acromegaly

Drugs
SIGNIFOR, SIGNIFOR LAR, SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML, SOMAVERT

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation of Acromegaly diagnosis

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

antineoplastics

Drugs

ABRAXANE, AFINITOR, AFINITOR DISPERZ, ALIMTA INTRAVENOUS RECON SOLN 500 MG, AVASTIN, *azacitidine*, BICNU, *bleomycin injection recon soln 30 unit*, BOSULIF ORAL TABLET 100 MG, 500 MG, BUSULFEX, CAPRELSA ORAL TABLET 100 MG, 300 MG, *carboplatin intravenous solution*, *cisplatin*, *cladribine*, CLOLAR, COMETRIQ, *cyclophosphamide oral capsule*, *cytarabine*, *cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)*, *dacarbazine intravenous recon soln 200 mg*, *decitabine*, *docetaxel intravenous solution 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)*, *doxorubicin intravenous solution 50 mg/25 ml*, ELIGARD, ELIGARD (3 MONTH), ELIGARD (4 MONTH), ELIGARD (6 MONTH), EMCYT, ERIVEDGE, ERWINAZE, FARESTON, FASLODEX, FIRMAGON KIT W DILUENT SYRINGE, *fludarabine intravenous recon soln*, FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML), *gemcitabine intravenous recon soln 1 gram*, GILOTRIF, GLEEVEC, HALAVEN, HEXALEN, ICLUSIG ORAL TABLET 45 MG, *idarubicin*, *ifosfamide intravenous recon soln 1 gram*, IMBRUVICA, INLYTA ORAL TABLET 1 MG, 5 MG, INTRON A INJECTION RECON SOLN, INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML, *irinotecan intravenous solution 100 mg/5 ml*, ISTODAX, JAKAFI, JEVTANA, KADCYLA INTRAVENOUS RECON SOLN 100 MG, LUPRON DEPOT, LUPRON DEPOT (3 MONTH), LUPRON DEPOT (4 MONTH), LUPRON DEPOT (6 MONTH), LUPRON DEPOT-PED INTRAMUSCULAR KIT 15 MG, MATULANE, MEKINIST ORAL TABLET 0.5 MG, 2 MG, *melphalan hcl*, *mitoxantrone*, MUSTARGEN, NEXAVAR, *oxaliplatin intravenous solution 100 mg/20 ml*, *paclitaxel*, PANRETIN, POMALYST, PROLEUKIN, REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 25 MG, 5 MG, RITUXAN, SOLTAMOX, SPRYCEL, STIVARGA, SUTENT, SYNRIBO, TABLOID, TAFINLAR, TARCEVA ORAL TABLET 100 MG, 150 MG, 25 MG, TARGRETIN, TASIGNA, *topotecan intravenous recon soln*, TORISEL, TREANDA INTRAVENOUS RECON SOLN 100 MG, TRELSTAR INTRAMUSCULAR SYRINGE 11.25 MG/2 ML, 3.75 MG/2 ML, TRISENOX, TYKERB, VELCADE, *vinblastine intravenous solution*, VINCASAR PFS INTRAVENOUS SOLUTION 1 MG/ML, *vincristine intravenous solution 1 mg/ml*, *vinorelbine intravenous solution 50 mg/5 ml*, VOTRIENT, XALKORI ORAL CAPSULE 200 MG, XTANDI, YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML), ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML), ZANOSAR, ZELBORAF, ZOLINZA, ZORTRESS

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

N/A

asthma therapy

Drugs
XOLAIR

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

Exclusion Criteria
N/A

Required Medical Information
For use of asthma therapy: Must have documented diagnosis of asthma and must provide all pulmonary function tests from within the previous 3 months. For use of chronic idiopathic urticaria: Must have documented diagnosis of chronic idiopathic urticaria and must provide trial and failure of antihistamine treatment.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a pulmonologist, an allergist, a dermatologist or an immunologist.

Coverage Duration
1 year

Other Criteria
N/A

bone marrow transplant

Drugs
MOZOBIL

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation of proper diagnosis.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
ADCIRCA, ADEMPAS, LETAIRIS, OPSUMIT, *sildenafil oral*, TRACLEER

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

Exclusion Criteria
N/A

Required Medical Information
Must have documentation of Pulmonary Arterial Hypertension Group 1

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a Cardiologist or Pulmonologist.

Coverage Duration
1 year

Other Criteria
N/A

Drugs
CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM

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

Exclusion Criteria
N/A

Required Medical Information
Must provide current progress notes.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
CINRYZE

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

Exclusion Criteria
1. Patient is diagnosed with idiopathic angioedema or drug induced angioedema.

Required Medical Information
Must provide clinical documentation detailing diagnosis, treatment history and disease history. Verify medication is being used for prophylaxis of HAE attacks

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by or in consultation with an allergist, immunologist or hematologist.

Coverage Duration
1 year

Other Criteria
N/A

Drugs
cidofovir, *ganciclovir sodium*

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of CMV Diagnosis.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

copd therapy

Drugs
DALIRESP

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

Exclusion Criteria
N/A

Required Medical Information
Must have documented diagnosis of COPD.

Age Restriction
N/A

Prescriber Restriction
Must have be prescribed by a pulmonologist.

Coverage Duration
1 year

Other Criteria
N/A

daklinza

Drugs
DAKLINZA ORAL TABLET 30 MG, 60 MG

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

Exclusion Criteria
N/A

Required Medical Information
Criteria will be applied consistent with current AASLD-IDSA guidance.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a gastroenterologist, Infectious Disease specialist or Hepatologist.

Coverage Duration
1 year

Other Criteria
N/A

desmopressin

Drugs
desmopressin injection

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of Hemophilia A with Factor VIII coagulant level greater than 5% or Von Willebrands Disease Type 1

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
EXJADE, FERRIPROX ORAL TABLET

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of trial and failure of Desferal.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by Hematologist.

Coverage Duration
1 year

Other Criteria
N/A

Drugs
CARBAGLU, CYSTAGON, ESBRIET ORAL CAPSULE, FARYDAK, HETLIOZ, JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 5 MG, KYNAMRO, LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1/DAY), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), NORTHERA, NOVAREL INTRAMUSCULAR RECON SOLN 10,000 UNIT, PREGNYL, RAVICTI, SIRTURO, VPRIV

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

fentanyl

Drugs
fentanyl citrate, LAZANDA NASAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 400 MCG/SPRAY

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation detailing diagnosis of Cancer and trial/failure of Fentanyl patches.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
FIRAZYR

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

Exclusion Criteria
1. Medication is being used for prophylaxis of HAE attacks. 2. Patient is diagnosed with idiopathic angioedema or drug induced angioedema.

Required Medical Information
Must provide clinical documentation detailing diagnosis, treatment history and disease history.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by or in consultation with an allergist, immunologist or hematologist.

Coverage Duration
1 year

Other Criteria
N/A

forteo

Drugs
FORTEO

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

Exclusion Criteria
Cannot be used for longer than 2 years

Required Medical Information
Must provide clinical documentation detailing the diagnosis and treatment history, documented trial and failure or intolerance to oral biphosphonates and injectable biphosphonates (including date range of therapy), BMD results confirming T-score of -2.5 or less.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

growth deficiency

Drugs
INCRELEX, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR 10 MG/2 ML (5 MG/ML), 5 MG/2 ML (2.5 MG/ML)

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation of Primary Growth Deficiency diagnosis

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
HARVONI

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

Exclusion Criteria
1. Autoimmune hepatitis 2. Request is for greater than 24 weeks of therapy

Required Medical Information
Documented diagnosis of Genotype 1a, 1b, 4, 5, or 6 infection, lab report documenting viral load, detailed medical history of previous treatment.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a gastroenterologist, hepatologist, or infectious disease specialist

Coverage Duration
1 year

Other Criteria
N/A

hepatitis c

Drugs
PEGASYS SUBCUTANEOUS SOLUTION, REBETOL ORAL SOLUTION, RIBASPHERE ORAL TABLET 400 MG, 600 MG, *ribavirin oral capsule*, *ribavirin oral tablet 200 mg*

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of Hepatitis C. Documentation of appropriate genotype.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

invega

Drugs
INVEGA SUSTENNA, INVEGA TRINZA

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

Exclusion Criteria
1. Member is not receiving concomitant treatment with Carbamazepine. 2. Members over 65 with dementia and psychosis.

Required Medical Information
Must provide clinical documentation detailing diagnosis and treatment history, documented trial and failure of Risperdal and Zyprexa or Geodon.

Age Restriction
Must be 18 years or older.

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

iv antibiotics

Drugs
CUBICIN, DORIBAX INTRAVENOUS RECON SOLN 500 MG, *imipenem-cilastatin*, *piperacillin-tazobactam intravenous recon soln 3.375 gram, 4.5 gram*

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

Exclusion Criteria
N/A

Required Medical Information
Current Culture and Sensitivity to support the use of the requested antibiotic and excludes use of non restricted antibiotics. Documentation of failure or rationale documenting why non-restricted antibiotics cannot be used. Must add current progress notes.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by an Infectious Disease Specialist.

Coverage Duration
1 year

Other Criteria
N/A

iv antifungal

Drugs
ABELCET, AMBISOME, CANCIDAS, *fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml*, *voriconazole intravenous*

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

Exclusion Criteria
N/A

Required Medical Information
Current Culture and Sensitivity to support the use of the antifungal medication. Documentation of failure or rationale documenting why non-restricted antifungals cannot be used. Must add current progress notes.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

juxtapid

Drugs
JUXTAPID ORAL CAPSULE 30 MG, 40 MG, 60 MG

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by hematologist, oncologist, cardiologist, endocrinologist or nephrologist.

Coverage Duration
1 year

Other Criteria
N/A

kineret

Drugs
KINERET

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

Exclusion Criteria
N/A

Required Medical Information
For use of Rheumatoid Arthritis: Must have documented diagnosis of Rheumatoid Arthritis and must provide documentation of failed intolerance to Methotrexate and Humira. For use of Cryopyrin-Associated Periodic Syndromes (CAPS): Must have documented diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS).

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
KORLYM

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

Exclusion Criteria
1. Member has type 2 diabetes mellitus unreleated to Endogenours Cushings Syndrome. 2. Member is diagnosed with exogenous or iatrogenic Cushings syndrome. 3. Drug is being used to treat psychotic features of psychotic depression. 4. Drug is being used primarily for hypertension.

Required Medical Information
N/A

Age Restriction
Must be 18 years or older.

Prescriber Restriction
Must be prescribed by or in consultation with an endocrinologist.

Coverage Duration
1 year

Other Criteria
N/A

kuvan

Drugs
KUVAN ORAL TABLET,SOLUBLE

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

Exclusion Criteria
N/A

Required Medical Information
Must have documentation of PKU

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

leukine

Drugs
LEUKINE INJECTION RECON SOLN

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

leuprolide

Drugs
leuprolide subcutaneous kit

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

Exclusion Criteria
N/A

Required Medical Information
Must provide current progress notes.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

lidoderm

Drugs
lidocaine topical adhesive patch,medicated

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation of diagnosis of postherpetic neuralgia.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

lumizyme

Drugs
LUMIZYME

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

Exclusion Criteria
N/A

Required Medical Information
Confirmed diagnosis of Pompe's disease.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

lung enzyme therapy

Drugs
PROLASTIN-C, ZEMAIRA

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

Exclusion Criteria
N/A

Required Medical Information
Clinically documented alpha-1 antitrypsin deficiency. Clinical evidence of emphysema. PiZZ, PiZ() or Pi(,) phenotype (homozygous) alpha 1-antitrypsin deficiency or other phenotypes associated with serum alpha 1-antitrypsin concentrations less than 80 mg/dl. Serum alpha 1-antitrypsin (ATT) greater than 80mg/dl (35% of normal). Progressive panacinar emphysema with documented rate of decline in FEV1.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a pulmonologist.

Coverage Duration
1 year

Other Criteria
N/A

lupus

Drugs
BENLYSTA INTRAVENOUS RECON SOLN 120 MG

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of diagnosis.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a rheumatologist.

Coverage Duration
1 year

Other Criteria
N/A

Drugs
MULTAQ

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

Exclusion Criteria
Patients with NYHA Class IV heart failure or NYHA Class II - III heart failure with a recent decompensation requiring hospitalization or referral to a specialized heart failure clinic. Second- or third- degree atrioventicular (AV) block or sick sinus syndrome

Required Medical Information
Must provide clinical documentation of proper diagnosis.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

narcolepsy

Drugs
modafinil

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation detailing the diagnosis of Narcolepsy, Shift Work Sleep Disorder , or obstructive sleep apnea. If for Narcolepsy, must show trial and failure to at least one formulary/preferred agent, such as Methylphenidate or dextroamphetamine, or rationale as to why these agents cannot be used. Must provide clinical documentation indicating the use to improve wakefulness in patients with excessive sleepiness associated with obstructive sleep apnea.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a Sleep specialist, Neurologist or Pulmonary specialist.

Coverage Duration
1 year

Other Criteria
N/A

neutropenic

Drugs
NEULASTA SUBCUTANEOUS SYRINGE, NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML, NEUPOGEN INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML

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

Exclusion Criteria
N/A

Required Medical Information
Labs must be submitted that support the diagnosis of neutropenia.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

nuedexta

Drugs
NUEDEXTA

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

Exclusion Criteria
N/A

Required Medical Information
Documented diagnosis of pseudobulbar affect (PBA).

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
NULOJIX

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation of a new kidney transplant, patient must be Epstein-Barr virus seropositive

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a physician experienced in immunosuppresive therapy and management of kidney transplant patients

Coverage Duration
1 year

Other Criteria
N/A

octreotide

Drugs
octreotide acetate injection solution 1,000 mcg/ml

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

Exclusion Criteria
N/A

Required Medical Information
Must provide current progress notes.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

oral antibiotics

Drugs
linezolid oral suspension for reconstitution, *linezolid oral tablet*, ZYVOX ORAL SUSPENSION FOR RECONSTITUTION

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

Exclusion Criteria
N/A

Required Medical Information
Current Culture and Sensitivity to support the use of the requested antibiotic and excludes use of non restricted antibiotics. Documentation of failure or rationale documenting why non-restricted oral antibiotics cannot be used. Must add current progress notes

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by an Infectious Disease Specialist.

Coverage Duration
1 year

Other Criteria
N/A

osteoporosis

Drugs
PROLIA, XGEVA, *zoledronic acid intravenous solution*, *zoledronic acid-mannitol-water*

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

Exclusion Criteria
N/A

Required Medical Information
Must have labs and bone density scan submitted to establish proper diagnosis.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
REPATHA SURECLICK, REPATHA SYRINGE

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

Exclusion Criteria
N/A

Required Medical Information
Repatha: Must provide clinical documentation of primary heterozygous familial hypercholesterolemia in combination with a statin or primary hypercholesterolemia in combination with a statin or homozygous familial hypercholesterolemia, or provide clinical documentation indicating a contraindication or intolerance to statin therapy.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a Gastroenterologist, Infectious Disease specialist, Cardiologist, Endocrinologist or Hepatologist.

Coverage Duration
1 year

Other Criteria
N/A

photochemotherapy

Drugs
methoxsalen, OXSORALEN ULTRA

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
PICATO

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation detailing the diagnosis and treatment history, documented trial and failure of Fluorouracil or Imiquimod.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
PROMACTA

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

Exclusion Criteria
N/A

Required Medical Information
Must provide current progress notes.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
RANEXA

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of angina with documentation of failure of nitrocglycerin.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
RISPERDAL CONSTA, RISPERDAL M-TAB

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation detailing the diagnosis and treatment history, documented trial and failure or inability to use oral antipsychotic agents.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
SABRIL

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation of refractory complex partial seizures or infantile spasms, documented trial and failure of 2 other anticonvulsant agents, baseline eye exam.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a specialist in the neurology field of study.

Coverage Duration
1 year

Other Criteria
N/A

Drugs
SOVALDI

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

Exclusion Criteria
1. Autoimmune hepatitis.

Required Medical Information
Criteria will be applied consistent with current AASLD-IDSA guidance.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a gastroenterologist, Infectious Disease specialist or Hepatologist.

Coverage Duration
1 year

Other Criteria
N/A

Drugs
SYMLINPEN 120, SYMLINPEN 60

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of Type II diabetes HbA1c greater than 7%. Failure to reach HbA1c goal with maximum dose of metformin (1,500mg/day) or TZD (pioglitazone at 45mg/day, rosiglitazone at 8mg/day), for at least 90 days over the past 120 days or Diagnosis of Type I diabetes who have failed to achieve desired glucose control despite optimal insulin therapy, or intolerance to the aforementioned therapies.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

synagis

Drugs
SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML

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

Exclusion Criteria
1. Patient has hemodynamically insignificant heart disease (eg. Secundum atrialseptal defect, small ventricular septal defect, pullmonic stenosis, uncomplicatedaortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus). Must provide clinical documentation of proper diagnosis.

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
TECHNIVIE

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

Exclusion Criteria
N/A

Required Medical Information
Criteria will be applied consistent with current AASLD-IDSA guidance.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a gastroenterologist, Infectious Disease specialist or Hepatologist.

Coverage Duration
1 year

Other Criteria
N/A

thalomid

Drugs
THALOMID

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation of proper diagnosis.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
ENBREL, ENBREL SURECLICK, HUMIRA, HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, HUMIRA PEN, HUMIRA PEN CROHN'S-UC-HS START, HUMIRA PEN PSORIASIS-UVEITIS, ORENCIA (WITH MALTOSE), ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML, REMICADE, SIMPONI SUBCUTANEOUS SYRINGE

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation of proper diagnosis.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by a dermatologist, ophthalmologist, gastroenterologist or rheumatologist.

Coverage Duration
1 year

Other Criteria
N/A

Drugs
tobramycin in 0.225 % nacl

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation of Cystic Fibrosis diagnosis

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
XENAZINE

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation of Huntingtons Disease diagnosis

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

Drugs
ZYTIGA ORAL TABLET 250 MG

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

Exclusion Criteria
N/A

Required Medical Information
Must provide clinical documentation of proper diagnosis.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A