acromegaly

Drugs
SIGNIFOR, SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML, SOMAVERT SUBCUTANEOUS RECON SOLN 15 MG, 20 MG, 25 MG, 30 MG

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

actimmune

Drugs
ACTIMMUNE

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
benztropine oral, *carisoprodol oral tablet 350 mg*, *cyclobenzaprine oral tablet*, *dexmethylphenidate oral capsule,er biphasic 50-50 15 mg, 30 mg, 40 mg*, *dexmethylphenidate oral tablet*, *estradiol oral*, *estradiol transdermal patch weekly*, *hydroxyzine hcl oral solution 10 mg/5 ml*, *hydroxyzine hcl oral tablet*, *hydroxyzine pamoate*, *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml*, *megestrol oral tablet*, MENOSTAR, *methocarbamol oral*, *orphenadrine citrate oral*, *promethazine oral*, *promethazine rectal suppository 12.5 mg, 25 mg*, *thioridazine*

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
Must be under the age of 65 unless there is documented proof that the benefit outweighs the risk.

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

alecensa

Drugs
ALECENSA

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

Exclusion Criteria

Required Medical Information
For NSCLC, patient meets all of the following: 1) Tumor is ALK-positive, and 2) Disease is recurrent or metastatic.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
AFINITOR, AFINITOR DISPERZ, BOSULIF ORAL TABLET 100 MG, 500 MG, CAPRELSA ORAL TABLET 100 MG, 300 MG, COMETRIQ, *cyclophosphamide oral capsule*, ELIGARD, ELIGARD (3 MONTH), ELIGARD (4 MONTH), ELIGARD (6 MONTH), ERIVEDGE, ERLEADA, FARESTON, FIRMAGON KIT W DILUENT SYRINGE, GILOTRIF, HEXALEN, ICLUSIG ORAL TABLET 45 MG, IMBRUVICA ORAL CAPSULE, IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG, INLYTA ORAL TABLET 1 MG, 5 MG, INTRON A INJECTION, JAKAFI, LUPRON DEPOT, LUPRON DEPOT (3 MONTH), LUPRON DEPOT (4 MONTH), LUPRON DEPOT (6 MONTH), MATULANE, MEKINIST ORAL TABLET 0.5 MG, 2 MG, NEXAVAR, PANRETIN, POMALYST, REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 25 MG, 5 MG, SOLTAMOX, SPRYCEL, STIVARGA, SUTENT, SYNRIBO, TABLOID, TAFINLAR, TARCEVA ORAL TABLET 100 MG, 150 MG, 25 MG, TARGRETIN, TASIGNA, TRELSTAR INTRAMUSCULAR SYRINGE 11.25 MG/2 ML, 3.75 MG/2 ML, TYKERB, VOTRIENT, XALKORI ORAL CAPSULE 200 MG, XTANDI, ZELBORAF, ZOLINZA

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

aralast np

Drugs
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG

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

Exclusion Criteria

Required Medical Information
Patients must have clinically evident emphysema. Patients must have a alpha 1 antitrypsin deficiency.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

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

Drugs
BANZEL

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

Exclusion Criteria

Required Medical Information
Adjunctive treatment of seizures associated with Lennox-Gastaut syndrome in adults and pediatric patients 1 year and older.

Age Restriction
1 year and older

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

bexarotene

Drugs
bexarotene

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
CABOMETYX

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

cardiovascular therapy agents pulmonary arterial hypertensive agents

Drugs
ADCIRCA, ADEMPAS, CIALIS ORAL TABLET 2.5 MG, 5 MG, LETAIRIS, OPSUMIT, REVATIO ORAL, *sildenafil (antihypertensive) oral*, TRACLEER ORAL TABLET, UPTRAVI

Covered Uses
All medically accepted indications not otherwise excluded from Part D. All medically-accepted 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
N/A

Coverage Duration
1 year

Other Criteria
N/A

carimune

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
CAYSTON

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

Exclusion Criteria

Required Medical Information
The diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Pseudomonas aeruginosa is present in the cultures of the airway.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
CERDELGA

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

Exclusion Criteria

Required Medical Information
Chronic type 1 Gaucher disease in patients who have undergone genetic testing and been proven to be extensive, intermediate, or poor CYP2D6 metabolizers

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
CIMZIA, CIMZIA POWDER FOR RECONST

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

Exclusion Criteria
N/A

Required Medical Information
Coverage will be provided for the indication of reducing signs and symptoms of Crohn's disease and maintaining clinical response in adult patients with moderately to severe active disease who had inadequate response to conventional therapy.1) treatment with adequate course of systemic corticosteroids has been ineffective, contraindicated, patient has been unable to taper, or is experiencing breakthrough disease while stabilized on an immunomodulatory medication for at least two months and, 2) patient has had previous trial of adalimumab (Humira®). Coverage is provided for the diagnosis of moderate to severe rheumatoid arthritis, psoriatic arthritis, and ankylosing spondylitis when there has been the trial of adalimumab (Humira®) and etanercept (Enbrel®).

Age Restriction
18 years or older

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

copd therapy

Drugs
DALIRESP ORAL TABLET 500 MCG

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

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

diastat

Drugs
diazepam intensol

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.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

doxepin hcl

Drugs
doxepin oral

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

Exclusion Criteria

Required Medical Information

Age Restriction
Must be under the age of 65 unless there is documented proof that the benefit outweighs the risk.

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

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
AURYXIA, *buprenorphine hcl sublingual*, CARBAGLU, CYSTAGON, DOPTELET, 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), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), *miglustat*, NORTHERA, RAVICTI, SIRTURO, YONSA

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

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

fycompa

Drugs
FYCOMPA ORAL SUSPENSION, FYCOMPA ORAL TABLET

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

Exclusion Criteria

Required Medical Information

Age Restriction
12 years of age or older

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

glassia

Drugs

GLASSIA

Covered Uses

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

Exclusion Criteria

Required Medical Information

Patients must have clinically evident emphysema. Patients must have a alpha 1 antitrypsin deficiency.

Age Restriction

Prescriber Restriction

Coverage Duration

1 year

Other Criteria

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

harvoni

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

Drugs
EPCLUSA, MAVYRET, 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

ibrance

Drugs
IBRANCE, KISQALI, KISQALI FEMARA CO-PACK, VERZENIO

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

imatinib mesylate

Drugs
imatinib

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

iressa

Drugs
IRESSA

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

Exclusion Criteria

Required Medical Information
Metastatic non-small cell lung cancer (NSCLC) with tumors that have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

iv antibiotics

Drugs
imipenem-cilastatin

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, *caspofungin*, *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

Drugs
KALYDECO

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, Genetic testing.

Age Restriction
Must be 2 years or older.

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

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

Drugs
LONSURF

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

Exclusion Criteria

Required Medical Information
Metastatic colorectal cancer, Previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based regimens, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

lung enzyme therapy

Drugs
PROLASTIN-C INTRAVENOUS RECON SOLN, ZEMAIRA

Covered Uses
All medically accepted indications not otherwise excluded from Part D. All medically-accepted 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 a pulmonologist.

Coverage Duration
1 year

Other Criteria
N/A

lynparza

Drugs
LYNPARZA

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
AMPYRA, AVONEX (WITH ALBUMIN), AVONEX INTRAMUSCULAR PEN INJECTOR KIT, BETASERON SUBCUTANEOUS KIT, EXTAVIA SUBCUTANEOUS KIT, GILENYA ORAL CAPSULE 0.5 MG, *glatiramer*, GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML, REBIF (WITH ALBUMIN)

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

Exclusion Criteria
N/A

Required Medical Information
Must have documentation of multiple sclerosis diagnosis.

Age Restriction
N/A

Prescriber Restriction
Must be prescribed by neurologist or gastroenterologist.

Coverage Duration
1 year

Other Criteria
N/A

narcolepsy

Drugs
armodafinil, *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

natpara

Drugs
NATPARA

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of hypocalcemia in patients with hypoparathyroidism.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

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

ninlaro

Drugs
NINLARO

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

Exclusion Criteria

Required Medical Information
Multiple myeloma, in combination with lenalidomide and dexamethasone in patients who have received at least 1 prior therapy

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

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
NUPLAZID ORAL TABLET 17 MG

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

Exclusion Criteria

Required Medical Information
Dementia-related psychosis that is unrelated to the hallucinations and delusions associated with Parkinson's disease psychosis. The diagnosis of Parkinson's disease was made prior to the onset of psychotic symptoms.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

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

Drugs
OFEV

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

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

Drugs
ORENCIA

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

Exclusion Criteria

Required Medical Information
For diagnosis of psoriatic arthritis, rheumatoid arthritis or juvenile arthritis when there has been a trial of adalimumab (Humira®) or etanercept (Enbrel®).

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
ORKAMBI ORAL TABLET

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

Exclusion Criteria
Orkambi will not be used in combination with Kalydeco.

Required Medical Information
The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene.

Age Restriction
2 years of age or older

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

osteoporosis

Drugs
PROLIA, XGEVA

Covered Uses
All medically accepted indications not otherwise excluded from Part D. All medically-accepted 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
OTEZLA, OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)

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

Exclusion Criteria

Required Medical Information
Coverage is provided for the diagnosis of psoriatic arthritis when there has been trial of: 1. An oral DMARD and 2. A preferred biologic such as etanercept (Enbrel®) or adalimumab (Humira®). Coverage is also provided for the diagnosis of moderate to severe plaque psoriasis in patients who are candidates for phototherapy or systemic therapy when there has been a trial of etanercept (Enbrel®) or adalimumab (Humira®).

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

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

phenobarbital

Drugs
phenobarbital

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

Exclusion Criteria

Required Medical Information

Age Restriction
Must be under the age of 65 unless there is documented proof that the benefit outweighs the risk.

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

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
PRALUENT PEN

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 heterozygous familial hypercholesterolemia in combination with a statin or primary hypercholesterolemia in combination with a statin (in patients with atherosclerotic cardiovascular disease) 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

promacta

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

rebif rebidose

Drugs
REBIF REBIDOSE

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
RELISTOR ORAL, RELISTOR SUBCUTANEOUS SOLUTION, RELISTOR SUBCUTANEOUS SYRINGE

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

Exclusion Criteria

Required Medical Information
1)The requested drug is being prescribed for opioid-induced constipationin an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care OR 2) The requested drug is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried. (Note: Examples are Amitiza or Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: Examples are Amitiza or Movantik) OR 6)The patient has a contraindication to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: Examples are Amitiza or Movantik).

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

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

symlin

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

Drugs
TAGRISSO

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

technivie

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

tetrabenazine

Drugs
tetrabenazine oral tablet 12.5 mg, 25 mg

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

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, HUMIRA PEN, HUMIRA PEN CROHN'S-UC-HS START, HUMIRA PEN PSORIASIS-UVEITIS, 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

tretinoin

Drugs
tretinoin

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
UPTRAVI

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

Exclusion Criteria

Required Medical Information
PAH: Pulmonary Arterial Hypertension (PAH) (WHO Group 1)

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

valchlor

Drugs
VALCHLOR

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
VRAYLAR

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

Exclusion Criteria

Required Medical Information
The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: Latuda, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
XELJANZ, XELJANZ XR

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

Exclusion Criteria

Required Medical Information
For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), or 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab). For active psoriatic arthritis (new starts only): Patient meets BOTH of the following criteria: 1)Inadequate response to methotrexate (MTX) or other nonbiologicdisease-modifying antirheumatic drugs (DMARDs) (e.g., leflunomide, sulfasalazine, etc.) OR a prior biologic DMARD (e.g., adalimumab), and 2)Xeljanz/Xeljanz XR is used in combination with a nonbiologicDMARD (e.g., methotrexate, leflunomide, sulfasalazine, etc.)

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

xyrem

Drugs
XYREM

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

Exclusion Criteria
Coverage is not provided for patients taking sedative hypnotics or in patients with succinic semialdehyde dehydrogenase deficiency.

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
ZAVESCA

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

Exclusion Criteria

Required Medical Information
Mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option (eg, because of allergy, hypersensitivity, or poor venous access)

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

zydelig

Drugs
ZYDELIG

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
ZYKADIA

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

Exclusion Criteria

Required Medical Information
Anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor. For NSCLC, patient meets all of the following: 1) Tumor is ALK-positive, and 2) Disease is recurrent or metastatic

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
ZYTIGA

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

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