ABSTRAL

Products Affected

- ABSTRAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of cancer with breakthrough cancer pain AND has tried and failed fentanyl citrate lozenge (generic Actiq) AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer.

ACTEMRA

Products Affected

- ACTEMRA INTRAVENOUS SOLUTION 200 MG/10 ML (20 MG/ML)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Tuberculosis, or invasive fungal infections or other active serious infections, or history if recurrent infections. Individuals who have not had a tuberculin skin test or Center for Disease Control recommended equivalent to evaluate for latent tuberculosis, using Actemra in combination with other TNF antagonists, IL-1R antagonists anti-cd20 monoclonal antibodies or selective co-stimulation modulators. At initiation of therapy, absolute neutrophil count (ANC) below 2000/mm3, platelet count below 100,000/mm3, or ALT or AST above 1.5 times the upper limit of normal.
Required Medical Information	N/A
Age Restrictions	Member is 18 years of age or older, except for the diagnosis of JIA, PJIA. For JIA, PJIA patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For rheumatoid arthritis (RA), member has had an inadequate response to ONE non-biological or biologic disease modifying anti-rheumatic drug (DMARD) such as methotrexate (MTX) or a tumor necrosis factor (TNF) antagonist drug AND an inadequate response to Humira, Remicade or Enbrel. For Systemic Juvenile Idiopathic Arthritis (SJIA), member has failed to respond to, is tolerant of, or has a medical contraindication to ONE corticosteroid or nonsteroidal anti-inflammatory drug (NSAID). For Polyarticular Juvenile Idiopathic Arthritis (PJIA), member has failed to respond to, is intolerant of, or has a medical contraindication to ONE non-biologic DMARD (such as methotrexate)

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ACTIQ

Products Affected

- ACTIQ BUCCAL LOZENGE ON A HANDLE 1,200 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of cancer with breakthrough cancer pain AND has tried and failed fentanyl citrate lozenge (generic Actiq) AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer.

ACTIQ GEN

Products Affected

- *fentanyl citrate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of cancer with breakthrough cancer pain AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer.

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For Renal Cell Carcinoma (RCC), member has failed treatment with ONE of the following: Sutent (sunitinib) OR Nexavar (sorafenib)

ALDURAZYME

Products Affected

- ALDURAZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ALIMTA

Products Affected

- ALIMTA INTRAVENOUS RECON SOLN 500 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ALPHA1-PROTEINASE INHIBITOR

Products Affected

- ARALAST NP INTRAVENOUS RECON SOLN 500 MG
- GLASSIA
- PROLASTIN-C
- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

AMPHETAMINE SALTS

Products Affected

- *amphetamine salt combo oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

AMPYRA

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Member has a history of seizures, OR moderate or severe renal impairment (defined as creatinine clearance less than or equal to 50 mL/min)
Required Medical Information	For initial approval, member has been objectively assessed for functional impairment related to ambulation AND documentation has been provided. For renewal, member achieved and sustained clinically significant improvement in ambulation related functional status AND documentation has been provided. Documentation may include chart notes, consultation notes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Intial approval 12 weeks, renewal 1 year
Other Criteria	N/A

ANDROXY

Products Affected

- *androxy*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For individuals beginning treatment for Primary hypogonadism (congenital or acquired) or Hypogonadotropic hypogonadism (congenital or acquired), An initial and a repeat (at least 24 hours apart) morning total testosterone level is provided to confirm a low testosterone serum level as determined by the reference laboratory assay will be required. For individuals continuing treatment for Primary hypogonadism (congenital or acquired) or Hypogonadotropic hypogonadism (congenital or acquired), A morning total testosterone level provided to confirm testosterone levels in the mid-normal range as determined by the reference laboratory assay will be required. Documentation of testosterone levels must be provided with request. Documentation may include, but is not limited to, chart notes, consultation notes, and laboratory data.
Age Restrictions	For Delayed puberty: age 14-17. For all other: 18 yr of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

APOKYN

Products Affected

- APOKYN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Erectile Dysfunction (ED) use
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ARANESP

Products Affected

- ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (IN POLYSORBATE) INJECTION SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Anemia in patients due to other factors such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic diseases (such as sickle cell anemia, thalassemia, and porphyria). Sudden loss of response with severe anemia and low reticulocyte count. Treatment of in any indication not listed in criteria including anemia of prematurity. Anemia in cancer patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure. Anemia in cancer patients receiving hormonal agents, therapeutic biologic products, or radiotherapy unless receiving concomitant myelosuppressive chemotherapy. Continued use when the hemoglobin level exceeds 11.0 g/dL unless otherwise specified in the criteria. Use beyond 12 weeks in the absence of response in individuals with chronic renal failure. Use beyond 8 weeks in the absence of response in individuals with myelodysplastic syndrome (MDS). Use beyond 8-9 weeks in the absence of response or if transfusions are still required in individuals with metastatic, non-myeloid cancer being treated with myelosuppressive chemotherapy agents known to produce anemia. Continued use beyond 6 weeks after therapy with myelosuppressive chemotherapy known to produce anemia is completed. Pre-operative use for individuals who are willing to donate autologous blood.

Required Medical Information	Hemoglobin (Hgb) levels are less than 10 g/dL, prior to initiation of therapy (unless otherwise specified) AND the patient's iron status, including transferrin saturation or serum ferritin or bone marrow, is evaluated and transferrin saturation at least 20% or ferritin at least 80 ng/mL or evidence of bone marrow demonstrates adequate iron stores AND For patients with hypertension, blood pressure is adequately controlled before initiation of therapy and closely monitored and controlled during therapy. Continued use may be allowed if hgb does not exceed 11g/dl AND iron stores (including transferrin saturation and ferritin) are adequately maintained and monitored periodically during therapy. For MDS, endogenous erythropoietin level is less than 500 mU/ml. For tx of anemia due to chemotherapy known to produce anemia, chemo is planned for a minimum of 2 months and the dx is non-myeloid cancer and the anticipated outcome is not cure. For CKD ON dialysis use is to achieve and maintain hgb levels within the range of 10 to 11 g/dL. For CKD NOT ON dialysis use is to achieve and maintain hgb levels of 10g/dL
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	8wk.IF No resp:MDS 8wk:CRF 12wk:Chemo complete 6wk: 8-9wk or transfusion req in met nonmyel CA tx
Other Criteria	N/A

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

AVASTIN

Products Affected

- AVASTIN

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

BANZEL

Products Affected

- BANZEL ORAL SUSPENSION
- BANZEL ORAL TABLET 200 MG, 400 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	4 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

BARACLUDE

Products Affected

- BARACLUDE

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

BENLYSTA

Products Affected

- BENLYSTA INTRAVENOUS RECON SOLN 120 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Clinical diagnosis of SLE per the American College of Rheumatology [ACR] criteria AND Unequivocally positive ANA (anti-nuclear antibody) titer greater than or equal to 1:80 or anti-dsDNA (double stranded DNA antibody) greater than or equal to 30 IU/mL AND SLE is active as documented by a SELENA-SLEDAI score greater than or equal to 6 while on current treatment regimen AND There is no evidence of severe renal disease (proteinuria greater than 6 gm/day, serum creatinine greater than 2.5 mg/dl, or requiring renal dialysis) AND There is no evidence of active central nervous system lupus (e.g. psychosis and seizures) AND SLE remains active while on corticosteroid, antimalarials, and/or immunosuppressants for at least the last 30 days
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

BOSULIF

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has resistance or intolerance to prior therapy with ONE of the following medications: imatinib, dasatinib, OR nilotinib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

BOTOX-MYOBLOC-DYSPORT

Products Affected

- BOTOX INJECTION RECON SOLN 100 UNIT
- DYSPORT INTRAMUSCULAR RECON SOLN 300 UNIT
- XEOMIN INTRAMUSCULAR RECON SOLN 50 UNIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Botulinum toxin is considered cosmetic as a treatment of skin wrinkles or other cosmetic indications and is not approvable.
Required Medical Information	For Cervical Dystonia (spasmodic torticollis) of moderate or greater severity when all of the following criteria are met: History of recurrent clonic and/or tonic involuntary contractions of one or more of the following muscles: sternocleidomastoid, splenius, trapezius and/or posterior cervical muscles, and Sustained head tilt and/or abnormal posturing with limited range of motion in the neck, and The duration of the condition is greater than 6 months. Subsequent injections for the treatment of cervical dystonia of moderate or greater severity when all the following criteria is met: there is a response to initial treatment documented in the medical records and patient still meets criteria above. For prevention of chronic migraine, patient must have migraine on 15 or more days per month with HA lasting 4 hours per day or longer AND first episode at least 6 months ago AND symptoms persist despite trials of at least ONE agent in ANY 2 classes of medications used to prevent migraines, antidepressants, antihypertensives, antiepileptics. Continuing tx medically nec when migraine HA frequency was reduced by at least 7 days per month by end of initial trial OR duration was reduced by at least 100 hours per month by end of initial trial.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year, chronic migrains 6months

Other Criteria	Treatment of primary hyperhidrosis is approved when mbr has failed a 6 month trial of ONE nonsurgical treatment (i.e., topical dermatologics such as aluminum chloride, tannic acid, glutaraldehyde, anticholinergics, systemic anticholinergics, tranquilizers or non steroid anti-inflammatory drugs) AND Presence of medical complications or skin maceration with secondary infection OR Significant functional impairment, as documented in the medical record. Treatment of secondary hyperhidrosis is approved when Presence of medical complications or skin maceration with secondary infection AND Significant functional impairment, as documented in the medical record. Treatment of significant drooling in patients who are unable to tolerate scopolamine. Treatment of incontinence related detrusor overreactivity and incontinence of neurogenic origin (i.e., spinal cord injury, multiple sclerosis) that is inadequately controlled with anticholinergic therapy. Treatment of bladder detrusor spincter dyssynergia of neurogenic origin.

BUPHENYL

Products Affected

- *sodium phenylbutyrate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Management of acute hyperammonemia
Required Medical Information	Using as adjunctive therapy for chronic management of hyperammonemia, including but not limited to using in combination with dietary protein restriction and, in some cases, essential amino acid supplementation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

CAPRELSA

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

CARBAGLU

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For acute hyperammonemia, using as adjunctive therapy with other ammonia lowering therapies, including but not limited to the following: alternate pathway medications to eliminate nitrogen waste (such as, sodium phenylacetate) or hemodialysis or dietary protein restriction.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

CAYSTON

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a forced expiratory volume in 1 second (FEV1) of less than 25% or greater than 75% of predicted OR Individual has CF colonized with Burkholderia cepacia.
Required Medical Information	N/A
Age Restrictions	7 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

CHANTIX

Products Affected

- CHANTIX
- CHANTIX STARTING MONTH BOX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	At least 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

CIALIS BPH

Products Affected

- CIALIS ORAL TABLET 2.5 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Erectile dysfunction. Currently on nitrate therapy.
Required Medical Information	Individual has a diagnosis of benign prostatic hyperplasia (BPH) [with or without ED] AND individual has tried and failed TWO preferred products for BPH OR has contraindication to all preferred agents.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

CIMZIA

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Tuberculosis, invasive fungal infection, other active serious infections, or a history of recurrent infections. Individuals who have not had a tuberculin skin test or Center for Disease Control recommended equivalent to evaluate for latent tuberculosis. Using Cimzia in combination with other TNF antagonists, non-TNF immunomodulatory drugs: abatacept, anakinra, natalizumab, or rituximab.
Required Medical Information	N/A
Age Restrictions	Member is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For Crohn's Disease, member has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (e.g. 5-ASA products, systemic corticosteroids, or immunosuppressants) AND Member has had an inadequate response or is intolerant to Remicade (infliximab), or Humira. For Rheumatoid Arthritis, Member has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARDs AND Member has tried and failed Humira, Remicade or Enbrel in the previous 180 days. For Psoriatic Arthritis, mbr has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as nonbiologic DMARDs) AND has had an inadequate response or is intolerant to Remicade (infliximab), Enbrel, or Humira. For Active Ankylosing Spondylitis (AS), mbr has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as NSAIDs or non-biologic DMARDs) AND has had an inadequate response or is intolerant to Remicade (infliximab), Enbrel, or Humira

CINRYZE

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	HAE to be confirmed by a C4 level below the lower limit of normal (as defined by the laboratory performing the test) and ANY of the following: 1. C1 inhibitor antigenic level below the lower limit of normal (as defined by the lab performing test). 2. C1 inhibitor functional level below the lower limit of normal (as defined by the lab performing the test). Or 3. The presence of a known HAE-causing C1-INH mutation.
Age Restrictions	13 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a history of moderate or severe attacks and is using Cinryze as prophylaxis for short-term use prior to surgery, dental procedures or intubation OR for long-term prophylaxis and member has failed, or is intolerant to, or has contraindication to 17-alpha-alkylated androgens or antifibrinolytic agents.

COMETRIQ

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

COPAXONE

Products Affected

- COPAXONE 20 MG/ML SUBCUTANEOUS SYRINGE KIT 20 MG/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual with primary progressive MS (PPMS). Individual with secondary progressive MS (SPMS) without relapsing disease. Treatment of MS with glatiramer acetate (Copaxone) in combination with any IFN beta-1b (i.e., Betaseron, Extavia, Avonex, Rebif) or in combination with natalizumab
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

DALIRESP

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual is currently using a long-acting bronchodilator

DEXTROAMPHETAMINE IR

Products Affected

- *dextroamphetamine oral tablet 10 mg, 5 mg*
- *zenzedi oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member is using for ADHD, Narcolepsy.
Age Restrictions	3 and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

DIFICID

Products Affected

- DIFICID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	member has had a trial of OR a contraindication to a 14 day course of oral vancomycin
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	N/A

DOXEPIN HRM

Products Affected

- *doxepin oral*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

ELAPRASE

Products Affected

- ELAPRASE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ELIDEL, PROTOPIC

Products Affected

- ELIDEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	diagnosis of chronic mild to moderate atopic dermatitis
Age Restrictions	Member is equal to or greater than 2 years of age
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	A trial of one topical prescription corticosteroid within the previous 120 days

ELITEK

Products Affected

- ELITEK INTRAVENOUS RECON SOLN 1.5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a diagnosis of glucose-6-phosphate dehydrogenase (G6PD) deficiency.
Required Medical Information	Individual is receiving treatment in a setting appropriate for providing necessary monitoring and supportive care for tumor lysis syndrome AND Individual has a plasma uric acid level greater than 8.0 mg/dL in adults or above the upper limit of the normal range for age in children AND Individual has not received a course of Elitek therapy in the past.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	Individual has been diagnosed with leukemia, lymphoma or other hematologic malignancy with risk factors for tumor lysis syndrome, such as high tumor burden or elevated LDH AND Individual is receiving chemotherapy.

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has no known contraindications to the use of a monoamine oxidase inhibitor (MAOI).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ENBREL

Products Affected

- ENBREL SUBCUTANEOUS KIT
- ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51), 50 MG/ML (0.98 ML)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Enbrel used in combination with other TNF antagonist or in combination with the following non-TNF immunomodulatory drugs: abatacept (Orencia), anakinra (Kineret), or cyclophosphamides. Tuberculosis, invasive fungal infection, other active serious infection, or a history of recurrent infection. Individual who have not had a tuberculin skin test or a CDC-recommended equivalent to evaluate for latent tuberculosis.
Required Medical Information	For chronic moderate to severe plaque psoriasis with either of the following: Individual has greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	Patient is 18 years of age or older, except for the diagnosis of JIA. For JIA patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year except for Initial high dose tx chronic plaque psoriasis 12 wk
Other Criteria	For Ankylosing Spondylitis, individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE of the following conventional therapies: NSAIDs or nonbiologic DMARDs. For Moderate to severe Chronic Plaque Psoriasis individual has failed to respond to, is intolerant of, or has a medical contraindication to phototherapy OR ONE other systemic therapies (such as, methotrexate, acitretin, or cyclosporine). For moderately to severely active Rheumatoid Arthritis or Moderate to severe active Polyarticular-course JIA (previously known as JRA), individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD. For Psoriatic Arthritis, individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD.

EPOGEN AND PROCRIT

Products Affected

- EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML
- PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Anemia in patients due to other factors such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic diseases (such as sickle cell anemia, thalassemia, and porphyria). Sudden loss of response with severe anemia and low reticulocyte count. Treatment of anemia in patients with cancer not treated by chemotherapy known to produce anemia. Treatment of in any indication not listed in criteria including anemia of prematurity. Anemia in cancer patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure. Anemia in cancer patients receiving hormonal agents, therapeutic biologic products, or radiotherapy unless receiving concomitant myelosuppressive chemotherapy. Pre-operative use for patients who are willing to donate autologous blood.

Required Medical Information	Hemoglobin (Hgb) levels are less than 10 g/dL, prior to initiation of therapy (unless otherwise specified) AND the patient's iron status, including transferrin saturation or serum ferritin or bone marrow, is evaluated and transferrin saturation at least 20% or ferritin at least 80 ng/mL or evidence of bone marrow demonstrates adequate iron stores AND For patients with uncontrolled hypertension, blood pressure is adequately controlled before initiation of therapy and closely monitored and controlled during therapy. Continued use may be allowed if hgb does not exceed 11g/dl AND iron stores (including transferrin saturation and ferritin) are adequately maintained and monitored periodically during therapy. For MDS, endogenous erythropoietin level is less than 500 mU/ml. For anemia related to zidovudine in HIV-infected patients when the dose of zidovudine is less than or equal to 4200 mg per week, endogenous erythropoietin level is less than or equal 500 mU/ml. Reduction of Allogeneic Blood Transfusion in Pre-Operative Surgery Patients: Patient's hgb is greater than 10 and less than or equal to 13 g/dL, Patient is scheduled to undergo elective, noncardiac, nonvascular surgery, Patient is at high risk for perioperative transfusions with significant, anticipated blood loss, Patient is unable or unwilling to donate autologous blood, Antithrombotic prophylaxis has been considered. For tx of anemia due to chemotherapy known to produce anemia, chemo is planned for a minimum of 2 months and the dx is non-myeloid cancer and the anticipated outcome is not cure. For CKD ON dialysis use is to achieve and maintain hgb levels within the range of 10 to 11 g/dL. For CKD NOT ON dialysis use is to achieve and maintain hgb levels of 10g/dL
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	8wk.IF No resp:MDS 8wk:CRF 12wk:Chemo complete 6wk: 8-9wk or transfusion req in met nonmyel CA tx.
Other Criteria	For Hepatitis C, patient is concomitantly treated with combination of ribavirin and interferon alfa, or ribavirin and peginterferon alfa. Myelosuppressive drugs known to produce anemia in individuals with a diagnosis of chronic inflammatory disease. Allogeneic bone marrow transplantation.

ERBITUX

Products Affected

- ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Erbitux is used in combination with other anti-VEGF agents (e.g., bevacizumab). Erbitux is used in more than one line of therapy.
Required Medical Information	For stage IV, kras wild type colon, rectal, colorectal, or anal adenocarcinoma when used as a single agent or as part of combination therapy. For squamous cell carcinoma of the Head and/or Neck cancer, Erbitux is used in combination with radiation therapy, for the treatment of locally or regionally advanced disease. Or as a single agent for the treatment of patients with recurrent or metastatic disease for whom prior platinum-based therapy has failed. Or in combination with platinum-based therapy with 5-FU (fluorouracil) as first-line treatment for individuals with recurrent locoregional disease or metastatic SCCHN. OR as a single agent or in combination therapy with or without radiation therapy for any of the following indications, unresectable locoregional recurrence or second primary in individuals who have received prior radiation therapy OR resectable locoregional recurrence in individuals who have not received prior radiation therapy OR distant metastases. For TREATMENT of individuals with stage IIIB (with malignant pleural effusion) and stage IV non-small cell lung cancer, Cetuximab is used in first-line treatment in combination with cisplatin and vinorelbine AND No prior chemotherapy or anti-EGFR therapy AND EGFR expression (1 positive tumor cell) by immunohistochemistry (IHC) AND No known brain metastases. For Maintenance tx of individuals with stage IIIB and stage IV NSCLC, cetuximab was prev administered as an agent in a first line combination AND as a single agent AND may be used until disease progression or unacceptable cetuximab toxicities.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ETHYOL

Products Affected

- *amifostine crystalline*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

EXJADE

Products Affected

- EXJADE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

FABRAZYME

Products Affected

- FABRAZYME INTRAVENOUS RECON SOLN 35 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

FASLODEX

Products Affected

- FASLODEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

FENTORA

Products Affected

- FENTORA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of cancer with breakthrough cancer pain AND has tried and failed fentanyl citrate lozenge (generic Actiq) AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer.

FETZIMA

Products Affected

- FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK
- FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	May not be approved for treatment of fibromyalgia
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For MDD, individual has had a trial of one of the following: fluoxetine, citalopram, paroxetine, sertraline, mirtazapine, immediate-release venlafaxine, extended-release venlafaxine or bupropion within the past 180 days.

FIRAZYR

Products Affected

- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Prophylaxis for HAE attacks.
Required Medical Information	HAE to be confirmed by a C4 level below the lower limit of normal (as defined by the laboratory performing the test) and either a C1 inhibitor antigenic level below the lower limit of normal (as defined by the lab performing test) or a C1 inhibitor functional level below the lower limit of normal (as defined by the lab performing the test).
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a history of moderate or severe attacks and using Firazyr for acute HAE attacks.

FORTEO

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A Bone Mineral Density (BMD) must be provided with all requests. Osteoporosis is defined as a BMD T-Score of less than or equal to -2.5 as compared to young adult men OR a Clinical diagnosis can often be made in at risk individuals who sustain a low trauma fracture (fragility fracture). In the absence of fragility fracture, BMD T-Scores greater than -2.5 (closer to 0 or positive) are not considered osteoporotic. High risk for fracture is defined as follows: Hx of osteoporotic fracture, OR multiple risk factors for fractures (including but not limited to prior low-trauma fracture as an adult, advanced age, gender, ethnicity, low bone mineral density, low body weight, family history of osteoporosis, use of glucocorticoids (daily dosage equivalent to 5mg or greater of prednisone for at least 3 months), cigarette smoking, excessive alcohol consumption [3 or more drinks/day], secondary osteoporosis (such as, rheumatoid arthritis), early menopause, height loss or kyphosis, fall risk and low calcium intake, OR Failure or intolerance to other osteoporosis therapy. Intolerance or contraindications to oral bisphosphonate are defined as having at least one of the following: 1. Intolerance OR hypersensitivity to both risedronate (Actonel) and alendronate (Fosamax), 2. Inability to sit or stand upright for at least 30 minutes, 3. Pre-existing gastrointestinal disorders (Barrett's esophagus, hypersecretory disorders, delayed esophageal emptying, etc.). 4. Uncorrected hypocalcemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years. Requests to continue therapy beyond 24 months (2 years) should not be approved.
Other Criteria	Individual has had a trial of, is intolerant to or has contraindication to oral bisphosphonate therapy.

GAUCHERS

Products Affected

- CEREZYME INTRAVENOUS RECON SOLN 400 UNIT

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

GILENYA

Products Affected

- GILENYA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using in combination with other immunomodulatory agents (Aubagio, Tecfidera, Tysabri, Copaxone, Extavia, Rebif, Avonex, Betaseron). Individual has history or presence of Mobitz Type II second- or third-degree atrioventricular (AV) block or sick sinus syndrome, unless individual has a functioning pacemaker. Individual has a baseline QTc interval greater than or equal to 500 ms. Individual is being treated with Class Ia (such as quinidine, procainamide, or disopyramide) or Class III [such as amiodarone, Multaq (dronedarone), Tikosyn (dofetilide), or sotalol] anti-arrhythmic drugs. Individual has had a recent (within the past 6 months) occurrence of one of the following: Myocardial infarction, Unstable angina, Stroke, Transient ischemic attack (TIA), Decompensated heart failure requiring hospitalization, Class III/IV heart failure.
Required Medical Information	I. Individual has tried therapy with one of the following: Avonex (interferon beta-1a), Rebif (interferon beta-1-a), Tecfidera (dimethyl fumarate), Copaxone (glatiramer). OR II. Individual has high disease activity despite treatment with a disease modifying drug (Aubagio, Avonex, Rebif, Betaseron, Extavia, Copaxone, Tecfidera) defined as the following: At least 1 relapse in the previous year while on therapy AND At least 9 T2-hyperintense lesions in cranial MRI OR At least 1 Gadolinium-enhancing lesion. OR III. Individual is treatment naive (no previous history of use of disease modifying drugs such as Aubagio, Avonex, Rebif, Betaseron, Extavia, Copaxone, Tecfidera) AND IV. Individual has rapidly evolving severe relapsing multiple sclerosis defined as the following: Two or more disabling relapses in 1 year AND One or more Gadolinium-enhancing lesions on brain MRI.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Copy of the test results from a FDA-approved companion diagnostic test must be provided that document the exon 19 deletions or exon 21 (L858R) substitution mutation
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

GLEEVEC

Products Affected

- GLEEVEC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

HALAVEN

Products Affected

- HALAVEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Halven is used as a single agent and in a single line of therapy for recurrent or metastatic breast cancer. Member has has previously received at least two chemotherapeutic regimens for locally recurrent or metastatic disease and prior chemotherapy regimen has included an anthracycline and a taxane in either the adjuvant or metastatic setting.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

HECTOROL LINE

Products Affected

- HECTOROL INTRAVENOUS SOLUTION 4 MCG/2 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

HEPSERA

Products Affected

- HEPSERA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

HERCEPTIN

Products Affected

- HERCEPTIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with other targeted biologic agents (including but not limited to erlotinib, cetuximab, panitumumab, and bevacizumab).
Required Medical Information	Tumor(s) have been evaluated with an assay validated to predict HER2 protein overexpression. Individuals are considered HER2 positive whose tumors have HER2 protein overexpression documented by one of the following, immunohistochemistry (IHC) 3+ or fluorescent in situ hybridization (FISH) HER2 gene copy is greater than 6 OR FISH ratio of HER2 gene/chromosome 17 ratio is greater than or equal to 2.0.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For metastatic breast cancer, Using as a single agent or in combination with chemotherapy (any chemotherapy approved for use in breast cancer), either in treatment naive patients or in patients already receiving chemotherapy. In combination therapy with lapatinib as a treatment of metastatic breast cancer when Individual has received or is receiving trastuzumab-based therapy AND disease has progressed on or after this therapy. As adjuvant treatment for breast cancer to complete a 12 month course of herceptin. For neoadjuvant therapy prior to surgical treatment. In combination with pertuzumab for treatment of metastatic breast cancer. For gastric cancer (esophageal and gastroesophageal adenocarcinoma), using in combination treatment and in only one line of therapy (e.g. first, second, or third line of therapy etc.)

HORIZANT

Products Affected

- HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member has a diagnosis of restless leg syndrome (RLS) AND member has tried or has a contraindication to either pramipexole OR Ropinirole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

HP ACTHAR

Products Affected

- ACTHAR H.P.

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has a corticosteroid-responsive condition, including but not limited to acute exacerbation of multiple sclerosis AND individual has no contraindication to or intolerance of corticosteroids AND there is clear documentation that a corticosteroid cannot be used, and that a repository corticotropin injection can be used effectively
Age Restrictions	For West Syndrome, infant and children less than 2 years of age.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

HRM AGE

Products Affected

- *amitriptyline*
- *chlorpromazine*
- *clomipramine*
- *compro*
- *estradiol oral*
- *imipramine hcl*
- MENEST
- *phenobarbital oral elixir*
- *phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg*
- *prochlorperazine*
- *prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)*
- *prochlorperazine maleate oral*
- SURMONTIL

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

HRM AGE AU

Products Affected

- *benztropine injection*
- *benztropine oral*
- *clemastine oral tablet 2.68 mg*
- *cyclobenzaprine oral tablet*
- *diphenhydramine hcl injection solution 50 mg/ml*
- *ergoloid*
- *estradiol transdermal*
- *guanfacine*
- *nitrofurantoin macrocrystal oral capsule 50 mg*
- *nitrofurantoin monohyd/m-cryst*
- *promethazine injection solution*
- *reserpine oral tablet 0.1 mg*
- *zaleplon oral capsule 10 mg, 5 mg*
- *zolpidem*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

HUMAN GROWTH HORMONE

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- TEV-TROPIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use of GH tx when applicable criteria have not been met may not be approved for, but not limited to, the following: Renal transplant, Anabolic tx, except for AIDS, provided to counteract acute or chronic catabolic illness (e.g. surgery, trauma, cancer,chronic hemodialysis) producing catabolic (protein wasting) changes in both adult and ped. Anabolic tx to enhance body mass or strength for professional, recreational or social reasons, Constitutional delay of growth and development. Cystic fibrosis, GH Tx in combo with GnRH agonist (Lupron-leuprolide) as a Tx of precocious puberty. Hypophosphatemic rickets, osteogenesis imperfecta, osteoporosis, Short Stature associated with GH insensitivity (Laron Syndrome). Therapy in older adults with normally occurring decrease in GH, who are not congenitally GH deficient and who have no evidence of organic pituitary dz (this is referred to as age-related GH deficiency). Tx of CHF, burn patients, fibromyalgia, glucocorticoid-induced growth failure. Tx of HIV lipodystrophy (fat redistribution syndrome), also referred to as altered body habitus (e.g. buffalo hump), associated with antiviral therapy in HIV-infected patients. Tx of intrauterine growth restriction (IUGR)or Russell-Silver Syndrome that does not result in SGA. Tx of obesity. Other etiologies of SS where GH has not been shown to be associated with an increase in final height, including but not limited to achondrodoplasia and other skeletal dysplasias. GH tx used for reconstruction is terminated when BA =16 yr (M), or = 14 yr (F) is reached OR Epiphyseal fusion has occurred OR Mid-parenteral height is achieved. For individuals being treated for GHD due to trauma or aneurysmal subarachnoid hemorrhage, GHD must be reconfirmed at 12 months after the event for therapy to continue. If retesting is not confirmatory for GHD, continued Tx is considered not medically necessary. Child over 12: an X-ray report with evidence that epiphyses have closed or SMR of 3 or more

Required Medical Information	A subnormal (SubNL) response (less than10ng/ml)to 2GH stim tests OR Neonates with hypoglycemia and clinical/hormone evidence of hypopit and low GH (at least 1GH stim test is SubNL)OR 2other pit hormone deficiencies and low IGF-1.Child born SGA(birth wt or length 2 or more SD below the mean for gest age),Child fails to manifest catch up growth by age 4 yr(ht 2 or more SD below the mean for age,gender)AND Other causes for SS have been ruled out.Transitioning adolescent:GH tx has been stopped for at least a month, and GHD has been reconfirmed:idiopathic isolated GHD(SubNL response to 2 GH stim tests, OR SubNL response (GH conc of less than10 ng/mL)to 1 provocative test and low IGF-I/IGFBP-3)OR multiple pit hormone deficiency,(SubNL response to 1 provocative GH test and/or low IGF-I/IGFBP-3)or any of the following, known genetic mutation associated with def GH production or secretion or Hypothalamic-pit tumor or structural defect or 3 other pit hormone deficiencies.Adult GHD must be confirmed/reconfirmed:SubNL response in adults to 2 GH stim tests (GH conc of less than or equal to 5ng/ml when using insulin induced hypoglycemia OR GH conc of less than or equal to 4.1ng/ml when using arginine)OR SubNL response to 1 stim test for adults with hypothalamic or pit dz and 1 pit hormone deficits OR 3 other pit hormone deficiencies.Reconstructive GH tx who dont have GHD may be approved if either mean ht is at least 2.25 but less than 2.5SD below the mean for age, gender and GV is less than the 10th percentile over 1yr or mean ht is at least 2.5SD below the mean for age, gender for conditions known responsive to GH.Cont of GH tx in child is approved when doubling of pre-tx growth rate or an inc in pre-tx growth rate of 3cm/yr or more seen in the first yr of tx, for tx continuing past the 1st yr, growth remains above 2.5cm/yr (doesnt apply to child with prior hypopit).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	GH may be approved for Adolescents with childhood onset GHD who have completed linear growth. GH for Short bowel syndrome patient must be on specialized nutritional support and with optimal management of short bowel syndrome. Specialized nutrition support may consist of a high-carbohydrate, low-fat diet adjusted for individual patient requirements.

HUMIRA

Products Affected

- HUMIRA CROHN'S DIS START PCK
- HUMIRA SUBCUTANEOUS KIT 20 MG/0.4 ML, 40 MG/0.8 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using Humira in combination with other TNF agents, Abatacept, or Kineret (anakinra). Tuberculosis, invasive fungal infection, other active serious infections, or a history of recurrent. Patients who have not had a tuberculin skin test or CDC-recommended equivalent to evaluate for latent tuberculosis
Required Medical Information	For Chronic moderate to severe plaque psoriasis with either of the following: Patient has greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	Patient is 18 years of age or older for all indications except JIA. Patient must be at least 4 years old for JIA.
Prescriber Restrictions	N/A
Coverage Duration	1 year

Other Criteria	For moderate to severe active RA, Psoriatic Arthritis, and moderate to severe JIA, patient has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbologic DMARD. For Ankylosing Spondylitis, patient has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (e.g. NSAIDs or nonbiologic DMARDs). For Crohn's disease patient has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (e.g. 5-ASA products, sulfasalazine, systemic corticosteroids, or immunosuppressants). For chronic moderate to severe plaque psoriasis, patient has failed to respond to, is intolerant of, or has a medical contraindication to phototherapy or ONE other systemic therapy (e.g. methotrexate, acitretin, or cyclosporine). For moderately to severely active Ulcerative Colitis (UC), individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (e.g. 5-ASA products, Sulfasalazine, systemic corticosteroids, or immunosuppressive drugs)

ILARIS

Products Affected

- ILARIS (PF)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Tuberculosis, invasive fungal infection, other active serious infection, or a history of recurrent infection. Individual who have not had a tuberculin skin test or a CDC-recommended equivalent to evaluate for latent tuberculosis. Using Ilaris in combination with other biologic disease-modifying antirheumatic drugs (DMARDs) such as tumor necrosis factor (TNF) antagonists, IL-1R antagonists, or an IL-6 receptor antagonist
Required Medical Information	N/A
Age Restrictions	For cryopyrin-associated periodic syndromes age 4 years and older and for systemic juvenile idiopathic arthritis 2 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For SIJA, individual has failed to respond to, intolerant of, or has a medical contraindication to ONE corticosteroids or nonsteroidal anti-inflammatory drugs (NSAIDs) and used alone or in combination with corticosteroids, methotrexate or NSAIDs

IMBRUVICA

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

INCIVEK

Products Affected

- INCIVEK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using in combination with another serine protease inhibitor or polymerase inhibitor. Individual has received previous treatment for hepatitis C virus (HCV) with triple therapy regimen which consists of a pegylated interferon, ribavirin, and a serine protease inhibitor or a polymerase inhibitor.
Required Medical Information	Documentation must be provided of a diagnosis of Hep C genotype 1 AND using in combination with peginterferon alfa and ribavirin AND individual has compensated liver disease (including cirrhosis). Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual does not have closed epiphyses (closed bone growth plates signifying end of potential growth). Growth failure with severe primary IGFD is defined by: Height standard deviation score of less than or equal to -3.0 AND Basal IGF-1 standard deviation score of less than or equal to -3.0 AND normal or elevated growth hormone.
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

INLYTA

Products Affected

- INLYTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

INTERFERON BETA 1B

Products Affected

- EXTAVIA SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with primary progressive MS. Patients with secondary progressive MS without relapsing disease. Treatment of MS with IFN beta-1a (Avonex, Rebif) or IFN beta-1b (i.e., Betaseron, Extavia) in combination with glatiramer acetate (Copaxone) or in combination with natalizumab (Tysabri)
Required Medical Information	Member has been on Extavia or Betaseron in the past 180 days OR member has tried therapy with ONE of the following agents: Avonex (interferon beta-1a) OR Rebif (interferon beta-1a) OR Tecfidera (dimethyl fumarate) OR Copaxone (glatiramer). Member with a single demyelinating episode with consistent MRI findings, considered at high risk for clinically definite MS OR Patients with MS with relapsing or remitting disease OR Patients with secondary progressive MS with a history of superimposed relapses.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

INTERFERONS FOR MS

Products Affected

- AVONEX INTRAMUSCULAR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- REBIF (WITH ALBUMIN)
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members with primary progressive MS. Members with secondary progressive MS without relapsing disease. Treatment of MS with IFN beta-1a (Avonex, Rebif) or IFN beta-1b (i.e., Betaseron, Extavia) in combination with glatiramer acetate (Copaxone) or in combination with natalizumab (Tysabri).
Required Medical Information	Members with a single demyelinating episode with consistent MRI findings, considered at high risk for clinically definite MS OR Patients with MS with relapsing or remitting disease (RRMS) OR Members with secondary progressive MS (SPMS) with a history of superimposed relapses
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

INTUNIV

Products Affected

- INTUNIV ER

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

ISTODAX

Products Affected

- ISTODAX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ITRACONAZOLE

Products Affected

- *itraconazole*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For fingernail/toenail onychomycosis 12 weeks. For all other indications 1 year.
Other Criteria	For second-line non-onychomycosis indications include tinea infections (including, but limited to tinea versicolor, tinea cruris, tinea corporis, tinea pedis, tinea manuum, and tinea capitis) where the individual has received at least one prior topical therapy: clotrimazole, ketoconazole, econazole, or nystatin.

IVIG

Products Affected

- BIVIGAM
- CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 3 GRAM
- GAMASTAN S/D
- GAMMAGARD LIQUID
- GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- PRIVIGEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), medical records must indicate clinical presentation is not consistent with other polyneuropathies (Igm neuropathy, hereditary neuropathy, diabetic neuropathy) and ONE of the following clinical and electrodiagnostic criteria are met: proximal weakness or sensory dysfunction caused by neuropathy and nerve conduction studies confirm electodiagnostic evidence of a demyelinating neuropathy in at least 2 limbs. OR distal muscle weakness and results of diagnostic testing meet recognized set of diagnostic criteria as established by AAN, Saperstien, or INTAC. Continued use of IG for CDIP requires clinically significant improvement in neurological symptoms as documented on physical exam AND continued need is demonstrated by documentation that attempts on an annual basis to titrate the dose or the interval of therapy result in worsening symptoms. For Multifocal Motor Neuropathy (MMN) patient presents with asymmetric weakness that predominantly affects distal muscles AND nerve conduction studies confirm a demyelinating neuropathy is present (conduction block, slowing, or abnormal temporal dispersion in at least one nerve) OR clinical history or exam do not suggest upper motor neuron disease (no bulbar weakness, no upper motor neuron signs) and GM-1 antibody titers are elevated. OR after initial exam and electrodiagnostic testing clinical presentation suggests MMN but the diagnosis remains uncertain. Continued use for MMN requires clinical results document an improvement in strength and function within 3 weeks of start of infusion and need is demonstrated by documentation that attempts on an annual basis to titrate the dose or interval of therapy result in worsening of symptoms. Secondary hypoglobulinemia in individuals who are immunosuppressed (for example status-post bone marrow transplant) and have a documented total IgG less than 500 mg/dl

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	To reduce the risk of graft-versus-host disease associated with interstitial pneumonia (infectious or idiopathic) and infections (cytomegalovirus infections, Varicella-zoster virus infection, and recurrent bacterial infection) in allogeneic bone marrow transplant (BMT) recipients in the first 100 days after transplantation. Dermatomyositis, refractory (IVIG is used as a second line treatment of dermatomyositis. Corticosteroids are first-line treatments of dermatomyositis.). Myasthenia Gravis, severe refractory. Polymyositis, routine use of IG is not recommended. IG may be considered in patients with severe polymyositis for whom other treatments have been unsuccessful, have become intolerable, or are contraindicated. Prior to a medically necessary solid organ transplantation for suppression of panel reactive anti-HLA antibodies in patients with high panel reactive antibody (PRA) levels to human leukocyte antigens (HLA).. Stiff-person syndrome not controlled by other therapies. Toxic shock syndrome caused by staphylococcal or streptococcal organisms refractory to several hours of aggressive therapy. Solid organ transplant recipients at risk for CMV. Tx of chronic parvovirus B19 infection and severe anemia associated with bone marrow suppression. Refractory auto-immune mucocutaneous blistering diseases including: pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid, epidermolysis bullosa acquisita. Tx of primary humoral immunodeficiency when: no evidence of renal (nephrotic syndrome) and gastrointestinal (e.g. protein losing enteropathy) as causes of hypogammaglobulinemia AND initial pre-tx total IgG is less than 500 mg/dl. Treatment of IgG sub-class deficiency (IgG1, IgG2, IgG3, IgG4) when: One or more serum IgG subclasses are more than two standard deviations below the lower limits of the age adjusted norm AND hx of recurrent sinopulmonary infections requiring antibiotic therapy AND Lack of, or inadequate response to immunization. Tx of Kawasaki Syndrome when: within 10 days of onset and tx for no more than 5 days. For ITP when: symptomatic thrombocytopenia (for example, but not limited to hematuria, petechiae, bruising, gastrointestinal bleeding, gingival bleeding) or platelet count less than 20,000 (adult) or 30,000 (child). For hypogammaglobulinemia and recurrent bacterial infection associated with B-cell chronic lymphocytic leukemia (CLL) that includes both: Documented hx of recurrent bacterial infection or an active infection not responding to antimicrobial therapy AND Documentation that total IgG is less than 500mg/dL.

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

KADCYLA

Products Affected

- KADCYLA INTRAVENOUS RECON SOLN 100 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Tumor(s) have been evaluated with an assay validated to predict HER2 protein overexpression. Individuals are considered HER2 positive whose tumors have HER2 protein overexpression documented by one of the following, immunohistochemistry (IHC) 3+ or fluorescent in situ hybridization (FISH) HER2 gene copy is greater than 6 OR FISH ratio of HER2 gene/chromosome 17 ratio is greater than or equal to 2.0.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For metastatic breast cancer, individual has previously received trastuzumab and a taxane, separately or in combination. AND has either received prior therapy for metastatic disease OR developed disease recurrence during or within six (6) months of completing adjuvant therapy. Kadcyla is only used in one line of therapy.

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member has a diagnosis of cystic fibrosis (CF) AND Member has any of the following mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: G551D, G178R, S549N, S549R, G551S, G1244E, S1251N, S1255P and G1349D. A copy of test results from an FDA-cleared cystic fibrosis mutation test (e.g., xTAG CF kit) must be provided. Results must document a mutation in the CFTR gene
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

KINERET

Products Affected

- KINERET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual using in combination with other TNF antagonists.
Required Medical Information	N/A
Age Restrictions	Individual must be 18 years of age or older for RA
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For RA, Individual has failed or had an inadequate response to ONE DMARD AND Individual has tried and failed Enbrel, Remicade or Humira in the previous 180 days.

KLONOPIN

Products Affected

- *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- *clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

KUVAN

Products Affected

- KUVAN ORAL TABLET,SOLUBLE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	If blood phenylalanine levels do not decrease from baseline at a dose of 10mg/kg/day administered for up to one month. The dose may be increased up to 20mg/kg/day. Individuals are non-responders if phenylalanine levels do not decrease after 1 month and tx should be discontinued
Required Medical Information	For initial requests, Individual has Dx of Hyperphenylalaninemia (HPA) due to tetrahydrobiopterin-(BH4) responsive PKU and using in conjunction with a phenylalanine restricted diet. For continued use, individual is using in conjunction with a phenylalanine restricted diet and also shows signs of continuing improvement as evidenced by blood phenylalanine levels/dietary phenylalanine allowance
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial 8 weeks, 1 year for continuation
Other Criteria	N/A

LAZANDA

Products Affected

- LAZANDA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of cancer with breakthrough cancer pain AND has tried and failed fentanyl citrate lozenge (generic Actiq) AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer.

LETAIRIS

Products Affected

- LETAIRIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has catheterization-proven diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve exercise ability and delay clinical worsening AND individual has NYHA Functional Class II-III symptoms
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LEUKINE

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prognostic factors predictive of clinical deterioration: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10to the power of 9/L) neutropenia, Age greater than 65 years, Uncontrolled primary disease, Pneumonia, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than or equal to 20% based on chemotherapy in patients who have other patient specific risk factors for FN including any of the following: Individual age greater than 65 years, Poor performance status, Previous episodes of FN, history of previous chemotherapy or radiation, After completion of combined chemoradiotherapy, Bone marrow involvement by tumor producing cytopenias, Poor nutritional status, poor renal function, liver dysfunction, The presence of open wounds or active infections, recent surgery, advanced cancer or Other serious comorbidities.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year

Other Criteria	Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Adjunctive use in neutropenic patients who are at high risk for infection-associated complications or have any of the prognostic factors predictive of clinical deterioration. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for adjuvant treatment of breast cancer. For acute lymphocytic leukemia (ALL) after completion of the first few days of initial induction chemotherapy or first post-remission course of chemotherapy. For administration shortly after the completion of induction or repeat induction chemotherapy of acute myeloid leukemia (AML) for individuals over 55 years of age. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500 mm3 or experiencing recurrent infection. For radiation therapy in the absence of chemotherapy if prolonged delays secondary to neutropenia are expected. After accidental or intentional total body radiation of 3 to 10 Grays (Gy). After autologous hematopoietic progenitor stem cell transplant (HPCT/HSCT). To mobilize progenitor cells into peripheral blood for collection by leukapheresis, as an adjunct to peripheral blood/hematopoietic stem cell transplantation (PBSCT/PHSCT). For use in myeloid reconstitution after allogeneic bone marrow transplantation from HLA-matched related donors (MRD). Use in individuals who have undergone allogeneic or autologous bone marrow transplantation in whom engraftment is delayed or has failed.

LIDODERM PATCH

Products Affected

- *lidocaine topical adhesive patch,medicated*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LOTRONEX

Products Affected

- LOTRONEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Severe diarrhea-predominant Irritable Bowel Syndrome (IBS) where severe includes diarrhea and 1or more of the following: Frequent and severe abdominal pain/discomfort, Frequent bowel urgency or fecal incontinence, Disability or restriction of daily activities due to IBS. Member is female AND Member has chronic symptoms of IBS that have persisted for 6 months or longer AND does not have an anatomic or biochemical abnormality of the gastrointestinal tract
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LOVAZA

Products Affected

- *omega-3 acid ethyl esters*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Using as an adjunct to diet to reduce triglyceride (TG) levels AND TG must be greater than or equal to 500 mg/dL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LUPRON DEPOT

Products Affected

- LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG, 7.5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7, or prostate specific antigen (PSA) value of 10-20 ng/mL) or higher risk of recurrence OR Locally advanced disease OR Other advanced, recurrent, or metastatic disease. OR in combination with antiandrogen (flutamide or bicalutamide) for locally confined stage T2b-T4 (stage B2-C) disease OR shrink an enlarged prostate to an acceptable size prior to brachytherapy, cryosurgery or external beam radiation therapy for the treatment of prostate cancer. For Gynecology Uses: Endometriosis, Chronic pelvic pain not to continue beyond three months if there is no symptomatic relief, To decrease endometrial thickness prior to endometrial ablation procedures, Preoperative treatment as adjunct to surgical treatment of uterine fibroids (leiomyoma uteri). May be used to reduce size of fibroids to allow for a vaginal procedure, prior to surgical treatment (myomectomy or hysterectomy) in patients with documented anemia. To induce amenorrhea in women in certain patient populations including menstruating women diagnosed with severe thrombocytopenia or aplastic anemia. Precocious puberty, defined as beginning of secondary sexual characteristics before age 8 in girls and before age 9 in boys. Ovarian Cancer (including fallopian tube cancer and primary peritoneal cancer):Hormonal therapy for clinical relapse in individuals with stage II-IV granulosa cell tumors or Hormonal therapy for treatment of epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer as a single agent for: Progressive, stable or persistent disease on primary chemotherapy or Relapse after complete remission following primary chemotherapy or Stage II-IV disease showing partial response to primary treatment or Low grade or focal recurrences after a disease free interval of greater than 6 months
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	1 year, except for Endometriosis:6months, Uterine Fibroids:3months
Other Criteria	N/A

LUPRON KIT IR

Products Affected

- *leuprolide*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7, or prostate specific antigen (PSA) value of 10-20 ng/mL) or higher risk of recurrence OR Locally advanced disease OR Other advanced, recurrent, or metastatic disease. OR in combination with antiandrogen (flutamide or bicalutamide) for locally confined stage T2b-T4 (stage B2-C) disease OR shrink an enlarged prostate to an acceptable size prior to brachytherapy, cryosurgery or external beam radiation therapy for the treatment of prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LYRICA

Products Affected

- LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG
- LYRICA ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Fibromyalgia: Patient has widespread pain (on the left and right side of the body and above and below the waist) AND axial skeletal pain (cervical spine or anterior chest or thoracic spine or low back) present for at least 3 months AND Pain in at least 11 of 18 specific tender point sites after digital palpation with an approximate force of 4 kg. Tender point sites are bilateral and include the following: Occiput, Low Cervical, Trapezius, Supraspinatus, Second rib, Lateral epicondyle, Gluteal, Greater trochanter, Knee.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For diabetic peripheral neuropathy, member had a trial and failure of an FDA approved medication for neuropathic pain within the past 180 days(Cymbalta). For post herpetic neuralgia, member had a trial and failure of an FDA approved medication for post herpetic neuralgia within the past 180 days (Gabapentin, Lidoderm patch). For Fibromyalgia, member had a trial and failure of an FDA approved medication for Fibromyalgia (Cymbalta).

MEGACE SUSPENSION HRM

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml)*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has been on the requested medication and the prescriber would like to continue member on the requested high risk medication. OR individual is using for the treatment of anorexia, cachexia, or unexplained weight loss in individuals with HIV/AIDS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

MEGACE TABS HRM

Products Affected

- *megestrol oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has been on the requested medication and the prescriber would like to continue member on the requested high risk medication. OR individual is using for palliative treatment of advanced carcinoma of the breast or endometrium.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

MEKINIST

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has received prior BRAF-inhibitor therapy (e.g., Tafinlar (dabrafenib), Zelboraf (vemurafenib))
Required Medical Information	Copy of the test results must be provided that document the BRAF V600E or V600K mutation from a FDA-approved companion diagnostic test
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A

MEPRON

Products Affected

- *atovaquone*
- MEPRON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Intolerance to trimethoprim-sulfamethoxazole (TMP-SMX)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

METHOXSALEN

Products Affected

- *methoxsalen rapid*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

METHYLPHENIDATE

Products Affected

- *methylphenidate oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual is using for Attention Deficit Hyperactivity Disorder (ADHD)or Narcolepsy.
Age Restrictions	6 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

MODAFINIL

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Excessive daytime sleepiness due to Narcolepsy: Confirmed by Multiple sleep latency test (MLST) with mean sleep latency of less than 8 minutes with documented rapid eye movement (REM) sleep during at least 2 naps. Obstructive Sleep Apnea-Hypopnea syndrome: Confirmed by Epworth Sleepiness score greater than or equal to 10 AND Patient has excessive sleepiness or insomnia with frequent episodes of impaired breathing during sleep and ONE of the following associated feature: loud snoring, morning headaches or dry mouth upon awakening. OR Confirmed by polysomnography demonstrating more than 5 obstructive apneas, greater than 10 seconds in duration, per hour of sleep with one of the following: frequent arousals from sleep, bradytachycardia or arterial oxygen desaturation. Shift-work Sleep Disorder (SWSD): Confirmed by patient having excessive sleepiness or insomnia associated with a work period that occurs during the usual sleep phase, AND Symptoms occur over at least one month, AND No other medical disorder or mental disorder accounts for the symptoms, AND Symptoms do not meet criteria for any other sleep disorder (i.e. jet lag). Idiopathic Hypersomnia (also known as Primary Hypersomnia): Confirmed by MLST with mean sleep latency of less than 10 minutes with REM during less than 2 naps.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

MOZOBIL

Products Affected

- MOZOBIL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using as a mobilizing agent for an allogeneic stem cell donor, mobilizer of leukemic cells or as a component of a conditioning regimen prior to an allogeneic hematopoietic stem cell transplant.
Required Medical Information	Using in combination with granulocyte colony stimulating factor (G-CSF) and after stem cell mobilization and collection, a subsequent autologous hematopoietic stem cell transplant is anticipated.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Individual may use a maximum of up to four consecutive doses of plerixafor (Mozobil) injections per cycle for up to 2 cycles.

MYOZYME

Products Affected

- MYOZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	For the treatment of non-infantile onset (late-onset) Pompe disease.
Required Medical Information	Diagnosis of infantile-onset Pompe disease is confirmed with acid alpha-glucosidase deficiency (GAA) activity in skin fibroblasts of less than 1% of the normal mean or by GAA gene sequencing AND Presence of symptoms (for example respiratory and/or skeletal muscle weakness) of infantile-onset Pompe disease AND Evidence of hypertrophic cardiomyopathy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

NAGLAZYME

Products Affected

- NAGLAZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

NAMENDA LINE

Products Affected

- NAMENDA ORAL SOLUTION
- NAMENDA XR ORAL CAP,SPRINKLE,ER 24HR DOSE PACK
- NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Members that are 50 years of age or older are NOT subject to the prior authorization requirements. Prior Authorization applies to members that are 49 years of age or younger.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

NEULASTA

Products Affected

- NEULASTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prognostic factors predictive of clinical deterioration: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10to the power of 9/L) neutropenia, Age greater than 65 years, Uncontrolled primary disease, Pneumonia, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than or equal to 20% based on chemotherapy in patients who have other patient specific risk factors for FN including any of the following: Individual age greater than 65 years, Poor performance status, Previous episodes of FN, history of previous chemotherapy or radiation, After completion of combined chemoradiotherapy, Bone marrow involvement by tumor producing cytopenias, Poor nutritional status, poor renal function, liver dysfunction, The presence of open wounds or active infections, recent surgery, advanced cancer or Other serious comorbidities.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year

Other Criteria	Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Adjunctive use in neutropenic patients who are at high risk for infection-associated complications or have any of the prognostic factors predictive of clinical deterioration. In an individual with acute lymphocytic leukemia (ALL) after completion of the first few days of initial induction chemotherapy or first post-remission course of chemotherapy. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500 mm3 or experiencing recurrent infection. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for adjuvant treatment of breast cancer. After autologous hematopoietic progenitor stem cell transplant (HPCT/HSCT).

NEUMEGA

Products Affected

- NEUMEGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual is as high risk of developing severe thrombocytopenia (platelet count of less than or equal to 20,000/?L) defined as either of the following: Severe thrombocytopenia occurred following the prior chemotherapy cycle OR Individual has received a dose-dense or dose-intensive chemotherapy likely to cause severe thrombocytopenia.
Age Restrictions	18 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A

NEUPOGEN

Products Affected

- NEUPOGEN INJECTION SOLUTION 480 MCG/1.6 ML
- NEUPOGEN INJECTION SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prognostic factors predictive of clinical deterioration: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10to the power of 9/L) neutropenia, Age greater than 65 years, Uncontrolled primary disease, Pneumonia, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than or equal to 20% based on chemotherapy in patients who have other patient specific risk factors for FN including any of the following: Individual age greater than 65 years, Poor performance status, Previous episodes of FN, history of previous chemotherapy or radiation, After completion of combined chemoradiotherapy, Bone marrow involvement by tumor producing cytopenias, Poor nutritional status, poor renal function, liver dysfunction, The presence of open wounds or active infections, recent surgery, advanced cancer or Other serious comorbidities.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year

Other Criteria	Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Adjunctive use in neutropenic patients who are at high risk for infection-associated complications or have any of the prognostic factors predictive of clinical deterioration. Use in acute lymphocytic leukemia (ALL) after completion of the first few days of initial induction chemotherapy or first post-remission course of chemotherapy. Use in individuals with acute myeloid leukemia (AML) shortly after the completion of induction or repeat induction chemotherapy, or after the completion of consolidation chemotherapy for AML. For tx of moderate to severe aplastic anemia. Tx of severe neutropenia in individuals with hairy cell leukemia. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500 mm3 or experiencing recurrent infection. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for adjuvant treatment of breast cancer. For chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic individuals with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. For tx of (non-chemotherapy) drug-induced neutropenia. For tx of low neutrophil counts in individuals with glycogen storage disease type 1b. For tx of neutropenia associated with human immunodeficiency virus (HIV) infection and antiretroviral therapy. In individuals receiving radiation therapy in the absence of chemotherapy if prolonged delays secondary to neutropenia are expected. After accidental or intentional total body radiation of 3 to 10 Grays (Gy). After autologous hematopoietic progenitor stem cell transplant (HPCT/HSCT). To mobilize progenitor cells into peripheral blood for collection by leukapheresis, as an adjunct to peripheral blood/hematopoietic stem cell transplantation (PBSCT/PHSCT). Use as an alternate or adjunct to donor leukocyte infusions (DLI) in individuals with leukemic relapse after an allogeneic hematopoietic stem cell transplant.

NEUPRO

Products Affected

- NEUPRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has had a previous trial of or has a contraindication to either Mirapex (pramipexole) or Requip (ropinirole). OR Individual is unable to swallow or take oral medications.

NEXAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

NON-PEGYLATED INTERFERONS

Products Affected

- INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML)
- INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Hepatitis B when: HBeAg is either positive or negative AND Detectable levels of Hepatitis B DNA AND member has Compensated liver disease AND ALT at least 2X upper limit of normal
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1yr
Other Criteria	N/A

NOXAFIL

Products Affected

- NOXAFIL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year.
Other Criteria	N/A

NP STATIN

Products Affected

- ALTOPREV

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	1.Documentation must be provided for at least a 60 day trial of one generic statin drug and did not achieve LDL cholesterol goal AND at least a 60 day trial of Crestor 20mg or greater and did not achieve LDL cholesterol goal. OR 2. Individual has had a trial of generic statin or Crestor at any dose in the previous 180 days and documentation is provided for one of the following: Diagnosis of rhabdomyolysis, Elevated CPK levels deemed clinically significant by the provider, or Elevated LFT levels deemed clinically significant by the provider. OR 3. Individual is currently on a product that interacts with both preferred generic statin and Crestor. Documentation should include, but is not limited to, chart notes, prescription claims records, prescription receipts, laboratory data, reason for failure of medications tried (e.g. symptoms, frequency)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

OLYSIO

Products Affected

- OLYSIO

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

ONFI

Products Affected

- ONFI ORAL SUSPENSION
- ONFI ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

OXANDRIN

Products Affected

- *oxandrolone oral tablet 10 mg, 2.5 mg*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

PAH

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnostic Criteria for PAH: right heart catheterization which shows a mean pulmonary artery pressure (mPAP) greater than 25mmhg, a pulmonary capillary wedge pressure (PCWP), left atrial pressurem or left ventricular end diastolic pressure (LVEDP) l ess than or equal to 15mmhg AND a pulmonary vascular resistance (PVR) greater than 3 wood units. Criteria for Vasodilator Response: a favorable response is defined as a fall in mPAP of at least 10mmhg to an absolute mPAP of less than 40mmhg without a decrease in cardiac output, when challenged with inhaled nitric oxide, intravenous epoprostenol or intravenous adenosine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year

Other Criteria	For Remodulin patient must meet all of the following: meets diagnostic criteria for PAH AND demonstrates an unfavorable acute response to vasodilators AND meets one of the following patient selection criteria with New York Heart Association (NYHA) functional class II, III, or IV symptoms: World health Organization (WHO) Group I idiopathic pulmonary arterial hypertension including all subtypes of WHO Group I PAH or Pulmonary hypertension associated with connective tissue disorders (scleroderma, systemic sclerosis, etc.) or pulmonary hypertension associated with congenital heart defects. For Continuous intravenous infusion of Remodulin the individual must also be able document the inability to tolerate treatment by subcutaneous infusion. For Ventavis and Tyvaso patient must meet all of the following: meets diagnostic criteria for PAH AND demonstrates an unfavorable acute response to vasodilators AND meets one of the following patient selection criteria with New York Heart Association (NYHA) functional class III, or IV symptoms: World health Organization (WHO) Group I idiopathic pulmonary arterial hypertension including all subtypes of WHO Group I PAH or Pulmonary hypertension associated with connective tissue disorders (scleroderma, systemic sclerosis, etc.) or pulmonary hypertension associated with congenital heart defects.

PEGYLATED INTERFERONS

Products Affected

- PEGASYS
- PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 135 MCG/0.5 ML

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

PENLAC

Products Affected

- *ciclopirox topical solution*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has a confirmed fungal infection (i.e. physical exam).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has had a trial of, or is contraindicated to itraconazole and Terbinafine OR Patient has used Penlac/ciclopirox/ciclodan 8 percent solution within the previous 6 months.

PERJETA

Products Affected

- PERJETA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with other targeted biologic agents (including but not limited to erlotinib, cetuximab, panitumumab, bevacizumab, and lapatinib).
Required Medical Information	Tumor(s) have been evaluated with an assay validated to predict HER2 protein overexpression. Individuals are considered HER2 positive whose tumors have HER2 protein overexpression documented by one of the following, immunohistochemistry (IHC) 3+ or fluorescent in situ hybridization (FISH) HER2 gene copy is greater than 6 OR FISH ratio of HER2 gene/chromosome 17 ratio is greater than or equal to 2.0.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For breast cancer use Perjeta will be used in combination with trastuzumab AND either docetaxel or paclitaxel. (Note If docetaxel or paclitaxel treatment is discontinued (for example, related to toxicity), treatment with Perjeta and trastuzumab may continue.) AND combination chemotherapy with Perjeta (pertuzumab) will be used as single line anti-HER2 chemotherapy for metastatic disease until progression. For neoadjuvant treatment (prior to surgery) of individuals with HER2-positive, locally advanced, inflammatory, or operable early stage breast cancer AND primary tumor is larger than 2cm or individual is node positive (clinically evident by palpation or imaging) AND ECOG performance status 0-1 AND used in combination with trastuzumab and docetaxel with or without carboplatin AND complete surgical resection is planned if neoadjuvant therapy results in a sufficient therapeutic response AND not continued post-operatively (adjuvant)

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

PRISTIQ

Products Affected

- PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HR 100 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Trial of a generic selective serotonin reuptake inhibitor (SSRI) AND Trial of venlafaxine IR/ER and is unable to tolerate doses greater than 150mg OR Individual is currently taking a medication that would interact with venlafaxine IR/ER (e.g. CYP2D6 inducers/inhibitors) where Pristiq would be the better drug of choice, please specify.

PROLIA

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone Mineral Density (BMD) must be provided with all requests. Osteoporosis is defined as a BMD T-Score of less than or equal to -2.5. Risk factors for osteoporotic fracture is defined as: Hypogonadism or premature ovarian failure, Low body mass, Smoking, Rheumatoid arthritis, Alcohol intake of 3 or more drinks/day, Vitamin D deficiency, Low calcium intake, Hyperkyphosis, Parental hip fracture, Multiple falls, Medication: Anticoagulants, anticonvulsants, cancer chemotherapeutic drugs, gonadotropin-releasing hormone agonists, (glucocorticoid daily dosage equivalent to 5 mg or greater of prednisone for at least 3 months)
Age Restrictions	For Osteoporosis 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For osteoporosis treatment, member has had at least ONE osteoporotic (minimal trauma) fracture OR has two or more risk factors for osteoporotic fracture OR Individual has failed or is intolerant to other available osteoporosis therapies (such as, bisphosphonates). For treatment of bone loss, member has had at least ONE osteoporotic (minimal trauma) fracture OR has one or more risk factors for osteoporotic fracture.

PROMACTA

Products Affected

- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using Promacta to normalize platelet counts. Use in individuals with ITP whose degree of thrombocytopenia and clinical condition do not increase the risk of bleeding. Use in individuals with chronic hepatitis C whose degree of thrombocytopenia does not prevent the initiation of interferon therapy or limits the ability to maintain an optimal interferon-based therapy.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For diagnosis of chronic hepatitis C-associated thrombocytopenia, member will be initiated and maintained on an interferon-based regimen. For dx of chronic immune (idiopathic) thrombocytopenia purpura (ITP), member has had an insufficient response to one of the following interventions: a) corticosteroids or b) immunoglobulins or c) splenectomy.

RANEXA

Products Affected

- RANEXA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

RELISTOR

Products Affected

- RELISTOR SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a known or suspected mechanical gastrointestinal obstruction.
Required Medical Information	Individual has advanced illness and receiving palliative care
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

REMICADE

Products Affected

- REMICADE

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

REVATIO

Products Affected

- *sildenafil*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual is NOT on concurrent therapy with oral erectile dysfunction drugs AND Individual is NOT on concurrent therapy with nitrates (nitric oxide is excluded)
Required Medical Information	Catheterization-proven diagnosis of Pulmonary Arterial Hypertension (WHO Group I) to improve exercise ability and delay clinical worsening and NYHA Functional Class II-III symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

REVLIMID

Products Affected

- REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For transfusion-dependent anemia associated with low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion of 5q cytogenetic abnormality. For chronic lymphoid leukemia, relapsed or refractory disease.

RIBAVIRIN AGENTS

Products Affected

- REBETOL ORAL SOLUTION
- *ribasphere oral capsule*
- *ribasphere oral tablet 200 mg*
- *ribavirin oral capsule*
- *ribavirin oral tablet 200 mg*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

RITUXAN

Products Affected

- RITUXAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For RA, Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For RA, Member is currently taking methotrexate unless intolerant or contraindicated AND Member has had an inadequate response to Enbrel, Humira, or Remicade. For non-Hodgkin and Hodgkin lymphoma: treatment of CD20+ lymphoma, maintenance therapy of CD20+ follicular B cell Non Hodgkin lymphoma for up to 2 years. Zevalin regimen, as part of the Zevalin therapeutic regimen for NHL.

SABRIL

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For infantile spasm 1 month to 2yr old. For seizure 10 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SAMSCA

Products Affected

- SAMSCA ORAL TABLET 15 MG, 30 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SANDOSTATIN IR

Products Affected

- *octreotide acetate injection solution*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For brand Sandostatin requests, the member has tried, failed or is intolerant to generic octreotide
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SANDOSTATIN LAR

Products Affected

- SANDOSTATIN LAR DEPOT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SERAX

Products Affected

- *oxazepam*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

SIMPONI

Products Affected

- SIMPONI SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use of golimumab in combination with other TNF antagonists, abatacept, or anakinra. Tuberculosis, invasive fungal infections, other active serious infections, or a history of recurrent infections. Individuals who have not had a TST or a CDC-recommended equivalent to evaluate for latent tuberculosis.
Required Medical Information	N/A
Age Restrictions	Patient is 18 years or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For RA, member is taking in combination with methotrexate OR member has failed to respond to, is intolerant of, or has a medical contraindication to ONE immunosuppressive agent (e.g. 6-mercaptopurine, azathioprine, cyclophosphamide, cyclosporine, methotrexate, tacrolimus) OR ONE nonbiologic DMARD AND member has tried and failed Humira, Remicade or Enbrel in the previous 180 days. For Psoriatic Arthritis, member has failed to respond to, is intolerant of, or has a medical contraindication to ONE DMARD therapy AND member has tried and failed Humira, Remicade or Enbrel in the previous 180 days. For Ankylosing Spondylitis, member has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (e.g. NSAIDs or nonbiologic DMARDs) AND member has tried and failed Humira, Remicade OR Enbrel in the previous 180 days. For UC with demonstrated corticosteroid dependence, member has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as 6-mercaptopurine, azathioprine, oral aminosalicylates, or oral corticosteroids) AND member has tried and failed Humira or Remicade in the previous 180 days.

SOLARAZE

Products Affected

- *diclofenac sodium topical gel*
- SOLARAZE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Dx of Actinic Keratosis AND member has tried and failed one of the following agents, Fluorouracil solution, Fluorouracil cream, Carac Cream, or imiquimod cream.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SOMAVERT

Products Affected

- SOMAVERT SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Dx of acromegaly AND member has had an inadequate response to surgery or radiation OR mbr is unable to tolerate or is resistant to other therapies or are not appropriate therapies for the member.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SOVALDI

Products Affected

- SOVALDI

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

SPRYCEL

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	approved for 18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For diagnosis of ALL, member has disease progression or developed intolerance while using other chemotherapy.

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

STRATTERA

Products Affected

- STRATTERA ORAL CAPSULE 10 MG, 100 MG, 18 MG, 25 MG, 40 MG, 60 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	dx of adhd AND trial and failure of ONE stimulant medication OR patient or family member has a history of substance diversion or abuse OR patient has diagnosis of anxiety or a tic disorder (e.g. tourettes syndrome)
Age Restrictions	age 6 and up
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SUBOXONE

Products Affected

- *buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg*
- SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial Request may be approved if individual is being treated for opioid dependence, and Individual must participate in a comprehensive rehabilitation program that includes psychosocial support (documentation of treatment plan and taper strategy not required, but verification upon request must be provided). For Maintenance Request, individual must participate in a comprehensive rehabilitation program that includes psychosocial support (documentation of treatment plan and taper strategy not required, but verification upon request must be provided). Individual also has negative urine drug screen for opioids to continue treatment (documentation of negative result not required, but verification upon request must be provided) and has positive urine drug screen for buprenorphine to continue treatment (documentation of positive result not required, but verification upon request must be provided).
Age Restrictions	16 years or older
Prescriber Restrictions	Prescribers personal DEA and unique Drug Addiction Treatment Act (DATA) 2000 Waiver identification number must be provided.
Coverage Duration	Initial request is 6 months. Maintenance therapy every 6 months.
Other Criteria	N/A

SUBSYS

Products Affected

- SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY, 400 MCG/SPRAY, 600 MCG/SPRAY, 800 MCG/SPRAY

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of cancer with breakthrough cancer pain AND has tried and failed fentanyl citrate lozenge (generic Actiq) AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving: at least 60mg morphine per day, OR at least 25mcg/hr transdermal fentanyl/hour, OR at least 30mg of oxycodone daily, OR at least 8mg of oral hydromorphone daily, OR at least 25 mg of oral oxymorphone daily OR an equianalgesic dose of another opioid for a week or longer.

SUBUTEX

Products Affected

- *buprenorphine hcl sublingual tablet 2 mg, 8 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial Request may be approved if being used for opioid addiction treatment and Individual participates in a comprehensive rehabilitation program that includes psychosocial support (documentation of treatment plan and taper strategy not required, but verification upon request must be provided) and individual is pregnant OR has a documented allergic reaction to Suboxone (hypersensitivity to naloxone component). For Maintenance Request, individual must participate in a comprehensive rehabilitation program that includes psychosocial support (documentation of treatment plan and taper strategy not required, but verification upon request must be provided). Individual also has negative urine drug screen for opioids to continue treatment (documentation of negative result not required, but verification upon request must be provided) and has positive urine drug screen for buprenorphine to continue treatment (documentation of positive result not required, but verification upon request must be provided) and the individual is pregnant or has a documented allergic reaction to Suboxone (hypersensitivity to naloxone component)
Age Restrictions	16 years or older
Prescriber Restrictions	Prescribers personal DEA and unique Drug Addiction Treatment Act (DATA) 2000 Waiver identification number must be provided.
Coverage Duration	Initial request is 6 months. Maintenance therapy every 6 months.
Other Criteria	N/A

SUTENT

Products Affected

- SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For GIST, Has disease progression or intolerance while on imatinib (Gleevec). For metastatic breast cancer, Individual was previously treated with an anthracycline and a taxane.

SYLATRON

Products Affected

- SYLATRON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member is being treated for melanoma after surgery AND has confirmed lymph node involvement (visually or microscopically) AND medication is being used within 84 days of surgery
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SYMLIN

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	May not be approved if patient has any of the following, not currently taking insulin, HBA1C greater than 9 percent, receiving drugs that stimulate gastric motility (i.e. metoclopramide), diagnosis of sever gastroparesis, hypoglycemia unawareness or recent hypoglycemia requiring assistance within past 6 months
Required Medical Information	Type 1 or type 2 diabetes AND taking mealtime insulin therapy AND failed to achieve desired glucose goal despite optimal insulin therapy AND HBA1C is less than or equal to 9.
Age Restrictions	18 or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SYNAGIS

Products Affected

- SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Administration of more than 5 doses of palivizumab in one RSV season. Administration of more than 3 doses of palivizumab or any dose after 90 days of age for infants born between 32 and 35 weeks gestational age unless they have a condition listed in criteria below. Continued RSV immunoprophylaxis regimen with monthly doses of palivizumab when the National Respiratory and Enteric Virus Surveillance System (NREVSS) epidemiologic data has confirmed that the present-year RSV season has ended. Immunoprophylaxis for RSV for children who reach ages 24 months prior to the commencement of the RSV season. Treatment in children or infants with known RSV disease except as indicated above.

Required Medical Information	Immunoprophylaxis for respiratory syncytial virus (RSV) for the prevention of serious lower respiratory tract disease in infants and young children who are at high risk, when the following are met: A. Five (5) doses of palivizumab within the RSV season which begins during the first year of life with any of the following clinical presentations: Born at 28, or less, weeks of gestation (up to and including 28 weeks, 6 days) and less than 12 months of age at the start of the RSV season. OR born at 29 to 32 weeks gestation (beginning 29 weeks, 0 day through 31 weeks, 6 days) and less than 6 months of age at the start of the RSV season. OR Chronic lung disease (CLD) who have required medical tx within six months before the start of the RSV season with oxygen, steroids, bronchodilators or diuretics. OR Hemodynamically significant (for example, but not limited to, receiving medication for congestive heart failure or moderate to severe pulmonary hypertension) cyanotic or acyanotic congenital heart disease (CHD). OR infants with congenital abnormalities of the airway (i.e., tracheal ring) or a neuromuscular condition that compromises the handling of respiratory secretions. B. Up to three doses of palivizumab during one RSV season in the first year of life when ALL of the following apply: Infant born between 32 and 35 weeks gestation, (beginning 32 weeks, 0 day through 34 weeks, 6 days) AND Less than 3 months of age at the start of the RSV season AND Less than 90 days old at the time of dosing AND One or more of the following risk factors are present: a) Attends group child care (defined as a home or facility where care is provided along with at least one other infant or young child) OR b) If there are siblings or other children living in the household who are less than 5 years of age.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	5 months

Other Criteria	C. An additional dose of palivizumab may be allowed for children who undergo cardiopulmonary bypass for surgical procedures due to documented reduction in serum levels post-bypass. D. Completion of dosing schedule of palivizumab may be approved for an infant or child who is receiving RSV immunoprophylaxis and experiences break-through RSV infection. E. Five (5) doses of palivizumab within the RSV season during the second year of life may be approved for children with any of the following clinical presentations: Chronic lung diseases (CLD) who have required medical treatment within six months before the start of the RSV season with oxygen, steroids, bronchodilators or diuretics. OR Hemodynamically significant (for example, but not limited to, receiving medication for congestive heart failure or moderate to severe pulmonary hypertension) cyanotic or acyanotic congenital heart disease (CHD). OR Infants with congenital abnormalities of the airway (i.e., tracheal ring) or a neuromuscular condition that compromises the handling of respiratory secretions.

SYNAREL NASAL SOLUTION

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Precocious puberty, defined as sexual maturation before age 8 in girls and before age 9 in boys. Chronic pelvic pain, defined as noncyclical pain lasting 6 or more months that localizes to the anatomic pelvis, anterior abdominal wall at or below the umbilicus, the lumbosacral back, or the buttocks, and is of sufficient severity to cause functional disability or lead to medical care (ACOG, 2004).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SYNRIBO

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Copy of the test results must be provided that document the BRAF V600E mutation from a FDA-approved companion diagnostic test
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A

TARCEVA

Products Affected

- TARCEVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For NSCLC, tumors that have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations, a copy of the test results from the FDA-approved companion diagnostic test must be provided (i.e., cobas EGFR Mutation Test)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TARGRETIN

Products Affected

- TARGRETIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient is Age greater than 18 years
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	resistant or intolerant to prior therapy that included Gleevec (imatinib)

TAZORAC

Products Affected

- TAZORAC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	May not be approved for cosmetic purposes such as, but not limited to the following: Photoaging, Wrinkles, Hyperpigmentation, Sun damage, or Melasma.
Required Medical Information	For psoriasis, individual has up to 20% of body surface area involvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For acne, individual has had a trial of ONE topical tretinoin product. For psoriasis, individual has had a trial of either: Any two (2) topical corticosteroids or any one (1) topical corticosteroids plus calcipotriene. For psoriasis use greater than 1 year, efficacy must be documented for continued use. Documentation may include chart notes, consultation notes.

TECFIDERA

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using in combination with other immunomodulatory products (such as Aubagio, Gilenya, Tysabri, Copaxone, Extavia, Rebif, Avonex, or Betaseron).
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

THALOMID

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Approve a category X medicine for a woman taking prenatal vitamins if the member is not pregnant.

THIORIDAZINE HRM

Products Affected

- *thioridazine*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has been on the requested medication and the prescriber would like to continue member on the requested high risk medication. OR individual tried any TWO of the following medications: Fanapt, Invega, Risperidone, Abilify, Latuda, Olanzapine, Quetiapine, Ziprasidone, Haloperidol. OR Individual has a contraindication or has a clinical reason not to use safer alternatives
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TOPAMAX

Products Affected

- *topiramate oral capsule, sprinkle*
- *topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TOPICAL ANDROGENS

Products Affected

- ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)
- ANDROGEL TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)
- TESTIM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual is male. For individuals beginning treatment for Primary hypogonadism (congenital or acquired) or Hypogonadotropic hypogonadism (congenital or acquired), An initial and a repeat (at least 24 hours apart) morning total testosterone level is provided to confirm a low testosterone serum level as determined by the reference laboratory assay will be required. For individuals continuing treatment for Primary hypogonadism (congenital or acquired) or Hypogonadotropic hypogonadism (congenital or acquired), A morning total testosterone level provided to confirm testosterone levels in the mid-normal range as determined by the reference laboratory assay will be required. Documentation of testosterone levels must be provided with request. Documentation may include, but is not limited to, chart notes, consultation notes, and laboratory data.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TRACLEER

Products Affected

- TRACLEER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Catheterization-proven diagnosis of Pulmonary Arterial Hypertension (WHO Group I) to improve exercise ability and decrease clinical worsening and NYHA Functional Class II-IV symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TYKERB

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cancer has been confirmed HER2 positive
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TYZEKA

Products Affected

- TYZEKA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	chronic hepatitis B with evidence of viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease.
Age Restrictions	Patient is 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VALIUM

Products Affected

- *diazepam intensol*
- *diazepam oral tablet 10 mg, 2 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

VANCOCIN

Products Affected

- *vancomycin oral capsule 125 mg, 250 mg*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

VECTIBIX

Products Affected

- VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has received prior treatment with cetuximab (Erbitux) [Note: a course of cetuximab discontinued because of an adverse reaction is not considered prior treatment] OR Vectibix is used in combination with other anti-VEGF agents (e.g., bevacizumab) OR Vectibix is being used for more than one line (course) of therapy.
Required Medical Information	KRAS gene mutation testing is documented and the tumor is determined to be KRAS wild-type.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Used as a single agent or as part of combination therapy for stage IV colon, rectal, colorectal, small bowel or anal adenocarcinoma.

VELCADE

Products Affected

- VELCADE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VFEND

Products Affected

- VFEND ORAL SUSPENSION FOR RECONSTITUTION
- *voriconazole oral suspension for reconstitution*
- *voriconazole oral tablet 200 mg, 50 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Requests for onychomycosis will not be approved.
Required Medical Information	Transitioning from inpatient treatment of IV antifungal to an outpatient setting, The physican requires use of Vfend in a condition that has confirmed sensitivity to the Vfend.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For Disseminated (deep tissue) Candida infections in the abdomen, kidney, bladder wall or wounds, Patient has had an inadequate response or is contraindicated to one antifungal agent.

VICTRELIS

Products Affected

- VICTRELIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using in combination with another serine protease inhibitor or polymerase inhibitor. Individual has received previous treatment for hepatitis C virus (HCV) with triple therapy regimen which consists of a pegylated interferon, ribavirin, and a serine protease inhibitor or a polymerase inhibitor.
Required Medical Information	Documentation must be provided for a diagnosis of Hep C genotype 1 AND using in combination with peginterferon alfa and ribavirin AND individual has compensated liver disease (including cirrhosis) AND individual will receive treatment with peginterferon alfa and ribavirin for 4 weeks (treatment weeks 1-4) prior to starting therapy with Victrelis. Documentation may include but is not limited to chart notes, prescription claims records, prescription receipts and laboratory data.
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial approval 14 wks. Depending on HCV RNA results at 8wk, may approve an additional 14-34 wks.
Other Criteria	N/A

VIDAZA

Products Affected

- *azacitidine*
- VIDAZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VIMPAT

Products Affected

- VIMPAT INTRAVENOUS
- VIMPAT ORAL SOLUTION
- VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VIRAZOLE

Products Affected

- VIRAZOLE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

XENAZINE

Products Affected

- XENAZINE ORAL TABLET 12.5 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Mbr has Moderate Persistent to Severe Persistent Asthma AND has a positive skin test or in vitro reactivity to a perennial aeroallergen, AND Mbr has an FEV1 less than 80% predicted AND Mbr IgE level is equal to or greater than 30 IU/ml. Severe asthma as defined by the National Heart, Lung, and Blood Institute: Severe Persistent Asthma: symptoms throughout the day, extremely limited normal activity. Nocturnal symptoms are frequent, FEV1 or PEF is less than or equal to 60% predicted. Moderate Persistent Asthma as defined by the National Heart, Lung, and Blood Institute: Daily symptoms, daily use of inhaled short-acting beta2-agonist, somewhat limited activity, Nocturnal symptoms occur greater than 1 time per week, FEV1 or PEF is greater than 60% and less then 80% predicted, FEV1 FVC is reduced 5 percent or exacerbations requiring oral systemic corticosteroids use for more than or equal to 2 times per year.
Age Restrictions	Patient is 12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year

Other Criteria	Mbr symptoms are inadequately controlled after a minimum of 3 months with combination controller therapy (medium to high dose inhaled corticosteroids plus long acting beta-2 agonists or Leukotriene receptor antagonists), or cannot tolerate these medications. Continued treatment beyond 12 months is allowed when treatment has resulted in clinical improvement as documented by one or more of the following: Decreased utilization of rescue medications OR Decreased frequency of exacerbations (defined as worsening of asthma that requires increase in inhaled corticosteroid dose or treatment with systemic corticosteroids) OR Increase in percent predicted FEV1 from pretreatment baseline OR Reduction in reported asthma-related symptoms, such as, but not limited to, wheezing, shortness of breath, coughing, fatigue, sleep disturbance, or asthmatic symptoms upon awakening.

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual is currently taking a sedative hypnotic agent at the time of request.
Required Medical Information	Individual has a diagnosis of narcolepsy confirmed by multiple sleep latency test (MSLT) with mean sleep latency of less than 8 minutes with documented rapid eye movement sleep (REM) during at least 2 naps.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

YERVOY

Products Affected

- YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member has unresectable or metastatic melanoma AND used for a single course of 4 treatments AND member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-1
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ZALTRAP

Products Affected

- ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic colorectal cancer (mCRC) AND used in combination with an irinotecan based regimen AND cancer is resistant to or has progressed following treatment with an oxaliplatin containing regimen AND Zaltrap will be used in a single line of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ZAVESCA

Products Affected

- ZAVESCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	May not be approved for the treatment of pregnant women and for women who may become pregnant, or are considering becoming pregnant while taking this drug.
Required Medical Information	Presence of type 1 Gaucher disease is confirmed by either of the following: Glucocerebrosidase activity in the white blood cells or skin fibroblasts less then or equal to 30% of normal activity, OR genotype testing indicating mutation of two alleles of the glucocerebrosidase genome. And patient has clinically significant manifestations of of Type 1 gauchers disease including any of the following: skeletal disease (demonstrated by ANY of the following: avascular necrosis, erlenmeyer flask deformity, lytic disease, marrow infiltration, osteopenia, osteosclerosis, pathological fracture, radiological evidence of joint deterioration) OR patient presents with at least 2 of the following: clinically significant hepatomegaly, clinically significant splenomegaly, hgb less then or equal to 11.5 grams per dl for females or 12.5 grams per deciliter for males or 1 gram per deciliter below lower limit for normal for age and sex, platelet counts less than or equal to 120,000 mm3.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Enzyme replacement therapy with Ceredase, Cerezyme, ELELYSO or VPRIV is contraindicated due to intolerability, allergy to components of these drugs or poor venous access.

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individuals with wild-type BRAF melanoma.
Required Medical Information	Individual has Braf V600E mutation as detected by an FDA-approved companion diagnostic test (i.e., Cobas 4800 BRAF V600 Mutation Test) and a copy of the test results from the FDA-approved companion diagnostic test must be provided.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ZETIA

Products Affected

- ZETIA

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ZOMETA

Products Affected

- *zoledronic acid intravenous solution*
- ZOMETA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ZYTIGA

Products Affected

- ZYTIGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of metastatic castration resistant prostate cancer AND has not previously progressed on Zytiga AND is using in combination with prednisone AND using in combination with medical or surgical ADT AND is not currently receiving any other chemotherapy for prostate cancer.

ZYVOX

Products Affected

- ZYVOX ORAL SUSPENSION FOR RECONSTITUTION
- ZYVOX ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

PART B VERSUS PART D

Products Affected

- ABELCET
- ABILIFY INTRAMUSCULAR
- ABRAXANE
- *acetylcysteine solution*
- *acyclovir sodium intravenous solution*
- *albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml*
- *aloprim*
- AMBISOME
- *amikacin injection solution 500 mg/2 ml*
- AMINOSYN 8.5 %-ELECTROLYTES
- AMINOSYN II 10 %
- AMINOSYN II 15 %
- AMINOSYN II 7 %
- AMINOSYN II 8.5 %
- AMINOSYN II 8.5 %-ELECTROLYTES
- AMINOSYN M 3.5 %
- AMINOSYN-HBC 7%
- AMINOSYN-PF 10 %
- AMINOSYN-PF 7 % (SULFITE-FREE)
- *amiodarone intravenous solution*
- *amphotericin b*
- *ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg*
- *ampicillin-sulbactam injection recon soln 15 gram, 3 gram*
- ARRANON
- ARZERRA INTRAVENOUS SOLUTION 100 MG/5 ML
- ASTAGRAF XL
- *atropine injection syringe 0.05 mg/ml, 0.1 mg/ml*
- *azathioprine*
- *azithromycin intravenous*
- BICNU
- *bleomycin injection recon soln 30 unit*
- BONIVA INTRAVENOUS
- *buprenorphine injection syringe*
- BUSULFEX
- *calcitriol intravenous solution 1 mcg/ml*
- *calcitriol oral*
- CANCIDAS
- CAPASTAT
- *carboplatin intravenous solution*
- *cefazolin injection recon soln 1 gram, 10 gram, 500 mg*
- *cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 ml*
- *cefepime*
- *cefoxitin*
- *cefoxitin in dextrose, iso-osm*
- *ceftazidime injection recon soln 1 gram, 2 gram, 6 gram*
- *ceftriaxone injection recon soln 10 gram, 250 mg, 500 mg*
- *ceftriaxone intravenous recon soln*
- *cefuroxime sodium injection recon soln 1.5 gram, 750 mg*
- *cefuroxime sodium intravenous*
- CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION
- CELLCEPT INTRAVENOUS
- *cidofovir*
- *ciprofloxacin intravenous solution 400 mg/40 ml*
- *cisplatin*
- *cladribine*
- *clindamycin in dextrose 5 %*
- *clindamycin phosphate intravenous solution 600 mg/4 ml*
- CLINIMIX 5%/D15W SULFITE FREE
- CLINIMIX 5%/D25W SULFITE-FREE
- CLINIMIX 2.75%/D5W SULFIT FREE
- CLINIMIX 4.25%-D20W SULF-FREE
- CLINIMIX 4.25%-D25W SULF-FREE
- CLINIMIX 4.25%/D10W SULF FREE
- CLINIMIX 4.25%/D5W SULFIT FREE
- CLINIMIX 5%-D20W(SULFITE-FREE)
- CLINIMIX E 2.75%/D10W SUL FREE
- CLINIMIX E 2.75%/D5W SULF FREE
- CLINIMIX E 4.25%/D25W SUL FREE
- CLINIMIX E 4.25%/D5W SULF FREE

- CLINIMIX E 5%/D15W SULFIT FREE
- CLINIMIX E 5%/D20W SULFIT FREE
- CLINIMIX E 5%/D25W SULFIT FREE
- CLOLAR
- *colistin (colistimethate na)*
- COSMEGEN
- *cromolyn inhalation*
- CUBICIN
- *cyclophosphamide oral tablet*
- *cyclosporine intravenous*
- *cyclosporine oral capsule*
- *cyclosporine modified*
- *cytarabine*
- *cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)*
- *d10 % & 0.45 % sodium chloride*
- *d2.5 %-0.45 % sodium chloride*
- *d5 % and 0.9 % sodium chloride*
- *d5 %-0.45 % sodium chloride*
- *dacarbazine intravenous recon soln 200 mg*
- DACOGEN
- *daunorubicin intravenous solution*
- *decitabine*
- *desmopressin injection*
- *dexrazoxane intravenous recon soln 250 mg*
- *dextrose 10 % and 0.2 % nacl*
- *dextrose 10 % in water (d10w) intravenous parenteral solution*
- *dextrose 5 % in water (d5w) intravenous parenteral solution*
- *dextrose 5 %-lactated ringers*
- *dextrose 5%-0.2 % sod chloride*
- *dextrose 5%-0.3 % sod.chloride*
- *diltiazem hcl intravenous solution*
- DOCEFREZ
- *docetaxel intravenous solution 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)*
- *doxercalciferol intravenous*
- DOXIL
- *doxorubicin intravenous solution 50 mg/25 ml*
- *doxycycline hyclate intravenous*
- *dronabinol*
- *duramorph (pf)*
- EMEND ORAL CAPSULE 125 MG, 40 MG, 80 MG
- EMEND ORAL CAPSULE,DOSE PACK
- ENGERIX-B (PF) INTRAMUSCULAR SYRINGE
- ENGERIX-B PEDIATRIC (PF)
- *epirubicin intravenous solution 50 mg/25 ml*
- ERWINAZE
- ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG
- ETOPOPHOS
- *etoposide intravenous*
- *famotidine (pf)*
- *famotidine (pf)-nacl (iso-os)*
- FIRMAGON KIT W DILUENT SYRINGE
- *fluconazole in dextrose(iso-o) intravenous piggyback 400 mg/200 ml*
- *fludarabine intravenous recon soln*
- *fluorouracil intravenous solution 2.5 gram/50 ml*
- *fluphenazine decanoate*
- *fluphenazine hcl injection*
- FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML)
- *foscarnet*
- *fosphenytoin injection solution 100 mg pe/2 ml*
- *furosemide injection solution*
- FUSILEV
- *gemcitabine intravenous recon soln 1 gram*
- *gengraf*
- GEODON INTRAMUSCULAR
- *haloperidol decanoate*
- *haloperidol lactate injection*
- *heparin (porcine) injection solution*
- *heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml), 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)*
- *heparin (porcine) in nacl (pf) intravenous parenteral solution 1,000 unit/500 ml*
- HEPATAMINE 8%
- HEPATASOL 8 %
- *hydralazine injection*
- *ibandronate intravenous solution*

- IDAMYCIN PFS
- *idarubicin*
- IFEX INTRAVENOUS RECON SOLN 1 GRAM
- *ifosfamide intravenous recon soln 1 gram*
- *intralipid intravenous emulsion 20 %*
- INTRALIPID INTRAVENOUS EMULSION 30 %
- INVEGA SUSTENNA
- *ipratropium bromide inhalation*
- *ipratropium-albuterol*
- *irinotecan intravenous solution 100 mg/5 ml*
- ISOLYTE-P IN 5 % DEXTROSE
- IXEMPRA INTRAVENOUS RECON SOLN 45 MG
- JEVTANA
- *labetalol intravenous solution*
- *lactated ringers*
- *leucovorin calcium injection recon soln 100 mg, 350 mg*
- *levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml*
- *levetiracetam intravenous*
- *levocarnitine intravenous*
- *levocarnitine oral tablet*
- *levocarnitine (with sugar)*
- *liposyn iii intravenous emulsion 10 %, 20 %*
- *magnesium sulfate injection syringe*
- *medroxyprogesterone intramuscular suspension*
- *melphalan*
- *meropenem intravenous recon soln 500 mg*
- *mesna*
- MESNEX INTRAVENOUS
- *methotrexate sodium (pf)*
- *methylprednisolone acetate*
- *methylprednisolone sodium succ injection recon soln 125 mg, 40 mg*
- *metoclopramide hcl injection solution*
- *metoprolol tartrate intravenous solution*
- *mitomycin intravenous recon soln 20 mg*
- *mitoxantrone*
- MUSTARGEN
- *mycophenolate mofetil*
- *nafcillin injection recon soln 1 gram, 10 gram*
- *nafcillin in dextrose iso-osm intravenous piggyback 1 gram/50 ml*
- *nalbuphine injection*
- NEBUPENT
- NEPHRAMINE 5.4 %
- NIPENT
- *nitroglycerin intravenous*
- NORMOSOL-M IN 5 % DEXTROSE
- NORMOSOL-R IN 5 % DEXTROSE
- NORMOSOL-R PH 7.4
- NULOJIX
- *olanzapine intramuscular*
- ONCASPAR
- *ondansetron*
- *ondansetron hcl oral tablet 4 mg, 8 mg*
- *ondansetron hcl (pf) injection solution*
- *oxaliplatin intravenous solution 100 mg/20 ml*
- *paclitaxel*
- *pamidronate intravenous solution*
- *paricalcitol*
- PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML, 3 MILLION UNIT/50 ML
- *penicillin g potassium injection recon soln 5 million unit*
- *penicillin g procaine intramuscular syringe 1.2 million unit/2 ml*
- *penicillin g sodium*
- PERFOROMIST
- *pfizerpen-g injection recon soln 5 million unit*
- *phenytoin sodium intravenous solution*
- PHYSIOLYTE
- PHYSIOSOL IRRIGATION
- *piperacillin-tazobactam intravenous recon soln 3.375 gram, 4.5 gram*
- PLASMA-LYTE 148
- PLASMA-LYTE-56 IN 5 % DEXTROSE
- *potassium chlorid-d5-0.45%nacl*
- *potassium chloride intravenous parenteral solution*
- *potassium chloride intravenous piggyback 10 meq/100 ml, 20 meq/100 ml*

- *potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l*
- *potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 40 meq/l*
- *potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l*
- *potassium chloride-0.45 % nacl*
- *potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l*
- *potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l*
- *potassium chloride-d5-0.9%nacl*
- *premasol 10 %*
- PREMASOL 6 %
- *procainamide injection*
- PROCALAMINE 3%
- PROGRAF INTRAVENOUS
- PROLEUKIN
- *propranolol intravenous*
- PROSOL 20 %
- PULMOZYME
- *ranitidine hcl injection solution 25 mg/ml*
- RAPAMUNE
- RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML
- *rifampin intravenous*
- *ringers*
- RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML, 50 MG/2 ML
- SIMULECT INTRAVENOUS RECON SOLN 20 MG
- *sirolimus*
- *sodium chloride intravenous parenteral solution 2.5 meq/ml*
- *sodium chloride 0.45 % intravenous parenteral solution*
- *sodium chloride 0.9 % intravenous parenteral solution*
- *sodium chloride 3 %*
- *sodium chloride 5 %*
- *sulfamethoxazole-trimethoprim intravenous*
- *tacrolimus*
- TAXOTERE INTRAVENOUS SOLUTION 80 MG/4 ML (20 MG/ML)
- *testosterone cypionate*
- *testosterone enanthate*
- THYMOGLOBULIN
- TOBI
- *tobramycin in 0.225 % nacl*
- *tobramycin sulfate injection solution*
- *toposar*
- *topotecan intravenous recon soln*
- TORISEL
- TPN ELECTROLYTES
- *tranexamic acid intravenous*
- *travasol 10 %*
- TREANDA INTRAVENOUS RECON SOLN 100 MG
- TRISENOX
- TROPHAMINE 10 %
- TROPHAMINE 6%
- UVADEX
- *valproate sodium*
- *vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg*
- *verapamil intravenous solution*
- *vinblastine intravenous solution*
- *vincristine intravenous solution 1 mg/ml*
- *vinorelbine intravenous solution 50 mg/5 ml*
- VISTIDE
- *water for irrigation, sterile*
- ZANOSAR
- ZORTRESS

Details

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

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