Prior Authorization Group	RITUXAN HYCELA
Drug Names	RITUXAN HYCELA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RUBRACA
Drug Names	RUBRACA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	RYDAPT
Drug Names	RYDAPT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	For newly diagnosed FLT3 mutation-positive acute myeloid leukemia (AML), the requested medication is/was used in combination with standard cytarabine with daunorubicin or idarubicin induction followed by cytarabine consolidation chemotherapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SIGNIFOR
Drug Names	SIGNIFOR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	Patient has had pituitary surgery that was not curative or the patient is not a candidate for surgery.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SILDENAFIL
Drug Names	SILDENAFIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SIRTURO
Drug Names	SIRTURO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The requested drug is being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis, or infection caused by the non-tuberculous mycobacteria
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	6 Months
Other Criteria	-

Prior Authorization Group	SOMATULINE DEPOT
Drug Names	SOMATULINE DEPOT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, pancreas, and adrenal gland.
Exclusion Criteria	-
Required Medical Information	For acromegaly: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For NETs of the GI tract, thymus, and lung: patient has metastatic or unresectable disease.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

Prior Authorization Group	SOMAVERT
Drug Names	SOMAVERT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	Patient meets both of the following criteria: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	For continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

Prior Authorization Group	SPRYCEL
Drug Names	SPRYCEL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, gastrointestinal stromal tumor (GIST).
Exclusion Criteria	-
Required Medical Information	For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) patient is 21 years of age or younger, or b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have PDGFRA D842V mutation and disease progression on imatinib, sunitinib, or regorafenib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	STIVARGA
Drug Names	STIVARGA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, progressive GIST.
Exclusion Criteria	-
Required Medical Information	For colorectal cancer: The disease is unresectable advanced or metastatic. The patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SUTENT
Drug Names	SUTENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), angiosarcoma, solitary fibrous tumor, hemangiopericytoma, chordoma (bone cancer), thymic carcinoma.
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: Either 1) The disease is relapsed, metastatic, or unresectable, OR 2) The patient is at high risk of disease recurrence following nephrectomy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SYLATRON
Drug Names	SYLATRON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myelofibrosis, polycythemia vera, essential thrombocythemia.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SYMDEKO
Drug Names	SYMDEKO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductase regulator (CFTR) gene or the patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation
Age Restrictions	12 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Symdeko will not be used in combination with Orkambi or Kalydeco.

Prior Authorization Group	SYMPAZAN
Drug Names	SYMPAZAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	2 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	SYNRIBO
Drug Names	SYNRIBO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	For chronic myeloid leukemia (CML), the patient has experienced resistance, toxicity or intolerance to prior therapy with at least two tyrosine kinase inhibitors (TKIs) (eg, imatinib, dasatinib, nilotinib, bosutinib, ponatinib).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAFINLAR
Drug Names	TAFINLAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, brain metastases from melanoma.
Exclusion Criteria	-
Required Medical Information	For melanoma (including brain metastases), tumor is positive for a BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation). For NSCLC, tumor is positive for a BRAF V600 activating mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAGRISSO
Drug Names	TAGRISSO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, EGFR mutation-positive recurrent or metastatic non-small cell lung cancer, brain metastases if active against primary tumor (EGFR T790M mutation-positive non-small cell lung cancer).
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TALZENNA
Drug Names	TALZENNA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TARCEVA
Drug Names	TARCEVA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chordoma, renal cell carcinoma (RCC).
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer, patient has a known sensitizing EGFR mutation. For pancreatic cancer, the disease is locally advanced, unresectable, or metastatic.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TASIGNA
Drug Names	TASIGNA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST).
Exclusion Criteria	-
Required Medical Information	For CML or ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, the patient has one of the following: a) patient is 18 years of age or younger, b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TAZAROTENE
Drug Names	TAZAROTENE, TAZORAC
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	For plaque psoriasis, the requested drug is being prescribed to treat less than 20 percent of the patient's body surface area.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TECENTRIQ
Drug Names	TECENTRIQ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TESTOSTERONE CYPIONATE INJ
Drug Names	TESTOSTERONE CYPIONATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Gender Dysphoria in transgender male patients.
Exclusion Criteria	-
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Requested drug is being prescribed for gender dysphoria in a transgender male patient who is 12 years of age or older and able to make an informed, mature decision to engage in therapy.
Age Restrictions	12 years of age or older (applies to gender dysphoria only)
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TESTOSTERONE ENANTHATE INJ
Drug Names	TESTOSTERONE ENANTHATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Requested drug is being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal and who has had an incomplete response to other therapy for metastatic breast cancer OR 4) Requested drug is being prescribed for a pre-menopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor OR 5) Requested drug is being prescribed for delayed puberty in a male patient.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TETRABENAZINE
Drug Names	TETRABENAZINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic tics, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	THALOMID
Drug Names	THALOMID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myelofibrosis-related anemia, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, HIV-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease.
Exclusion Criteria	-
Required Medical Information	Cachexia: Cachexia must be due to cancer or HIV infection. Kaposi's sarcoma: The patient has HIV infection.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TIBSOVO
Drug Names	TIBSOVO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TOBRAMYCIN
Drug Names	TOBRAMYCIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-cystic fibrosis bronchiectasis.
Exclusion Criteria	-
Required Medical Information	Pseudomonas aeruginosa is present in the patient's airway cultures OR the patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	TOPICAL DOXEPIN
Drug Names	DOXEPIN HYDROCHLORIDE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	The patient has experienced an inadequate response to a generic topical corticosteroid or topical tacrolimus
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	1 Month
Other Criteria	-

Prior Authorization Group	TOPICAL LIDOCAINE
Drug Names	GLYDO, LIDOCAINE, LIDOCAINE HCL, LIDOCAINE HCL JELLY, LIDOCAINE/PRILOCAINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	1) The requested drug is being used for topical anesthesia, 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are FDA-approved for topical use
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	3 Months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	TOPICAL TESTOSTERONES
Drug Names	ANDRODERM, TESTOSTERONE, TESTOSTERONE PUMP
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TOPICAL TRETINOIN
Drug Names	AVITA, TRETINOIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TRELSTAR
Drug Names	TRELSTAR MIXJECT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Use as neoadjuvant therapy prior to radical prostatectomy is not approvable.

Prior Authorization Group	TREPROSTINIL INJ
Drug Names	REMODULIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	TRIENTINE
Drug Names	TRIENTINE HYDROCHLORIDE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TYKERB
Drug Names	TYKERB
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, metastatic CNS lesions from HER2-positive breast cancer.
Exclusion Criteria	-
Required Medical Information	For HER2-positive breast cancer, the requested drug will be used in combination with: 1) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane), or 2) capecitabine, or 3) trastuzumab.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	TYMLOS
Drug Names	TYMLOS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following (1. or 2.): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or osteopenia with a high pre-treatment FRAX fracture probability and patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous osteoporosis therapy (i.e., oral bisphosphonates or injectable antiresorptive agents)
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide)
Other Criteria	Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20% for any major osteoporotic fracture or greater than or equal to 3% for hip fracture

Prior Authorization Group	VALCHLOR
Drug Names	VALCHLOR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic or smoldering adult T-cell leukemia/lymphoma, mycosis fungoides, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VELCADE
Drug Names	BORTEZOMIB, VELCADE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	VENCLEXTA
Drug Names	VENCLEXTA, VENCLEXTA STARTING PACK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, small lymphocytic lymphoma, mantle cell lymphoma.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VENTAVIS
Drug Names	VENTAVIS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	VERSACLOZ
Drug Names	VERSACLOZ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VERZENIO
Drug Names	VERZENIO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VIGABATRIN
Drug Names	SABRIL, VIGABATRIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	For complex partial seizures (CPS): patient had an inadequate response to at least 2 alternative therapies for CPS (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine).
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VITRAKVI
Drug Names	VITRAKVI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VIZIMPRO
Drug Names	VIZIMPRO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VOSEVI
Drug Names	VOSEVI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	-

Prior Authorization Group	VOTRIENT
Drug Names	VOTRIENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma, ovarian cancer (epithelial ovarian, fallopian tube, or primary peritoneal).
Exclusion Criteria	-
Required Medical Information	For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma, AND 2) The patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk, head/neck sarcoma.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	VRAYLAR
Drug Names	VRAYLAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XALKORI
Drug Names	XALKORI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer (NSCLC) with high-level MET amplification or MET exon 14 skipping mutation, inflammatory myofibroblastic tumors (IMT).
Exclusion Criteria	-
Required Medical Information	For IMT, the tumor is ALK-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XELJANZ
Drug Names	XELJANZ, XELJANZ XR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab). For active psoriatic arthritis (new starts only): Patient meets BOTH of the following criteria: 1) Inadequate response to methotrexate (MTX) or other nonbiologic disease-modifying antirheumatic drugs (DMARDs) (e.g., leflunomide, sulfasalazine, etc.) OR a prior biologic DMARD (e.g., adalimumab), AND 2) The requested drug is used in combination with a nonbiologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, etc.). For moderately to severely active ulcerative colitis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to at least one conventional therapy option (e.g., oral aminosalicylates, corticosteroids), or 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab)
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XGEVA
Drug Names	XGEVA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	For hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy (eg, zoledronic acid, pamidronate) or there is a clinical reason to avoid IV bisphosphonate therapy.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	XIFAXAN
Drug Names	XIFAXAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Reduction in risk of overt hepatic encephalopathy recurrence-6 Months, IBS-D - Plan Year
Other Criteria	-

Prior Authorization Group	XOLAIR
Drug Names	XOLAIR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	For allergic asthma initial therapy: 1)Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid, b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on the requested drug since initiation of therapy. Chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.
Age Restrictions	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.
Prescriber Restrictions	-
Coverage Duration	Allergic asthma: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year.
Other Criteria	-

Prior Authorization Group	XOSPATA
Drug Names	XOSPATA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XTANDI
Drug Names	XTANDI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	The requested drug will be used to treat prostate cancer.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	XYREM
Drug Names	XYREM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	1) The drug is being prescribed for the treatment of excessive daytime sleepiness in a patient with narcolepsy AND 2) The patient experienced an inadequate treatment response or intolerance to at least one CNS stimulant drug and one CNS promoting wakefulness drug OR 3) the patient has a contraindication to at least one CNS stimulant drug and one CNS wakefulness promoting drug (NOTE: Examples of a CNS stimulant drug are amphetamine, dextroamphetamine, or methylphenidate. Example of a CNS wakefulness promoting drug is armodafinil. Coverage of armodafinil or amphetamines or methylphenidates may require prior authorization). OR 4) The drug is being prescribed for the treatment of cataplexy in a patient with narcolepsy
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	If the request is for the continuation of Xyrem (sodium oxybate), then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

Prior Authorization Group	ZAVESCA
Drug Names	MIGLUSTAT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	18 years of age or older
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZEJULA
Drug Names	ZEJULA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	Treatment is being started or was started no later than 8 weeks after the most recent platinum-based chemotherapy.

Prior Authorization Group	ZELBORAF
Drug Names	ZELBORAF
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, brain metastases from melanoma, non-small cell lung cancer, hairy cell leukemia, and thyroid carcinoma (papillary, follicular, and Hurthle).
Exclusion Criteria	-
Required Medical Information	For melanoma (including brain metastases), tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation). For non-small cell lung cancer, tumor is positive for the BRAF V600E mutation. For thyroid carcinoma the tumor is positive for BRAF mutation.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZEPATIER
Drug Names	ZEPATIER
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions (eg, NS5A polymorphisms) where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	-

Prior Authorization Group	ZOLINZA
Drug Names	ZOLINZA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome.
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZYDELIG
Drug Names	ZYDELIG
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), refractory, relapsed or progressive follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].
Exclusion Criteria	-
Required Medical Information	-
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZYKADIA
Drug Names	ZYKADIA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor.
Exclusion Criteria	-
Required Medical Information	For non-small cell lung cancer (NSCLC), the requested medication is used for the treatment of recurrent or metastatic ALK-positive NSCLC. For inflammatory myofibroblastic tumor, the tumor is ALK-positive.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZYPREXA RELPREVV
Drug Names	ZYPREXA RELPREVV
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	-
Required Medical Information	Tolerability with oral olanzapine has been established.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-

Prior Authorization Group	ZYTIGA
Drug Names	ABIRATERONE ACETATE, ZYTIGA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D and newly diagnosed metastatic or high-risk locally advanced prostate cancer.
Exclusion Criteria	-
Required Medical Information	For metastatic castration-resistant prostate cancer: The requested drug will be used in combination with prednisone. For castration-sensitive metastatic or locally advanced prostate cancer: 1) The requested drug will be used in combination with prednisone and concurrent androgen-deprivation therapy. Androgen deprivation therapy is not required in patients who have had bilateral orchiectomy, 2) Disease is newly diagnosed and metastatic, node-positive, high-risk locally advanced, or was previously treated with radical surgery or radiotherapy and is now relapsing with high risk features.
Age Restrictions	-
Prescriber Restrictions	-
Coverage Duration	Plan Year
Other Criteria	-