis of acne vulgaris AND 3) For female patients who are able to bear children, the pregnancy status of the patient has been evaluated.</td>
</tr>
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<td>Prescriber Restrictions</td>
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</tbody>
</table>
**Other Criteria**

1) For patients being treated for plaque psoriasis a trial of at least one topical corticosteroid (e.g., clobetasol, fluocinonide, mometasone, triamcinolone) (patient may still be using a corticosteroid product in addition to Tazorac) OR 2) Patient has an adverse event, intolerance, or 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**

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

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group**

TEMAZEPAM

**Drug Names**

TEMAZEPAM

**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.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

Plan Year

**Coverage Duration**

This Prior Authorization requirement only applies to patients 65 years of age or older.

**Other Criteria**

APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

**Prior Authorization Group**

THALOMID

**Drug Names**

THALOMID

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, progressive solitary plasmacytoma, myelofibrosis with myeloid metaplasia, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, HIV-related aphthous ulcers of mouth/esophagus, cancer cachexia, chronic graft-versus-host disease, AIDS-related diarrhea, and mucocutaneous lesions associated with Behcet's syndrome.

**Exclusion Criteria**
### Required Medical Information

1) For myeloma or progressive solitary plasmacytoma: 
   a) Thalomid is used as primary therapy in combination with dexamethasone OR with melphalan and prednisone, OR 
   b) Thalomid is used as maintenance monotherapy, OR 
   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 as monotherapy or in combination with rituximab.  
4) For Behcet's syndrome: Thalomid is used for treatment of mucocutaneous lesions.

### 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, non-cystic fibrosis bronchiectasis.

### Exclusion Criteria

**Required Medical Information**

Patient has diagnosis of cystic fibrosis that was confirmed by appropriate diagnostic or genetic testing OR patient has diagnosis of non-cystic fibrosis bronchiectasis. Pseudomonas aeruginosa is present in the cultures of the airways OR patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.

### 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

**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**

**Drug Names**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.
### Required Medical Information
- NYHA Functional Class II to IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization.

### 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, metastatic central nervous system (CNS) lesions from primary tumor (breast).

### Exclusion Criteria
- For breast cancer, patient has recurrent or metastatic, HER2 positive disease. 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 (eg, anastrozole, letrozole, exemestane) for postmenopausal women with hormone receptor positive disease. For metastatic CNS lesions, Tykerb must be used with capecitabine in patient with recurrent HER2 positive breast cancer.

### Age Restrictions

### Prescriber Restrictions

### 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 Crohn's disease (CD), patient must have an inadequate response or intolerance to conventional CD therapy and a TNF-inhibitor.
**Age Restrictions**
**Prescriber Restrictions**
**Coverage Duration**
**Other Criteria**
MS: Plan Year. CD: initial = 3 months, renewal = Plan Year.
Upon renewal for CD, patient's condition must have improved or stabilized with Tysabri treatment.

**Prior Authorization Group**
**Drug Names**
**Covered Uses**
VALCHLOR
All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**
History of clozapine-induced agranulocytosis or severe granulocytopenia. Dementia-related psychosis.

**Required Medical Information**
The patient is unwilling or unable to take tablets or capsules orally or is at high risk for non-compliance.

**Age Restrictions**
**Prescriber Restrictions**
**Coverage Duration**
**Other Criteria**
Plan year

**Prior Authorization Group**
**Drug Names**
**Covered Uses**
VERSACLOZ
All FDA-approved indications not otherwise excluded from Part D.

**Exclusion Criteria**
Failed previous treatment with a HCV protease inhibitor (i.e., Incivek, Olysio, Victrelis) despite adequate dosing and duration of therapy. HIV co-infection (Initial only).

**Required Medical Information**
Diagnosis of chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to starting therapy. Must have genotype 1 infection. Must be given in combination with pegylated interferon (i.e., Pegasys or Peglntron) and ribavirin (RBV) only. Patient will receive 4 weeks of pegylated interferon (PEG-IFN) and RBV prior to starting Victrelis. Allow a total of 44 weeks in the following patients: 1) patients with cirrhosis, 2) patients with HIV coinfection (renewal only), 3) poorly IFN-responsive OR 4) null responders with prior therapy with PEG-IFN and RBV. For all other patients, allow a total of 32 weeks.

**Age Restrictions**
**Prescriber Restrictions**
**Coverage Duration**
- 32 weeks to 44 weeks

**Other Criteria**

**Prior Authorization Group**
- VIMIZIM

**Drug Names**
- VIMIZIM

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

**Exclusion Criteria**

**Required Medical Information**
- Diagnosis of mucopolysaccharidosis IVA (MPS IVA) is confirmed by an enzyme assay demonstrating a deficiency in N-acetylgalactosamine 6-sulfatase enzyme activity or by DNA testing.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Plan Year

**Other Criteria**
- Appropriate medical support is readily available when Vimizim is administered in the event of anaphylaxis, severe allergic reaction, or acute respiratory failure.

**Prior Authorization Group**
- VOTRIENT

**Drug Names**
- VOTRIENT

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

**Exclusion Criteria**

**Required Medical Information**
- 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 ULN.
- Patient must have one of the following diagnoses: advanced STS, advanced RCC or uterine sarcoma. For STS, patient does not have GIST or adipocytic STS AND has received a prior chemotherapy (e.g., doxorubicin, ifosfamide, epirubicin or dacarbazine).

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**
- Plan Year

**Other Criteria**

**Prior Authorization Group**
- VPRIV

**Drug Names**
- VPRIV

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

**Exclusion Criteria**

**Required Medical Information**
- Concomitant therapy with miglustat (Zavesca).
- Diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity. Patient has Type 1 Gaucher disease. Patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.

**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, inflammatory myofibroblastic tumors, non-small cell lung cancer (NSCLC) with ROS1-positive tumors.

**Exclusion Criteria**

**Required Medical Information**

For NSCLC, the tumor is ROS1- or ALK-positive. For IMT, the tumor is ALK-positive.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

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**Prior Authorization Group**

**Drug Names**

**Covered Uses**

Combination therapy with a potent immunosuppressant such as azathioprine or cyclosporine.

**Exclusion Criteria**

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 moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response to a self-injectable tumor necrosis factor (TNF) inhibitor (eg, Cimzia, Enbrel, Humira or Simponi), OR 2) Intolerance or contraindication to a self-injectable TNF inhibitor.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

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**Prior Authorization Group**

**Drug Names**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, chronic tics associated with Tourette's syndrome, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.

**Exclusion Criteria**

Patients who are actively suicidal or have untreated or inadequately treated depression.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

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**Prior Authorization Group**

**Drug Names**

**Covered Uses**

XEOMIN

**Required Medical Information**
**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, Upper limb spasticity related to stroke.

**Exclusion Criteria**

Cosmetic use.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

**Prior Authorization Group**

XGEVA

**Drug Names**

XGEVA

**Covered Uses**

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

**Exclusion Criteria**

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.

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

Plan Year

**Other Criteria**

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.

**Prior Authorization Group**

XIFAXAN

**Drug Names**

XIFAXAN

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D, Irritable Bowel Syndrome without constipation.

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

18 years of age or older for reduction in risk of overt hepatic encephalopathy (HE) recurrence.

**Prescriber Restrictions**

**Coverage Duration**

Reduction in risk of overt HE recurrence - 6 mos, IBS w/o constipation -3 mos

**Other Criteria**

**Prior Authorization Group**

XOLAIR

**Drug Names**

XOLAIR

**Covered Uses**

All FDA-approved indications not otherwise excluded from Part D.
**Required Medical Information**

For allergic asthma, Xolair will be used in combination with other medications for long-term control of asthma. Patient will have a rapid-acting beta2-agonist available for rescue therapy. For initial therapy, must meet ALL of the following criteria: 1) has a diagnosis of moderate to severe persistent asthma, 2) has positive skin test (or blood test) to at least 1 perennial aeroallergen, 3) 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 optimizing the use of a long-acting inhaled beta2-agonist, leukotriene modifier, or theophylline at the optimal dose. For continuation therapy, patient must have improved asthma control while on Xolair. For chronic idiopathic urticaria, patient initiating Xolair therapy must meet ALL of the following criteria: 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 therapy, patient's symptom has been improved with Xolair treatment. 12 years of age or older.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

Xolair will be administered in a controlled healthcare setting with access to emergency medications (e.g., anaphylaxis kit).

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

Plan Year

Patient must have metastatic prostate cancer and meet one of the following: 1) cancer is castration-resistant OR 2) Xtandi is being used to enhance the effectiveness of radiation therapy in combination with ADT OR 3) patient is ADT naive and is at risk of developing symptoms associated with androgen flare and Xtandi will be used in combination with ADT.

**Age Restrictions**

**Prescriber Restrictions**

**Coverage Duration**

**Other Criteria**

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

**Exclusion Criteria**

**Required Medical Information**

For the treatment of cataplexy or excessive daytime sleepiness in a patient with narcolepsy.

**Age Restrictions**

**Prescriber Restrictions**

Updated 01/01/2015
Coverage Duration: Plan Year
Other Criteria: If the request is for the continuation of Xyrem, the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

Prior Authorization Group: ZAVESCA
Drug Names: ZAVESCA
Covered Uses: All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria: 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 (eg, due to constraints such as allergy, hypersensitivity, or poor venous access). Age Restrictions: 18 years of age or older.

Prior Authorization Group: ZELBORAF
Drug Names: ZELBORAF
Covered Uses: All FDA-approved indications not otherwise excluded from Part D, melanoma with BRAF V600K mutation.
Exclusion Criteria: Patient has a diagnosis of melanoma AND the tumor is positive for either BRAF V600E or V600K mutation.
Age Restrictions: 

Prior Authorization Group: ZOLINZA
Drug Names: ZOLINZA
Covered Uses: All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, multiple myeloma.
Exclusion Criteria: For multiple myeloma: Zolinza will be used as salvage therapy in combination with bortezomib (Velcade)
Age Restrictions: 

Prior Authorization Group: ZORBTIVE
<table>
<thead>
<tr>
<th>Drug Names</th>
<th>ZORBTIVE</th>
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<tbody>
<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. Patient has received more than 8 weeks of Zorbtive therapy.</td>
</tr>
<tr>
<td>Required Medical Information</td>
<td>Diagnosis of short bowel syndrome (SBS).</td>
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<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 SBS.</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Prior Authorization Group</th>
<th>ZYKADIA</th>
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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>Patient has metastatic disease. The tumor is ALK-positive. Patient has progressed on or is intolerant to crizotinib.</td>
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<tr>
<td>Required Medical Information</td>
<td></td>
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<tr>
<th>Prior Authorization Group</th>
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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>Patient has metastatic, castration-resistant prostate cancer and Zytiga is used in combination with prednisone.</td>
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<td>Required Medical Information</td>
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