You may need prior authorization for certain drugs that are on the formulary or drugs that are not on the formulary. Below is a drug that requires prior authorization with the prior authorization requirements.
MEDICATION(S)
ADEMPAS

COVERED USES
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
ONE YEAR

OTHER CRITERIA
For chronic thromboembolic pulmonary hypertension, must be in World Health Organization Group 4. For pulmonary arterial hypertension, must be in World Health Organization Group 1, and patients not previously treated for pulmonary arterial hypertension must first try sildenafil (generic Revatio).
AMITIZA

MEDICATION(S)
AMITIZA

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS SUCH AS HISTORY OF MECHANICAL GASTROINTESTINAL OBSTRUCTION, OR CONSTIPATION CAUSED BY USE OF OTHER MEDICATIONS

REQUIRED MEDICAL INFORMATION
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING DIAGNOSIS OF CHRONIC IDIOPATHIC CONSTIPATION, FAILURE TO AT LEAST TWO OF THE FOLLOWING, FIBER, ANTISPASMOTICS, LATULOSE, EXERCISE, OR FLUIDS, AND GASTROENTEROLOGIST ASSESSMENT RULING OUT MECHANICAL OBSTRUCTION

AGE RESTRICTION
FOR PATIENTS 18 YEARS OF AGE AND OLDER ONLY

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
CHRONIC IDIOPATHIC CONSTIPATION IS DEFINED ON AVERAGE AS LESS THAN 3 SEVERE BOWEL MOVEMENTS PER WEEK WITH ONE OR MORE OF THE FOLLOWING 1 VERY HARD STOOLS FOR AT LEAST QUARTER OF ALL BOWEL MOVEMENTS, 2 SENSATION OF INCOMPLETE EVALUATION FOLLOWING AT LEAST A QUARTER OF ALL BOWEL MOVEMENT, AND 3 STRAINING WITH DEFCATION AT LEAST A QUARTER OF THE TIME
MEDICATION(S)
STRENSIQ

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
12 months

OTHER CRITERIA
Regularly scheduled follow-up visits with prescribing physician (e.g., should have a plan to monitor for ectopic calcifications and other long term adverse reactions to therapy).
MEDICATION(S)
CARBAGLU

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

EXCLUSION CRITERIA
NONE

REQUIRED MEDICAL INFORMATION
Clinically diagnosed with hyperammonemia due to N-acetylglutamate synthase (NAG) deficiency.

AGE RESTRICTION
NONE

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
CHANTIX

MEDICATION(S)
CHANTIX

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

REQUIRED MEDICAL INFORMATION
MEDICAL RECORDS SUPPORTING COVERED USE. DOCUMENTING PRIOR USE OF BUPROPION

AGE RESTRICTION
FOR PATIENTS 18 YEARS OF AGE OR OLDER ONLY

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
24 WEEKS

OTHER CRITERIA
SPECIAL CONSIDERATIONS-PREGNANCY CATEGORY C, SAFETY AND EFFICACY IN CHILDREN AND ADOLESCENTS LESS THAN 18 YEARS OF AGE HAS NOT BEEN ESTABLISHED, CAUTION IN PATIENTS WITH RENAL DISEASE, IMPAIRMENT OR FAILURE
MEDICATION(S)
CRINONE 8% GEL

COVERED USES
All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Known hypersensitivity or contraindication to active or inactive ingredients

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
For the treatment of secondary amenorrhea.
**MEDICATION(S)**
DESOXYN, METHAMPHETAMINE HCL

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D

**EXCLUSION CRITERIA**
Known hypersensitivity or contraindication to active or inactive ingredients

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
For the treatment of attention deficit disorder with hyperactivity
MEDICATION(S)
ENTRESTO

COVERED USES
All FDA-approved indications not otherwise excluded from Part D. To reduce the risk of cardiovascular death and hospitalization for heart failure in patients with chronic heart failure (NYHA Class II-IV) and reduced ejection fraction. Used in place of an ACE inhibitor or ARB.

EXCLUSION CRITERIA
Known hypersensitivity or contraindication to active or inactive ingredients

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Reduced ejection fraction (left ventricular ejection fraction less than or equal to 40%)
EVOLOCUMAB

MEDICATION(S)
REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

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

EXCLUSION CRITERIA
Known hypersensitivity or contraindication to active or inactive ingredients

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Adjunct to maximally tolerated statin therapy (which includes zero tolerance to statin therapy) for the treatment of adults with heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease. Adjunct to other LDL-lowering therapies (e.g. statins, ezetimibe) for the treatment of patients with homozygous familial hypercholesterolemia.
MEDICATION(S)
EXONDYS 51

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

EXCLUSION CRITERIA
Known hypersensitivity or contraindication to active or inactive ingredients.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Diagnosis of Duchenne muscular dystrophy (DMD) and a confirmed mutation of the DMD gene that is amenable exon 51 skipping.
MEDICATION(S)
FORTEO

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

REQUIRED MEDICAL INFORMATION
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING FAILURE ON TWO PART D DRUGS USED TO TREAT OSTEOPOROSIS, AND BONE SCAN RESULTS

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
GATTEX

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
NONE

REQUIRED MEDICAL INFORMATION
NONE

AGE RESTRICTION
FOR PATIENTS 18 YEARS OF AGE AND OLDER ONLY

PRESCRIBER RESTRICTION
PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
GROWTH HORMONES

MEDICATION(S)
GENOTROPIN, HUMATROPE 12 MG CARTRIDGE, HUMATROPE 24 MG CARTRIDGE, NORDITROPIN FLEXPRO, NORDITROPIN NORDIFLEX 30 MG/3, NORDITROPIN NORDIFLEX 5 MG/1.5, NORDITROPIN NORDIFLX 15 MG/1.5, NUTROPIN AQ 20 MG/2ML PEN CART, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN, SEROSTIM 4 MG VIAL, SEROSTIM 5 MG VIAL, SEROSTIM 6 MG VIAL, ZOMACTON, ZORBIVE

COVERED USES
All FDA-approved indications not otherwise excluded from Part D. Somatropin products, except Serostim and Zorbtive, are all covered for Growth hormone deficiency (GHD), idiopathic short stature (ISS), Chronic Kidney disease (CKD) in children or adolescents, Noonan Syndrome in children/adolescents, Prader-Willi Syndrome (PW), SHOX deficiency in children/adolescents, Children born small for gestational age (SGA), and Turner's Syndrome (TS) in girls. All Somatropin products except Serostim is covered for Short Bowel Syndrome (SBS).

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
ISS - 6 mos intial, 12 months cont tx, SBS 4 weeks, HIV 24 weeks, others 12 mos

OTHER CRITERIA
None
HIGH RISK MEDICATIONS- BENZODIAZEPINES

MEDICATION(S)
ALPRAZOLAM 0.25 MG TABLET, ALPRAZOLAM 0.5 MG TABLET, ALPRAZOLAM 1 MG TABLET,
ALPRAZOLAM 2 MG TABLET, ALPRAZOLAM ER, ALPRAZOLAM INTENSOL, ALPRAZOLAM ODT,
ALPRAZOLAM XR, CHLORDIAZEPoxide HCL, FLURAZEPAM HCL, LORAZEPAM 0.5 MG
TABLET, LORAZEPAM 1 MG TABLET, LORAZEPAM 2 MG TABLET, LORAZEPAM INTENSOL,
OXAZEPAM, TEMAZEPAM

COVERED USES
All FDA-approved indications not otherwise excluded from Part D. All medically accepted indications
not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Procedure-related sedation = 1 month, All other conditions = 12 months

OTHER CRITERIA
Insomnia, approve lorazepam, oxazepam, or temazepam if the patient has had a trial with two of the
following: ramelteon, trazodone, doxepin 3mg or 6 mg, eszopiclone, zolpidem, or zaleplon
HIGH RISK MEDICATIONS- FIRST GENERATION ANTIHISTAMINES

MEDICATION(S)
HYDROXYZINE 10 MG/5 ML SOLN, HYDROXYZINE 10 MG/5 ML SYRUP, HYDROXYZINE 50 MG/25 ML SYRUP, HYDROXYZINE HCL 10 MG TABLET, HYDROXYZINE HCL 25 MG TABLET, HYDROXYZINE HCL 50 MG TABLET, HYDROXYZINE PAM 100 MG CAP, HYDROXYZINE PAM 25 MG CAP, HYDROXYZINE PAM 50 MG CAP, PROMETHAZINE 12.5 MG TABLET, PROMETHAZINE 25 MG TABLET, PROMETHAZINE 50 MG 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
None

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Authorization will be for twelve months

OTHER CRITERIA
For promethazine tablets/syrup, authorize use without a previous drug trial for all FDA-approved indications other than emesis, including cancer/chemo-related emesis. For hydroxyzine hydrochloride tablets/syrup and hydroxyzine pamoate capsules, authorize use without a previous drug trial for all FDA-approved indications other than anxiety. For the treatment of non-cancer/chemo related emesis, approve promethazine hydrochloride tablets or syrup if the patient has tried a prescription oral anti-emetic agent (ondansetron, granisetron, dolasetron, palonosetron, aprepitant) for the current condition. Approve hydroxyzine hydrochloride (tablets and syrup) or hydroxyzine pamoate (capsules) if the patient has tried at least two other FDA-approved products for the management of anxiety (e.g. venlafaxine, duloxetine, clorazepate, Prochlorperazine, temazepam, lorazepam, diazepam).
MEDICATION(S)
AMRIX, CARISOPRODOL 250 MG TABLET, CARISOPRODOL 350 MG TABLET, CARISOPRODOL COMPOUND, CARISOPRODOL COMPOUND-CODEINE, CARISOPRODOL-ASPIRIN, CARISOPRODOL-ASPIRIN-CODEINE, CHLORZOXAZONE 500 MG TABLET, CYCLOBENZAPRINE 10 MG TABLET, CYCLOBENZAPRINE 5 MG TABLET, CYCLOBENZAPRINE 7.5 MG TABLET, METAXALONE, METHOCARBAMOL 500 MG TABLET, METHOCARBAMOL 750 MG TABLET, ORPHENADRINE ER 100 MG TABLET, Soma 250 MG TABLET

COVERED USES
All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Authorization will be for 12 months

OTHER CRITERIA
The physician has assessed risk versus benefit in using this High Risk Medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.
MEDICATION(S)
ILARIS 180 MG VIAL

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
WHEN USED IN COMBINATION WITH CONCURRENT BIOLOGIC THERAPY (E.G. TNF ANTAGONISTS ETANERCEPT, ADALIMUMAB, CERTOLIZUMAB PEGOL, GOLIMUMAB, INFliximab), ANAKINRA, OR RILONACEPT

REQUIRED MEDICAL INFORMATION
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING DIAGNOSIS OF SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA) CRYOPYRIN ASSOCIATED PERIODIC SYNDROME (CAPS), FAMILIAL COLD URTICARIA (FCAS), OR MUCKLE-WELLS SYNDROME (MWS)

AGE RESTRICTION
CAPS, 4 YEARS OF AGE AND OLDER SJIA, 2 YEARS OF AGE AND OLDER

PRESCRIBER RESTRICTION
PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, GENETICIST, IMMUNOLOGIST, OR DERMATOLOGIST

COVERAGE DURATION
3 MONTHS INITIAL, 12 MONTHS CONTINUATION OF THERAPY

OTHER CRITERIA
N/A
MEDICATION(S)
JUXTAPID

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
CONCOMITANT USE WITH MODERATE OR STRONG CYP34A INHIBITORS, MODERATE OR SEVERE (CHILD-PUGH CATEGORY B OR C), ACTIVE LIVER DISEASE (INCLUDING UNEXPLAINED PERSISTENT ELEVATIONS OF SERUM TRANSAMINASES), OR PREGNANCY.

REQUIRED MEDICAL INFORMATION
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING DIAGNOSIS OF FAMILIAL HYPERCHOLESTEROLEMIA - HOMOZYGOUS AND FAILURE OR INTOLERANCE TO ATORVASTATIN AND ROSUVASTATIN.

AGE RESTRICTION
FOR PATIENTS 18 YEARS OF AGE AND OLDER ONLY.

PRESCRIBER RESTRICTION
NONE

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
KALYDECO

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
NONE

REQUIRED MEDICAL INFORMATION
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING DIAGNOSIS OF CYSTIC FIBROSIS and confirmation that the patient has one of the following specific mutations in either CFTR gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R or R117H.

AGE RESTRICTION
NONE

PRESCRIBER RESTRICTION
PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
KORLYM

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
CONCOMITANT USE WITH SIMVASTATIN, LOVASTATIN, OR CYP3A SUBSTRATES WITH NARROW THERAPEUTIC RANGES, ENDOMETRIAL HYPERPLASIA WITH ATYPIA OR ENDOMETRIAL CARCINOMA, OR PREGNANCY

REQUIRED MEDICAL INFORMATION
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING DIAGNOSIS OF HYPERGLYCEMIA SECONDARY TO IDIOPATHIC CUSHING'S SYNDROME

AGE RESTRICTION
FOR PATIENTS 18 YEARS OF AGE AND OLDER ONLY

PRESCRIBER RESTRICTION
PRESCRIBED BY OR IN CONSULTATION WITH A ENDOCRINOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
EXCLUDE PREGNANCY PRIOR TO TREATMENT INITIATION. UNLESS PATIENT HAS HAD SURGICAL STERILIZATION, NON-HORMONAL CONTRACEPTION SHOULD BE USED DURING AND FOR ONE MONTH AFTER STOPPING TREATMENT
MEDICATION(S)
KYNAMRO

COVERED USES
All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Known hypersensitivity or contraindication to active or inactive ingredients

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Adjunct to lipid-lowering medications for the treatment of patients with homozygous familial hypercholesterolemia
MEDICATION(S)
LIDOCAINE 5% PATCH

COVERED USES
All FDA-approved indications not otherwise excluded from Part D*Plus diabetic neuropathic pain.

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
Authorization will be for 12 months

OTHER CRITERIA
None
MEDICATION(S)
ESZOPICLONE

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

REQUIRED MEDICAL INFORMATION
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING FAILURE ON AT LEAST TWO GENERIC SLEEP AGENTS (e.g., zolpidem, zaleplon), AND CLINICAL DIAGNOSES OF INSOMNIA.

AGE RESTRICTION
FOR PATIENTS 18 YEARS OF AGE AND OLDER ONLY

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SPECIAL CONSIDERATIONS-PREGNANCY CATEGORY C, ELDERLY PATIENTS MAY BE AT RISK FOR FALLS OR MENTAL STATUS CHANGES, NO DOSE ADJUSTMENT NECESSARY FOR PATIENTS WITH MILD-TO-MODERATE HEPATIC IMPAIRMENT, CAUTION IN PATIENTS WITH DEPRESSION SYMPTOMS, DOSE SHOULD BE REDUCED IN ELDERLY PATIENTS
**MEPOLIZUMAB**

**MEDICATION(S)**
NUCALA

**COVERED USES**
All FDA-approved indications not otherwise excluded from Part D. Add-on maintenance treatment of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.

**EXCLUSION CRITERIA**
Known hypersensitivity or contraindication to active or inactive ingredients. Not for the treatment of acute bronchospasm or status asthmaticus

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
Patients aged 12 years and older

**PRESCRIBER RESTRICTION**
Must be prescribed by or in consult with a pulmonologist, allergist, immunologist, or other specialist who is appropriate to prescribe Mepolizumab

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
N/A
**MEDICATION(S)**
MYTESI

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

**EXCLUSION CRITERIA**
Known hypersensitivity or contraindication to active or inactive ingredients.

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Clinical diagnosis of HIV infection. Currently being treated with anti-retroviral therapy. History of diarrhea greater than 1 month as defined by, persistently loose stools despite use of anti-diarrheal medication or one or more watery bowel movements a day.
**MEDICATION(S)**
NATPARA

**COVERED USES**
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**EXCLUSION CRITERIA**
BASELINE RISK OF OSTEOSARCOMA

**REQUIRED MEDICAL INFORMATION**
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING DIAGNOSIS OF HYPOCALCEMIA DUE TO HYPOPARATHYROIDISM AND FAILURE OR INTOLERANCE TO CALCIUM AND ACTIVE FORMS OF VITAMIN D

**AGE RESTRICTION**
FOR PATIENTS 18 YEARS OF AGE AND OLDER ONLY

**PRESCRIBER RESTRICTION**
NONE

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
CONFIRM THERE ARE SUFFICIENT 25-HYDROXYVITAMIN D STORES AND THAT SERUM CALCIUM IS GREATER THAN 7.5MG/DL BEFORE INITIATION OF THERAPY
NUVIGIL/ PROVIGIL

MEDICATION(S)
ARMODAFINIL, MODAFINIL

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
Patients must be greater than or equal to 17 years of age.

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
12 months

OTHER CRITERIA
None
MEDICATION(S)
OCALIVA

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

EXCLUSION CRITERIA
Known hypersensitivity or contraindication to active or inactive ingredients

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Clinical diagnosis of primary biliary cholangitis. Must have had a trial of a ursodeoxycholic acid or unable to tolerate ursodeoxycholic acid therapy.
MEDICATION(S)
OFEV

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
COMBINATION USE WITH PIRFENIDONE

REQUIRED MEDICAL INFORMATION
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING DIAGNOSIS OF IDIOPATHIC PULMONARY FIBROSIS

AGE RESTRICTION
FOR PATIENTS 18 YEARS OF AGE AND OLDER ONLY

PRESCRIBER RESTRICTION
PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
IPF BASELINE - MUST HAVE FVC GREATER THAN OR EQUAL TO 50 PERCENT OF THE PREDICTED VALUE AND IPF MUST BE DIAGNOSED WITH EITHER FINDINGS ON HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) INDICATING USUAL INTERSTITIAL PNEUMONIA (UIP) OR SURGICAL LUNG BIOPSY DEMONSTRATING UIP
MEDICATION(S)
OLYSIO

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 years or older

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a GI, hepatologist, ID, or a liver transplant MD

COVERAGE DURATION
12 weeks or 24 weeks depending on past medical history, cirrhosis history, and genotype.

OTHER CRITERIA
Criteria will be applied consistent with current AASLD-IDSA guidance
ORENCIA

MEDICATION(S)
ORENCIA, ORENCIA CLICKJECT

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

EXCLUSION CRITERIA
KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS.

REQUIRED MEDICAL INFORMATION
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING DIAGNOSIS OF RHEUMATOID ARTHRITIS, JUVENILE IDIOPATHIC ARTHRITIS, OR PSORIATIC ARTHRITIS WITH FAILURE OR INTOLERANCE OF HUMIRA OR ENBREL

AGE RESTRICTION
NONE

PRESCRIBER RESTRICTION
PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
**MEDICATION(S)**
ORKAMBI

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

**EXCLUSION CRITERIA**
Known hypersensitivity or contraindication to active or inactive ingredients

**REQUIRED MEDICAL INFORMATION**
N/A

**AGE RESTRICTION**
Patients aged 12 years and older

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
Clinical diagnosis of cystic fibrosis for homozygous F508del mutation in the CFTR gene.
MEDICATION(S)
A-HYDROCORT, ABELCET, ABILIFY MAINTENA ER 300 MG VL, ABRAXANE, ACETYLCYSTEINE 10% VIAL, ACETYLCYSTEINE 20% VIAL, ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML VIAL, ADAGEN, ADRUCIL, ALBUTEROL 0.083% INHAL SOLN, ALBUTEROL 15 MG/3 ML SOLUTION, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL 20 MG/4 ML SOLUTION, ALBUTEROL 5 MG/ML SOLUTION, ALBUTEROL SUL 0.63 MG/3 ML SOL, ALBUTEROL SUL 1.25 MG/3 ML SOL, ALBUTEROL SUL 2.5 MG/3 ML SOLN, ALDURAZYME, ALIMTA 500 MG VIAL, ALKERAN 50 MG VIAL, ALOXI 0.25 MG/5 ML VIAL, AMBISOME, AMINOSYN II, AMINOSYN 7%-ELECTROLYTE SOL, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-RF, AMIODARONE 150 MG/3 ML AMP, AMIODARONE 150 MG/3 ML VIAL, AMIODARONE 450 MG/9 ML VIAL, AMIODARONE 900 MG/18 ML VIAL, AMPHOTERICIN B 50 MG VIAL, ANZEMET 100 MG TABLET, ANZEMET 20 MG/ML VIAL, ANZEMET 50 MG TABLET, APOKYN, APREPITANT, ARALAST, ARALAST NP, ARANESP 10 MCG/0.4 ML SYRINGE, ARANESP 100 MCG/0.5 ML SYRINGE, ARANESP 100 MCG/ML VIAL, ARANESP 150 MCG/0.3 ML SYRINGE, ARANESP 200 MCG/0.4 ML SYRINGE, ARANESP 200 MCG/ML VIAL, ARANESP 25 MCG/0.42 ML SYRINGE, ARANESP 25 MCG/ML VIAL, ARANESP 300 MCG/0.6 ML SYRINGE, ARANESP 300 MCG/ML VIAL, ARANESP 40 MCG/0.4 ML SYRINGE, ARANESP 40 MCG/ML VIAL, ARANESP 500 MCG/1 ML SYRINGE, ARANESP 60 MCG/0.3 ML SYRINGE, ARANESP 60 MCG/ML VIAL, ARCALYST, ARIXTRA, ARRANON, ASTGRAF XL, ATGAM, AVASTIN, AVELOX IV, AVONEX, AZACITIDINE, AZASAN, AZATHIOPRINE 50 MG TABLET, AZATHIOPRINE SODIUM, BCG VACCINE (TICE STRAIN), BELEODAQ, BENLYSTA 120 MG VIAL, BETASERON, BETHKIS, BICNU, BLEOMYCIN SULFATE 30 UNIT VIAL, BONIVA 3 MG/3 ML SYRINGE, BROVANA, BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, BUSULFEX, CALCIUM FOLINATE 10 MG/ML VIAL, CANDIDAS, CAPASTAT SULFATE, CARBOPLATIN, CARIMUNE NF NANOFILTERED, CARNITOR 1 GM/5 ML VIAL, CEFUROXIME SOD 1.5 GM VIAL, CEFUROXIME SOD 750 MG VIAL, CELLCEPT, CEREZYME 400 UNITS VIAL, CESAMET, CHLORAMPHENICAL SOD SUCINNATE, CHLOROTHIAZIDE SODIUM, CIDOFOVIR 375 MG/5 ML VIAL, CINRYZE, CISPLATIN 1 MG/ML VIAL, CISPLATIN 100 MG/100 ML VIAL, CISPLATIN 200 MG/200 ML VIAL, CISPLATIN 50 MG/50 ML VIAL, CLADRIBINE, CLEOCIN 300 MG-D5W-GALAXY, CLEOCIN 600 MG-D5W-GALAXY, CLINIMIX 2.75%-5% SOLUTION, CLINIMIX 4.25%-10% SOLUTION, CLINIMIX 4.25%-20% SOLUTION, CLINIMIX 4.25%-5% SOLUTION, CLINIMIX 5%-15% SOLUTION, CLINIMIX 5%-20% SOLUTION, CLINIMIX 5%-25% SOLUTION, CLINIMIX E 2.75%-10% SOLUTION, CLINIMIX E 2.75%-5% SOLUTION, CLINIMIX E 4.25%-25% SOLUTION, CLINIMIX E 4.25%-5% SOLUTION, CLINIMIX E 5%-15% SOLUTION, CLINIMIX E 5%-20% SOLUTION, CLINIMIX E 5%-25% SOLUTION, CLOLAR, COSMEGEN, CROMOMYN 20 MG/2 ML NEB SOLN, CUBICIN, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 100 MG/ML SOLN, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE 50 MG/ML VIAL, CYCLOSPORINE 50 MG/ML VIAL, CYCLOSPORINE MODIFIED, CYRAMZA,
CYTARABINE 1 GM VIAL, CYTARABINE 2 G/20 ML VIAL, CYTARABINE 2 GM VIAL, CYTARABINE 20 MG/ML VIAL, CYTARABINE 500 MG/25 ML VIAL, CYTOVENE 500 MG VIAL, DACARBAZINE 200 MG VIAL, DACOGEN, DAPTOMYCIN, DAUNORUBICIN HCL, DECITABINE, DEPO-PROVERA 400 MG/ML VIAL, DESMOPRESSIN 40 MCG/10 ML VIAL, DESMOPRESSIN AC 4 MCG/ML AMPUL, DESMOPRESSIN AC 4 MCG/ML VIAL, DEXAMETHASONE 10 MG/ML VIAL, DEXAMETHASONE 100 MG/10 ML VIAL, DEXRAZOXANE 250 MG VIAL, DEXTROSE 10%-0.2% NACL, DEXTROSE 10%-0.45% NACL, DEXTROSE 10%-1/4NS, DEXTROSE 2.5%-0.45% NACL, DEXTROSE 5%-0.2% NACL, DEXTROSE 5%-0.2% NACL-KCL, DEXTROSE 5%-0.225% NACL, KCL 10 MEQ IN D5W-0.225% NACL, DEXTROSE 5%-0.3% NACL, DEXTROSE 5%-0.3% NACL-KCL, DEXTROSE 5%-0.33% NACL, DEXTROSE 5%-0.33% NACL-KCL, DEXTROSE 5%-0.45% NACL, DEXTROSE 5%-0.45% NACL-KCL, DEXTROSE 5%-0.9% NACL, DEXTROSE 5%-1/2NS-KCL, DEXTROSE 5%-1/3NS-KCL, DEXTROSE 5%-NS-KCL, KCL 20 MEQ IN D5W SOLUTION, KCL 40 MEQ IN D5W SOLUTION, DEXTROSE 10% AMPUL, DEXTROSE 10%-WATER IV SOLUTION, DEXTROSE 5%-WATER IV SOLUTION, DEXTROSE 5%-WATER VIII, DEXTROSE WITH SODIUM CHLORIDE, DIPHTHERIA-TETANUS TOXOIDS-PED, DIURIL SODIUM, DOCEFREZ 20 MG VIAL, DOCETAXEL 140 MG/7 ML VIAL, DOCETAXEL 160 MG/16 ML VIAL, DOCETAXEL 160 MG/8 ML VIAL, DOCETAXEL 20 MG/2 ML VIAL, DOCETAXEL 20 MG/ML VIAL, DOCETAXEL 200 MG/20 ML VIAL, DOCETAXEL 80 MG/4 ML VIAL, DOCETAXEL 80 MG/8 ML VIAL, DORIBAX 500 MG VIAL, DOXERCALCIFEROL 4 MCG/2 ML AMP, DOXERCALCIFEROL 4 MCG/2 ML VL, DOXIL, DOXORUBICIN HCL, DRONABINOL, ELAPRASE, ELIGARD, ELITEK 1.5 MG VIAL, ELLENCE, EMEND 125 MG CAPSULE, EMEND 40 MG CAPSULE, EMEND 80 MG CAPSULE, EMEND TRIPACK, EMPLICITI, ENGERIX-B, ENGERIX-B 20 MCG/ML SYRN, ENGERIX-B PEDIATRIC-ADOLESCENT, ENVARSUS XR, EPIRUBICIN 200 MG/100 ML VIAL, EPOGEN 2,000 UNITS/ML VIAL, EPOGEN 20,000 UNITS/2 ML VIAL, EPOGEN 20,000 UNITS/ML VIAL, EPOGEN 3,000 UNITS/ML VIAL, EPOGEN 4,000 UNITS/ML VIAL, ERAXIS(WATER DIL) 100 MG VIAL, ERTIBUX 100 MG/50 ML VIAL, ERWINAZE, ERYTHROCIN 500 MG ADDVNT VL, ERYTHROCIN 500 MG VIAL, ETOPOPHOS, ETOPOSIDE 1,000 MG/50 ML VIAL, ETOPOSIDE 100 MG/5 ML VIAL, ETOPOSIDE 500 MG/25 ML VIAL, FABRAZYME, FASLODEX 250 MG/5 ML SYRINGE, FLUDARABINE PHOSPHATE, FLUOROURACIL 1,000 MG/20 ML VL, FLUOROURACIL 2,500 MG/50 ML VL, FLUOROURACIL 2.5 GM/50 ML BTL, FLUOROURACIL 2.5 GM/50 ML VIAL, FLUOROURACIL 5 GM/100 ML VIAL, FLUOROURACIL 5,000 MG/100 ML, FLUOROURACIL 500 MG/10 ML VIAL, FONDAPARINUX SODIUM, FRAGMIN 10,000 UNITS/ML SYRING, FRAGMIN 12,500 UNITS/0.5 ML, FRAGMIN 15,000 UNITS/0.6 ML, FRAGMIN 18,000 UNITS/0.72 ML, FRAGMIN 2,500 UNITS/0.2 ML SYR, FRAGMIN 25,000 UNITS/ML VIAL, FRAGMIN 5,000 UNITS/0.2 ML SYR, FRAGMIN 7,500 UNITS/0.3 ML SYR, FRAGMIN 95,000 UNITS/3.8 ML VL, FUSILEV, GAMASTAN S-D VIAL, GAMMAGARD LIQUID, GAMMAGARD S-D 10 G (IGA<1) SOL, GAMMAGARD S-D 5 G (IGA<1) SOLN, GAMUNEX-C, GANCICLOVIR SODIUM, GEMCITABINE HCL 1 GRAM VIAL, GEMZAR 1 GRAM VIAL, GENGRAF, GEODON 20 MG/ML VIAL, GRANISETRON HCL, HALAVEN, HEPARIN-D5W 20,000 UNIT/500 ML, HEPARIN 20,000 UNIT/500 ML-D5W, HEPATAMINE, HERCEPTIN 440 MG VIAL, HYCAMTIN 4 MG VIAL, IBANDRONATE 3 MG/3 ML VIAL, IDARUBICIN HCL, IFEX, IFOSFAMIDE, IMIPENEM-CILASTATIN SODIUM, INCRELEX, INTRALIPID 20% IV FAT EMUL, INTRALIPID 30% IV FAT EMUL, INTRON A 10 MILLION UNITS
VIAL, INTRON A 18 MILLION UNIT/3 ML, INTRON A 18 MILLION UNITS VIAL, INTRON A 25 MILLION UNIT/2.5ML, INTRON A 50 MILLION UNITS VIAL, INVANZ 1 GM VIAL, INVEGA SUSTENNA 156 MG/ML SYRG, IPRATROPIUM BR 0.02% SOLN, IPRATROPIUM-ALBUTEROL, ISOLYTE S IV SOLUTION-EXCEL, KENALOG-10, KENALOG-40, KEPIVANCE, KEYTRUDA, LEUCOVORIN CAL 500 MG/50 ML VL, LEUCOVORIN CALCIUM 100 MG VIAL, LEUCOVORIN CALCIUM 200 MG VIAL, LEUCOVORIN CALCIUM 350 MG VIAL, LEUCOVORIN CALCIUM 50 MG VIAL, LEUCOVORIN CALCIUM 500 MG VL, LEUKINE 250 MCG VIAL, LEVALBUTEROL CONCENTRATE, LEVALBUTEROL 0.31 MG/3 ML SOL, LEVALBUTEROL 0.63 MG/3 ML SOL, LEVALBUTEROL 1.25 MG/3 ML SOL, LEVETIRACETAM 500 MG/5 ML VIAL, LEVOFLOXACIN 500 MG/20 ML VIAL, LEVOFLOXACIN 750 MG/30 ML VIAL, LEVOFLOXACIN 500 MG/100 ML-D5W, LEVOLEUCOVORIN 175 MG/17.5 ML, LEVOLEUCOVORIN 250 MG/25 ML VL, LEVOLEUCOVORIN 50 MG VIAL, LUPRON DEPOT, LUPRON DEPOT (LUPANETA), LUPRON DEPOT-PED, MAGNESIUM SULFATE 50% SYRINGE, MELPHALAN HCL, MEROPENEM IV 500 MG VIAL, MERREM IV 500 MG VIAL, MESNA, METHOTREXATE 1 GM VIAL, METHOTREXATE 1 GM/40 ML VIAL, METHOTREXATE 100 MG/4 ML VIAL, METHOTREXATE 2.5 MG TABLET, METHOTREXATE 25 MG/ML VIAL, METHOTREXATE 250 MG/10 ML VIAL, METHOTREXATE 50 MG/2 ML VIAL, METHOTREXATE SODIUM, METHYLMPREDNISOLONATE ACETATE, METHYLMPREDNISOLONE SOD SUCC, METHYLMPREDNISOLONE SS 1 GM VL, METHYLMPREDNISOLONE SS 125 MG, METHYLMPREDNISOLONE SS 40 MG VL, METOCLOPRAMIDE 10/2 ML VIAL, METOCLOPRAMIDE 5/ML AMPL, METOCLOPRAMIDE 5 MG/ML VIAL, METOPROLOL TART 5 MG/5 ML AMP, METOPROLOL TART 5 MG/5 ML VIAL, MITOMYCIN 20 MG VIAL, MITOMYCIN 40 MG VIAL, MITOMYCIN 5 MG VIAL, MITOXANTRONE HCL, MUSTARGEN, MYCAMINE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID, MYFORTIC, NAGLAZYME, NEBUPENT, NEORAL, NEPHRAMINE, NEULASTA, NEUPOGEN, NITROGLYCERIN 5 MG/ML VIAL, NORMAL SALINE FLUSH SYRINGE, NORMOSOL-R AND DEXTROSE, NORMOSOL-R PH 7.4, NULOJIX, OCTREOTIDE 1,000 MCG/5 ML VIAL, OCTREOTIDE 1,000 MCG/ML VIAL, OCTREOTIDE 5,000 MCG/5 ML VIAL, OCTREOTIDE ACET 0.05 MG/ML VL, OCTREOTIDE ACET 100 MCG/ML AMP, OCTREOTIDE ACET 100 MCG/ML VL, OCTREOTIDE ACET 200 MCG/ML AMP, OCTREOTIDE ACET 200 MCG/ML VL, OCTREOTIDE ACET 50 MCG/ML AMP, OCTREOTIDE ACET 50 MCG/ML VL, OCTREOTIDE ACET 100 MCG/5 ML SOLUTION, ONDANSETRON HCL 24 MG TABLET, ONDANSETRON HCL 4 MG TABLET, ONDANSETRON HCL 4 MG/2 ML AMP, ONDANSETRON HCL 4 MG/2 ML VIAL, ONDANSETRON HCL 8 MG TABLET, ONDANSETRON OD T, OPDIVO 40 MG/4 ML VIAL, OXALIPLATIN 100 MG/20 ML VIAL, PACLITAXEL, PENICILLIN G SODIUM, PENTAM 300, PERFOROMIST, PERJETA, PIPERACIL-TAZOBACT 3.375 GM VL, PIPERACIL-TAZOBACT 4.5 GM VIAL, PIPERACIL-TAZOBACT 40.5 GRAM, PLASMA-LYTE 148, PLASMA-LYTE 56 IN DEXTROSE, PLASMA-LYTE A PH 7.4, POTASSIUM CHL-NORMAL SALINE, POTASSIUM CL 10 MEQ/100 ML SOL, POTASSIUM CL 10 MEQ/5 ML CONC, POTASSIUM CL 10 MEQ/50 ML SOL, POTASSIUM CL 2 MEQ/ML IV SOL, POTASSIUM CL 2 MEQ/ML VIAL, POTASSIUM CL 20 MEQ/10 ML CONC, POTASSIUM CL 20 MEQ/100 ML SOL, POTASSIUM CL 20 MEQ/50 ML SOL, POTASSIUM CL 30 MEQ/15 ML CONC, POTASSIUM CL 40 MEQ/100 ML SOL, POTASSIUM CL 40 MEQ/20 ML CONC, POTASSIUM CHLORIDE-NACL, PREDNISONE INTENSOL,
PREMARIN 25 MG VIAL, PREMASOL, PROCALAMINE, PROCRIT, PROGRAF, PROLASTIN, PROLASTIN C, PROLEUKIN, PROSOL, PULMICORT 1 MG/2 ML RESPULE, PULMOZYM, RABAVERT, RAPAMUNE, RECOMBIVAX HB 10 MCG/ML SYR, RECOMBIVAX HB 10 MCG/ML VIAL, RECOMBIVAX HB 40 MCG/ML VIAL, RECOMBIVAX HB 5 MCG/0.5 ML SYR, REMICADE, REMODULIN, RISPERDAL CONSTA, RITUXAN, SANDIMMUNE, SIGNIFOR LAR, SIMULECT 20 MG VIAL, SIROLIMUS 0.5 MG TABLET, SIROLIMUS 1 MG TABLET, SIROLIMUS 2 MG TABLET, SALINE 0.45% SOLN-EXCEL CON, SALINE 0.9% SOLN-EXCEL CONT, SODIUM CHLORIDE 0.45% SOLN, SODIUM CHLORIDE 0.45% SOLUTION, SODIUM CHLORIDE 0.9% 1,000 ML, SODIUM CHLORIDE 0.9% 100 ML, SODIUM CHLORIDE 0.9% 250 ML, SODIUM CHLORIDE 0.9% 50 ML, SODIUM CHLORIDE 0.9% 500 ML, SODIUM CHLORIDE 0.9% SOLN, SODIUM CHLORIDE 0.9% SOLUTION, SODIUM CHLORIDE 0.9% SYRINGE, SODIUM CHLORIDE 0.9% VIAL, SODIUM CHLORIDE 100 MEQ/40 ML, SODIUM CHLORIDE 3% IV SOLN, SODIUM CHLORIDE 5% IV SOLN, SODIUM CHLORIDE 50 MEQ/20 ML, SODIUM CL 2.5 MEQ/ML VIAL, SODIUM DIURIL, SODIUM LACTATE 5 MEQ/ML VIAL, SOLU-CORTEF 100 MG VIAL, SOLU-CORTEF 250 MG VIAL, SOLUMEDROL 1,000 MG VIAL, SOLUMEDROL 2,000 MG VIAL, SOLUMEDROL 40 MG VIAL, SOLUMEDROL 500 MG VIAL, SOMATULINE 120 MG/0.5 ML SYRGE, SOMATULINE DEPOT 120 MG/0.5 ML, SOMATULINE DEPOT 90 MG/0.3 ML, SOMAVER 10 MG VIAL, SOMAVER 15 MG VIAL, SOMAVER 20 MG VIAL, SYNERCID, SYNYRI, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 1 MG CAPSULE, TACROLIMUS 5 MG CAPSULE, TALWIN, TENVAC SYRINGE, TESTOSTERON CYP 2,000 MG/10 ML, TESTOSTERONE CYP 200 MG/ML, TETANUS DIPHTHERIA TOXOIDS, THYMoglobulin, TOBI, TOBRAMYCIN 300 MG/5 ML AMPULE, TOPOTECAN HCL, TORISEL, TRAVASOL, TREANDA 100 MG VIAL, TREANDA 25 MG VIAL, TRELSTAR 11.25 MG SYRINGE, TRELSTAR 11.25 MG VIAL, TRELSTAR 3.75 MG SYRINGE, TRELSTAR 3.75 MG VIAL, TRIXALL, TRISENOX, TROPHAMINE, TWINRIX VACCINE VIAL, TYGACIL, TYSABRI, TYVASO, UVADEX, VANCOMYCIN 500 MG A-V VIAL, VANCOMYCIN 500 MG VIAL, VANCOMYCIN HCL 10 GM VIAL, VARIUBI, VECTIBIX 100 MG/5 ML VIAL, VELCADE, VFEND IV, VIDAZA, VINBLASTINE SULFATE, VINCASAR PFS, VINCristine Sulfate, VINORELBINE 50 MG/5 ML VIAL, VIVITROL, VORICONAZOLE 200 MG VIAL, XGEVA, XOLAIR, YERVOY 50 MG/10 ML VIAL, ZALTRAP 100 MG/4 ML VIAL, ZANOSAR, ZEMAIRA, ZEMPLAR 10 MCG/2 ML VIAL, ZEMPLAR 2 MCG/ML VIAL, ZEMPLAR 5 MCG/ML VIAL, ZINCARD 250 MG VIAL, ZOLEDRONIC ACID 4 MG VIAL, ZOLEDRONIC ACID 4 MG/5 ML VIAL, ZORTRESS, ZOSYN 2.25 GM/50 ML GALAXY BAG, ZOSYN 3.375 GM/50 ML GALAXY, ZOSYN 40.5 GRAM BULK VIAL, ZYPREXA RELPREVV 210 MG VIAL, ZYPREXA RELPREVV 210 MG VL KIT, ZYVOX 600 MG/300 ML IV SOLN

DETAILS
This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
MEDICATION(S)
VELTASSA

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

EXCLUSION CRITERIA
Known hypersensitivity or contraindication to active or inactive ingredients

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Clinical diagnosis of hyperkalemia (greater than 5.1 mEq/L). Should not be used as an emergency treatment for life-threatening hyperkalemia because of its delayed onset of action.
PHOSPHODIESTERASE-5 INHIBITORS FOR PAH

**MEDICATION(S)**
ADCIRCA, REVATIO 10 MG/ML ORAL SUSP, REVATIO 20 MG TABLET, SILDENAFIL

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

**EXCLUSION CRITERIA**
None

**REQUIRED MEDICAL INFORMATION**
None

**AGE RESTRICTION**
None

**PRESCRIBER RESTRICTION**
For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.

**COVERAGE DURATION**
12 months

**OTHER CRITERIA**
N/A
**MEDICATION(S)**
RANEXA

**COVERED USES**
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**EXCLUSION CRITERIA**
KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

**REQUIRED MEDICAL INFORMATION**
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING DIAGNOSIS OF CHRONIC STABLE ANGINA, AND FAILURE OF ALTERNATIVE FORMULARY ANTIANGINAL AGENT

**AGE RESTRICTION**
N/A

**PRESCRIBER RESTRICTION**
None

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
SPECIAL CONSIDERATIONS-RANEXA DOES NOT POSSESS NEGATIVE CHRONOTROPIC OR INOTROPIC EFFECTS AND HAS HAD MINIMAL EFFECTS ON HEART RATE AND BLOOD PRESSURE
MEDICATION(S)
ROZEREM

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

REQUIRED MEDICAL INFORMATION
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING DIAGNOSIS OF INSOMNIA, AND FAILURE OR INTOLERANCE TO AT LEAST TWO GENERIC SLEEP AGENTS SUCH AS ZOLPIDEM OR ZALEPLON.

AGE RESTRICTION
FOR PATIENTS 18 YEARS OF AGE AND OLDER ONLY

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
KANUMA

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

EXCLUSION CRITERIA
Known hypersensitivity or contraindication to active or inactive ingredients

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Confirmation of Lysosomal Acid Lipase (LAL) deficiency diagnosis through enzymatic blood test within 3 months of initiation of therapy.
MEDICATION(S)
SIRTURO

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
Prescription is written by or in consultation with an infectious disease specialist, a pulmonologist, or cardiologist.

COVERAGE DURATION
24 WEEKS

OTHER CRITERIA
N/A
**MEDICATION(S)**
SOVALDI

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

**EXCLUSION CRITERIA**
N/A

**REQUIRED MEDICAL INFORMATION**
Will not be used in combination Use with NS3/4A Protease Inhibitor (i.e., telaprevir, boceprevir)

**AGE RESTRICTION**
18 years or older

**PRESCRIBER RESTRICTION**
Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
Geno 1 - prescribed in combination with either a NS3 inhibitor or NS5A inhibitor. Genotype 2,3,4,5, and 6 have options of sofosbuvir with ribavirin and PEG-IFN and sofosbuvir with just ribavirin.
**MEDICATION(S)**
SYMLINPEN 120, SYMLINPEN 60

**COVERED USES**
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**EXCLUSION CRITERIA**
KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS OR PATIENT HAS RECURRENT EPISODES OF SEVERE HYPOGLYCEMIA REQUIRING ASSISTANCE WITHIN THE PAST 6 MONTHS OR PATIENT REQUIRES DRUGS THAT STIMULATE GASTROINTESTINAL MOTILITY

**REQUIRED MEDICAL INFORMATION**
MEDICAL RECORDS SUPPORTING COVERED USE, DOCUMENTING DIAGNOSIS OF TYPE I OR TYPE II DIABETES, NAMES OF PRIOR DRUGS USED WITH INADEQUATE GLYCEMIC CONTROL, AND MOST RECENT HGB A1C

**AGE RESTRICTION**
SHOULD NOT BE USED IN PEDIATRIC PATIENTS

**PRESCRIBER RESTRICTION**
N/A

**COVERAGE DURATION**
12 MONTHS

**OTHER CRITERIA**
SPECIAL CONSIDERATIONS-CAUTION IN PATIENTS WITH A HISTORY OF POOR COMPLIANCE WITH CURRENT INSULIN REGIMEN, CAUTION IN PATIENTS WITH A HISTORY OF POOR COMPLIANCE WITH SELF-BLOOD GLUCOSE MONITORING, PREGNANCY CATEGORY C, FDA BLACK BOX WARNING REGARDING HYPOGLYCEMIA
MEDICATION(S)
TECHNIVIE

COVERED USES
All FDA-Approved Indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Concomitant use with drugs that are highly dependent on CYP3A4 for clearance and elevated exposures are associated with serious adverse affects. Concomitant use with drugs that are moderate or strong CYP3A4 inducers. Hypersensitivity to any component of this product.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 years or older

PRESCRIBER RESTRICTION
Prescribed by or in consultation with Gastroenterologist, Hepatologist, Infectious Disease Specialist, or Liver Transplant MD.

COVERAGE DURATION
12 weeks

OTHER CRITERIA
Indicated in combination with ribavirin for the treatment of patients with genotype 4 Chronic HCV infection without cirrhosis.
MEDICATION(S)
TRACLEER

COVERED USES
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

EXCLUSION CRITERIA
KNOWN HYPERSENSITIVITY OR CONTRAINDICATION TO ACTIVE OR INACTIVE INGREDIENTS

REQUIRED MEDICAL INFORMATION
MEDICAL RECORD NOTES SUPPORTING COVERED USE

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
SPECIAL CONSIDERATIONS-ENROLLMENT OF PATIENTS IN THE TRACLEER ACCESS PROGRAM IS REQUIRED AS TRACLEER CANNOT BE DISPENSED THROUGH TRADITIONAL RETAIL PHARMACIES. ENROLLMENT FORM MUST BE SIGNED BY BOTH THE PATIENT AND PHYSICIAN.
TRANSMUCOSAL FENTANYL DRUGS

MEDICATION(S)
FENTANYL CIT OTFC 1,200 MCG, FENTANYL CIT OTFC 1,600 MCG, FENTANYL CITRATE OTFC 200 MCG, FENTANYL CITRATE OTFC 400 MCG, FENTANYL CITRATE OTFC 600 MCG, FENTANYL CITRATE OTFC 800 MCG

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

EXCLUSION CRITERIA
None

REQUIRED MEDICAL INFORMATION
None

AGE RESTRICTION
None

PRESCRIBER RESTRICTION
None

COVERAGE DURATION
12 Months

OTHER CRITERIA
N/A
MEDICATION(S)
UPTRAVI

COVERED USES
All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA
Known hypersensitivity or contraindication to active or inactive ingredients

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pulmonologist or cardiologist

COVERAGE DURATION
12 months

OTHER CRITERIA
Treatment of pulmonary arterial hypertension
MEDICATION(S)
VIEKIRA PAK

COVERED USES
All FDA-approved indications not otherwise excluded from Part D. Criteria will be applied consistent with current AASLD-IDSA guidance

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
18 years or older

PRESCRIBER RESTRICTION
Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD

COVERAGE DURATION
12 MONTHS

OTHER CRITERIA
N/A
MEDICATION(S)
ZINBRYTA

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

EXCLUSION CRITERIA
Known hypersensitivity or contraindication to active or inactive ingredients

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
MEDICATION(S)
ZURAMPIC

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

EXCLUSION CRITERIA
Known hypersensitivity or contraindication to active or inactive ingredients.

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Clinical diagnosis of hyperuricemia associated with symptomatic gout. Must be taken with a xanthine oxidase inhibitor.