

## PA Criteria

<b>Prior Authorization Group</b>	ACITRETIN
<b>Drug Names</b>	ACITRETIN
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ACTIMMUNE
<b>Drug Names</b>	ACTIMMUNE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, atopic dermatitis.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ADAGEN
<b>Drug Names</b>	ADAGEN
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ADEMPAS
<b>Drug Names</b>	ADEMPAS
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For pulmonary arterial hypertension (PAH) (WHO Group 1): PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, AND 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.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	AFINITOR
<b>Drug Names</b>	AFINITOR, AFINITOR DISPERZ
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangiomyomatosis, neuroendocrine tumor of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), osteosarcoma.

<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For breast cancer: 1) The patient has recurrent or metastatic hormone receptor positive, HER2 negative disease, 2) Afinitor will be used in combination with exemestane, and 3) The patient's disease either a) has progressed while on or within 12 months of nonsteroidal aromatase inhibitor therapy, OR b) was previously treated with tamoxifen. For renal cell carcinoma: 1) The disease is relapsed, metastatic or unresectable, and 2) For disease that is of predominantly clear cell histology, disease has progressed on prior antiangiogenic therapy (e.g., sunitinib).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ALDURAZYME
<b>Drug Names</b>	ALDURAZYME
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Diagnosis of mucopolysaccharidosis I was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic testing. Patients with Scheie syndrome must have moderate to severe symptoms.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ALECENSA
<b>Drug Names</b>	ALECENSA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ALOSETRON
<b>Drug Names</b>	ALOSETRON HYDROCHLORIDE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) Chronic IBS symptoms lasting at least 6 months AND 3) Gastrointestinal tract abnormalities have been ruled out AND 4) Inadequate response to conventional therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ALPHA1-PROTEINASE INHIBITOR
<b>Drug Names</b>	ARALAST NP, PROLASTIN-C, ZEMAIRA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Patients must have clinically evident emphysema. Patients must have a pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dl by radial immunodiffusion or 50 mg/dl by nephelometry). Patients must have a pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) greater than or equal to 25 percent and less than or equal to 80 percent of predicted.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ALUNBRIG
<b>Drug Names</b>	ALUNBRIG
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	AMPYRA
<b>Drug Names</b>	AMPYRA, DALFAMPRIDINE ER
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment. For continuation of therapy: Patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting the requested medication.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ANADROL
<b>Drug Names</b>	ANADROL-50
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting), Fanconi's anemia.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 Months
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	APOKYN
<b>Drug Names</b>	APOKYN
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ARCALYST
<b>Drug Names</b>	ARCALYST
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, prevention of gout flares in patients initiating or continuing urate-lowering therapy.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, AND 3) concurrent use with urate-lowering therapy (i.e., allopurinol or febuxostat). For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (continuation): 1) member must have achieved or maintained a clinical benefit (i.e., fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	For prevention of gout flares: 4 months. Other: Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ARMODAFINIL
<b>Drug Names</b>	ARMODAFINIL
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is Shift Work Disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	AURYXIA
<b>Drug Names</b>	AURYXIA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	AUSTEDO
<b>Drug Names</b>	AUSTEDO
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

**Prior Authorization Group**

**Drug Names**

**Covered Uses**

AVASTIN

AVASTIN

All FDA-approved indications not otherwise excluded from Part D, breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity.

**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**

**Drug Names**

B VS. D

ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ADRUCIL, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMINOSYN, AMINOSYN 7%/ELECTROLYTES, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 8.5%/ELECTROL, AMINOSYN M, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-PF 7%, AMINOSYN-RF, AMPHOTERICIN B, APREPITANT, AZACITIDINE, AZATHIOPRINE, BENDEKA, BLEOMYCIN SULFATE, BUDESONIDE, CALCITONIN-SALMON, CALCITRIOL, CARBOPLATIN, CINACALCET HYDROCHLORIDE, CISPLATIN, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 2, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 5%/DEXTROSE 25%, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DACARBAZINE, DEPO-PROVERA, DEXRAZOXANE, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HCL LIPOSOME, DRONABINOL, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FLUOROURACIL, FREAMINE HBC 6.9%, FREAMINE III, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, IBANDRONATE SODIUM, IFEX, IFOSFAMIDE, IMOVAX RABIES (H.D.C.V.), INTRALIPID, INTRON A, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVALBUTEROL HYDROCHLORID, LEVOCARNITINE, LIDOCAINE HCL, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MITOMYCIN, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEBUPENT, NEPHRAMINE, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE, PROSOL, RABAVERT, RAPAMUNE, RECOMBIVAX HB, SANDIMMUNE, SENSIPAR, SIROLIMUS, TACROLIMUS, TAXOTERE, TDVAX, TENIVAC, TOPOSAR, TOPOTECAN HCL, TOPOTECAN HYDROCHLORIDE, TPN ELECTROLYTES, TRAVASOL, TROPHAMINE, VINBLASTINE SULFATE, VINCASAR PFS, VINCRISTINE SULFATE, VINORELBINE TARTRATE, XATMEP, ZOLEDRONIC ACID, ZORTRESS

**Covered Uses**

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.

**Exclusion Criteria**

-

**Required Medical Information**

-

**Age Restrictions**

-

**Prescriber Restrictions**

-

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<b>Coverage Duration</b>	N/A
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BANZEL
<b>Drug Names</b>	BANZEL
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	1 year of age or older.
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BENLYSTA
<b>Drug Names</b>	BENLYSTA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Severe active lupus nephritis. Severe active central nervous system lupus.
<b>Required Medical Information</b>	Patient has been diagnosed with active, autoantibody-positive systemic lupus erythematosus (SLE). Patient is currently receiving standard therapy for SLE (e.g., corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) OR patient is not currently receiving standard therapy for SLE because patient tried and had an inadequate response or intolerance to standard therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	BERINERT
<b>Drug Names</b>	BERINERT
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BETASERON
<b>Drug Names</b>	BETASERON
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	BEXAROTENE
<b>Drug Names</b>	BEXAROTENE, TARGRETIN
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), chronic or smoldering adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BOSENTAN
<b>Drug Names</b>	TRACLEER
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	BOSULIF
<b>Drug Names</b>	BOSULIF
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, relapsed/refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Diagnosis of CML was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) Patient has chronic phase CML, OR 2) Patient has accelerated or blast phase CML, OR 3) Patient received a hematopoietic stem cell transplant.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BRAFTOVI
<b>Drug Names</b>	BRAFTOVI
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BRIVIACT
<b>Drug Names</b>	BRIVIACT
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	4 years of age or older (tablets and oral solution).
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	BUPRENORPHINE
<b>Drug Names</b>	BUPRENORPHINE HCL
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for the treatment of opioid dependence AND 2) If the patient is pregnant or breastfeeding and being prescribed the requested drug for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) If the requested drug is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) If the requested drug is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	12 Months
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	BUPRENORPHINE PATCH
<b>Drug Names</b>	BUTRANS
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for pain associated with cancer, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient can safely take the requested dose based on their history of opioid use AND 4) The patient has been evaluated and will be monitored for the development of opioid use disorder.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

**Prior Authorization Group** CABOMETYX  
**Drug Names** CABOMETYX  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer.  
**Exclusion Criteria** -  
**Required Medical Information** For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic.  
**Age Restrictions** -  
**Prescriber Restrictions** -  
**Coverage Duration** Plan Year  
**Other Criteria** -

**Prior Authorization Group** CALCIPOTRIENE  
**Drug Names** CALCIPOTRIENE, CALCITRENE, ENSTILAR  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** -  
**Required Medical Information** 1) The requested drug is being prescribed for the treatment of psoriasis AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic topical steroid.  
**Age Restrictions** -  
**Prescriber Restrictions** -  
**Coverage Duration** Plan Year  
**Other Criteria** -

**Prior Authorization Group** CALQUENCE  
**Drug Names** CALQUENCE  
**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** -

<b>Prior Authorization Group</b>	CAPRELSA
<b>Drug Names</b>	CAPRELSA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, non-small lung cancer and differentiated thyroid carcinoma: papillary, follicular, Hurthle cell.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For non-small cell lung cancer (NSCLC): the requested drug is used for NSCLC with RET gene rearrangements.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CARBAGLU
<b>Drug Names</b>	CARBAGLU
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, methylmalonic acidemia, propionic acidemia.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CAYSTON
<b>Drug Names</b>	CAYSTON
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	CERDELGA
<b>Drug Names</b>	CERDELGA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CEREZYME
<b>Drug Names</b>	CEREZYME
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, type 3 Gaucher disease.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CHANTIX
<b>Drug Names</b>	CHANTIX, CHANTIX CONTINUING MONTH, CHANTIX STARTING MONTH PA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 Months
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	CLOMIPRAMINE
<b>Drug Names</b>	CLOMIPRAMINE HCL
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, Depression, Panic Disorder.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) Obsessive-Compulsive Disorder (OCD) or Panic Disorder AND 2) The patient has experienced an inadequate treatment response, intolerance or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI), mirtazapine OR 3) Depression AND 4) The patient has experienced an inadequate treatment response, intolerance or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI), mirtazapine, bupropion.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	CLORAZEPATE
<b>Drug Names</b>	CLORAZEPATE DIPOTASSIUM
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal OR 4) For the short-term relief of the symptoms of anxiety AND 5) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.

<b>Prior Authorization Group</b>	CLOZAPINE ODT
<b>Drug Names</b>	CLOZAPINE ODT
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	COMETRIQ
<b>Drug Names</b>	COMETRIQ
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, non-small lung cancer and differentiated thyroid carcinoma: papillary, follicular, Hurthle cell.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For non-small cell lung cancer (NSCLC): The requested drug is used for NSCLC with RET gene rearrangements.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	COPIKTRA
<b>Drug Names</b>	COPIKTRA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	COTELLIC
<b>Drug Names</b>	COTELLIC
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	CYSTAGON
<b>Drug Names</b>	CYSTAGON
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	CYSTARAN
<b>Drug Names</b>	CYSTARAN
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by DNA testing. The patient has corneal cystine crystal accumulation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	DEFERASIROX
<b>Drug Names</b>	JADENU, JADENU SPRINKLE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

**Prior Authorization Group** DEMSER  
**Drug Names** DEMSER  
**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** DESVENLAFAXINE  
**Drug Names** DESVENLAFAXINE ER  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** -  
**Required Medical Information** Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following: a generic serotonin and norepinephrine reuptake inhibitor (SNRI), a generic selective serotonin reuptake inhibitor (SSRI), mirtazapine, bupropion.  
**Age Restrictions** -  
**Prescriber Restrictions** -  
**Coverage Duration** Plan Year  
**Other Criteria** -

<b>Prior Authorization Group</b>	DIAZEPAM
<b>Drug Names</b>	DIAZEPAM, DIAZEPAM INTENSOL
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of skeletal muscle spasms OR 4) For adjunctive therapy in the treatment of convulsive disorders OR 5) For the short-term relief of the symptoms of anxiety AND 6) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored
<b>Prior Authorization Group</b>	DICLOFENAC GEL 1%
<b>Drug Names</b>	DICLOFENAC SODIUM
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The patient has osteoarthritis pain in joints susceptible to topical treatment such as feet, ankles, knees, hands, wrist, or elbow AND 2) Treatment with the requested drug is necessary due to intolerance or a contraindication to oral nonsteroidal anti-inflammatory (NSAID) drugs.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	EMSAM
<b>Drug Names</b>	EMSAM
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (e.g., venlafaxine), selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline), tricyclic or tetracyclic antidepressants (e.g., amitriptyline, nortriptyline) OR 2) Patient is unable to swallow oral formulations.
<b>Age Restrictions</b>	18 years of age or older.
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ENDARI
<b>Drug Names</b>	ENDARI
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	5 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	EPCLUSA
<b>Drug Names</b>	EPCLUSA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Criteria will be applied consistent with current AASLD-IDSa guidance.
<b>Other Criteria</b>	-

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

<b>Prior Authorization Group</b>	EPO
<b>Drug Names</b>	PROCRIT
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa), anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis.
<b>Exclusion Criteria</b>	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
<b>Required Medical Information</b>	For all uses except surgery: Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL (less than 9 g/dL for anemia in CHF only). Additional requirements for primary myelofibrosis (MF), post-polycythemia vera MF, post-essential thrombocythemia MF: 1) Patient has symptomatic anemia and 2) For initial therapy, pretreatment serum erythropoietin level is less than 500mU/mL. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery and 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	16 weeks
<b>Other Criteria</b>	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 (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion. For reauthorizations (patient received erythropoietin in previous month): 1) For all uses except surgery, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy, 2) For anemia in CKD, MDS, CHF, RA, HIV, hepatitis C treatment, primary MF, post-polycythemia vera MF, post-essential thrombocythemia MF, or patients whose religious beliefs forbid blood transfusions: current Hgb is less than or equal to 12 g/dL, and 3) For anemia due to myelosuppressive cancer chemotherapy: current Hgb is less than 11 g/dL.



<b>Prior Authorization Group</b>	ERIVEDGE
<b>Drug Names</b>	ERIVEDGE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ERLEADA
<b>Drug Names</b>	ERLEADA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ESBRIET
<b>Drug Names</b>	ESBRIET
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Initial Review Only: The patient does not have a known etiology for interstitial lung disease and meets one of the following: 1) a high-resolution computed tomography (HRCT) study of the chest or surgical lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, or 2) HRCT study of the chest reveals a possible UIP pattern and the diagnosis is supported either by surgical lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if surgical lung biopsy has not been conducted. For continuation: The patient does not have a known etiology for interstitial lung disease.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	FABRAZYME
<b>Drug Names</b>	FABRAZYME
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is an obligate female carrier with a first degree male relative diagnosed with Fabry disease.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	FARYDAK
<b>Drug Names</b>	FARYDAK
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	FENTANYL PATCH
<b>Drug Names</b>	FENTANYL
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for pain associated with cancer, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient can safely take the requested dose based on their history of opioid use AND 4) The patient has been evaluated and will be monitored for the development of opioid use disorder.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	FETZIMA
<b>Drug Names</b>	FETZIMA, FETZIMA TITRATION PACK
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	FIRAZYR
<b>Drug Names</b>	FIRAZYR
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	The requested drug is being used for the treatment of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	FORTEO
<b>Drug Names</b>	FORTEO
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	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). For primary or hypogonadal osteoporosis in men: patient has a) a history of osteoporotic vertebral or hip fracture OR b) a pre-treatment T-score of less than or equal to -2.5 OR c) osteopenia with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: Patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND Patient has a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) osteopenia with a high pre-treatment FRAX fracture probability.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	24 months (lifetime)
<b>Other Criteria</b>	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
<b>Prior Authorization Group</b>	FYCOMPA
<b>Drug Names</b>	FYCOMPA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	Partial-onset seizures - 4 years of age or older. Primary generalized tonic-clonic seizures - 12 years of age or older.
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	GATTEX
<b>Drug Names</b>	GATTEX
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For initial therapy: Patient was dependent on parenteral support for at least 12 months. For continuation: Requirement for parenteral support has decreased from baseline while on teduglutide therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	GILENYA
<b>Drug Names</b>	GILENYA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	GILOTRIF
<b>Drug Names</b>	GILOTRIF
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For non-small cell lung cancer (NSCLC), patient meets either of the following: 1) patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) patient has a known sensitizing epidermal growth factor receptor (EGFR) mutation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	GLATIRAMER
<b>Drug Names</b>	GLATIRAMER ACETATE, GLATOPA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, first clinical episode of MS.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	GRANIX
<b>Drug Names</b>	GRANIX
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), stem cell transplantation related indications, acute lymphocytic leukemia (ALL), acute myeloid leukemia (AML), severe chronic neutropenia (congenital, cyclic, or idiopathic), myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplantation.
<b>Exclusion Criteria</b>	Use of the requested product within 24 hours prior to or following chemotherapy.
<b>Required Medical Information</b>	For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	GROWTH HORMONE
<b>Drug Names</b>	GENOTROPIN, GENOTROPIN MINIQUICK
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Pediatric patients with closed epiphyses (except in patients with PWS).
<b>Required Medical Information</b>	<p>Pediatric GHD: 1) Younger than 2.5 yrs old, when applicable: a) Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2) 2.5 yrs old or older: a) Pre-tx 1-year ht velocity more than 2 SD below mean OR b) Pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) Patient is a neonate or was diagnosed with GHD as a neonate. TS: 1) Confirmed by karyotyping AND 2) Pre-treatment height is less than the 5th percentile for age. SGA: 1) Birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) Did not manifest catch-up growth by age 2. Adult GHD: 1) Failed 2 stimulation tests (peak below 5 ng/mL) or test with Macrilen (peak below 2.8 ng/ml) prior to starting tx, OR 2) Structural abnormality of the hypothalamus/pituitary AND 3 or more pituitary hormone deficiencies, OR 3) Childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS, OR 4) Low pre-tx IGF-1 and failed 1 stimulation test prior to starting tx.</p> <p>SGA: 2 years of age or older</p>
<b>Age Restrictions</b>	SGA: 2 years of age or older
<b>Prescriber Restrictions</b>	Endocrinologist, pediatric endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, geneticist.
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Renewal for pediatric GHD, TS, SGA, and adult GHD: patient is experiencing improvement.

<b>Prior Authorization Group</b>	HAEGARDA
<b>Drug Names</b>	HAEGARDA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	This medication is being used for the prevention of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	HARVONI
<b>Drug Names</b>	HARVONI
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Criteria applied consistent with current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	HERCEPTIN
<b>Drug Names</b>	HERCEPTIN
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, neoadjuvant treatment for HER2-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction cancer.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b>Other Criteria</b>	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.
<b>Prior Authorization Group</b>	HETLIOZ
<b>Drug Names</b>	HETLIOZ
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For initial therapy and continuation of HetlioZ therapy: 1) diagnosis of Non-24 Hour Sleep-Wake Disorder and 2) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and 3) unable to perceive light in both eyes. For patients currently on therapy with the requested medication, must meet at least one of the following: 1) increased total nighttime sleep or 2) decreased daytime nap duration.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Initiation: 6 Months, Renewal: Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	HIGH RISK MEDICATION
<b>Drug Names</b>	CYPROHEPTADINE HCL, DIGITEK, DIGOX, DIGOXIN, GUANFACINE ER, SCOPOLAMINE, TRANSDERM-SCOP
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

<b>Prior Authorization Group</b>	HRM-ANTICONVULSANTS
<b>Drug Names</b>	PHENOBARBITAL, PHENOBARBITAL SODIUM
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

<b>Prior Authorization Group</b>	HRM-ANTIPARKINSON
<b>Drug Names</b>	BENZTROPINE MESYLATE, TRIHEXYPHENIDYL HCL, TRIHEXYPHENIDYL HYDROCHLO
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) EPS (extrapyramidal symptoms): 1) One non-HRM alternative drug amantadine has not been tried. AND 2) The patient has a contraindication to one non-HRM alternative drug amantadine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative drug amantadine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug amantadine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Parkinson's: 1) Two non-HRM alternative drugs amantadine, carbidopa/levodopa, pramipexole, or ropinirole have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

<b>Prior Authorization Group</b>	HRM-GLYBURIDE
<b>Drug Names</b>	GLYBURIDE, GLYBURIDE MICRONIZED, GLYBURIDE/METFORMIN HCL
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative drugs glimepiride, glipizide, or metformin have not been tried AND 2) The patient has a contraindication to two non-HRM alternative drugs glimepiride, glipizide, or metformin AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) Two non-HRM alternative drugs glimepiride, glipizide, or metformin have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs glimepiride, glipizide, or metformin AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

<b>Prior Authorization Group</b>	HRM-HYDROXYZINE
<b>Drug Names</b>	HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE, HYDROXYZINE PAMOATE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For pruritus: 1) A non-HRM alternative drug levocetirizine has not been tried AND 2) The patient has a contraindication to a non-HRM alternative drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) A non-HRM alternative drug levocetirizine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. For anxiety: 1) Two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release have been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

<b>Prior Authorization Group</b>	HRM-HYDROXYZINE INJ
<b>Drug Names</b>	HYDROXYZINE HCL
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Alcohol Withdrawal Syndrome: 1) One non-HRM alternative drug clorazepate or lorazepam has not been tried AND 2) The patient has a contraindication to one non-HRM alternative drug clorazepate or lorazepam AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative drug clorazepate or lorazepam has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug clorazepate or lorazepam AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient Anxiety: 1) Two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release have been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) If being requested for nausea/vomiting, prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

<b>Prior Authorization Group</b>	HRM-HYPNOTICS
<b>Drug Names</b>	ESZOPICLONE, ZALEPLON, ZOLPIDEM TARTRATE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has not been tried AND 2) The patient has a contraindication to two non-HRM alternative drugs Silenor (3mg or 6mg) and trazodone AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug Silenor (3mg or 6mg) or trazodone AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

<b>Prior Authorization Group</b>	HRM-NITROFURANTOIN
<b>Drug Names</b>	NITROFURANTOIN MACROCRYST, NITROFURANTOIN MONOHYDRAT
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have not been tried AND 2) The patient has a contraindication to two non-HRM alternative drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) Two non-HRM alternative drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.



<b>Prior Authorization Group</b>	HRM-PROMETHAZINE
<b>Drug Names</b>	PROMETHAZINE HCL, PROMETHAZINE HYDROCHLORID
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Rhinitis: 1) One non-HRM alternative drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal has been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Urticaria: 1) One non-HRM alternative drug levocetirizine has not been tried AND 2) The patient has a contraindication to one non-HRM alternative drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative drug levocetirizine has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 7) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 8) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

<b>Prior Authorization Group</b>	HRM-SKELETAL MUSCLE RELAXANTS
<b>Drug Names</b>	CARISOPRODOL, CYCLOBENZAPRINE HYDROCHLO, METHOCARBAMOL
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

<b>Prior Authorization Group</b>	HUMIRA
<b>Drug Names</b>	HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PS/UV STARTER
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD (e.g., tofacitinib). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to MTX, 2) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR 2) intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one immunosuppressant therapy (e.g., corticosteroids, azathioprine, mercaptopurine), OR 2) intolerance or contraindication to immunosuppressant therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	HYPNOTIC BENZODIAZEPINES
<b>Drug Names</b>	TEMAZEPAM
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has not been tried AND 2) The patient has a contraindication to two non-HRM alternative drugs Silenor (3mg or 6mg) and trazodone AND 3) Prescriber must acknowledge that medication benefits outweigh potential risk in a patient 65 years of age or older OR 4) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug Silenor (3mg or 6mg) or trazodone AND 6) Prescriber must acknowledge that medication benefits outweigh potential risk in a patient 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

<b>Prior Authorization Group</b>	IBRANCE
<b>Drug Names</b>	IBRANCE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, well-differentiated/dedifferentiated liposarcoma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

**Prior Authorization Group** ICLUSIG  
**Drug Names** ICLUSIG  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D.  
**Exclusion Criteria** -  
**Required Medical Information** For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.  
**Age Restrictions** -  
**Prescriber Restrictions** -  
**Coverage Duration** Plan Year  
**Other Criteria** -

**Prior Authorization Group** IDHIFA  
**Drug Names** IDHIFA  
**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** IMATINIB  
**Drug Names** IMATINIB MESYLATE  
**Covered Uses** All FDA-approved indications not otherwise excluded from Part D, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, and melanoma.  
**Exclusion Criteria** -  
**Required Medical Information** For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor (eg, dasatinib, nilotinib, bosutinib, ponatinib). For melanoma, c-Kit mutation is positive.  
**Age Restrictions** -  
**Prescriber Restrictions** -  
**Coverage Duration** Plan Year  
**Other Criteria** -

<b>Prior Authorization Group</b>	IMBRUVICA
<b>Drug Names</b>	IMBRUVICA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, hairy cell leukemia, and lymphoplasmacytic lymphoma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For mantle cell lymphoma: 1) the requested medication will be used in a patient who has received at least one prior therapy, OR 2) the requested medication will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen. For gastric MALT lymphoma and non-gastric MALT lymphoma: 1) disease is recurrent, refractory, or progressive, AND 2) the requested medication will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested medication will be used as a single agent for disease progression.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	INCRELEX
<b>Drug Names</b>	INCRELEX
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Must meet all of the following prior to beginning therapy with the requested medication (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. For renewal, patient is experiencing improvement.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	INLYTA
<b>Drug Names</b>	INLYTA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, papillary, Hurthle cell, or follicular thyroid carcinoma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	IR BEFORE ER
<b>Drug Names</b>	HYSINGLA ER, METHADONE HCL, METHADONE HCL INTENSOL, MORPHINE SULFATE ER, NUCYNTA ER, OXYCONTIN
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	1) The requested drug is being prescribed for pain associated with cancer, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient can safely take the requested dose based on their history of opioid use AND 4) The patient has been evaluated and will be monitored for the development of opioid use disorder AND 5) The request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR 6) The patient has severe continuous pain and has received an immediate-release opioid for at least one week.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	IRESSA
<b>Drug Names</b>	IRESSA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For non-small cell lung cancer, patient has a known sensitizing EGFR mutation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ISOTRETINOIN
<b>Drug Names</b>	AMNESTEEM, CLARAVIS, ISOTRETINOIN, MYORISAN, ZENATANE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, refractory acne, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	ITRACONAZOLE
<b>Drug Names</b>	ITRACONAZOLE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, Coccidioidomycosis, Cryptococcosis, Microsporidiosis, Penicilliosis, Sporotrichosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea manuum/Tinea pedis.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed by a fungal diagnostic test.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	-

<b>Prior Authorization Group</b>	IVIG
<b>Drug Names</b>	BIVIGAM, CARIMUNE NANOFILTERED, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PANZYGA, PRIVIGEN
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, primary immunodeficiency, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, idiopathic thrombocytopenic purpura, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, Stiff-person syndrome, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections. For dermatomyositis and polymyositis: at least one standard first-line treatment (corticosteroids or immunosuppressants) has been tried but was unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. PRCA is secondary to parvovirus B19 infection.
<b>Age Restrictions</b>	For pediatric HIV infection: age 12 years or younger.
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	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.
<b>Prior Authorization Group</b>	JAKAFI
<b>Drug Names</b>	JAKAFI
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, low-risk, intermediate-risk, accelerated phase, or blast phase myelofibrosis, polycythemia vera in patients with inadequate response or intolerance to interferon therapy (interferon alfa-2b, peginterferon alfa-2a, or peginterferon alfa-2b).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



<b>Prior Authorization Group</b>	JUXTAPID
<b>Drug Names</b>	JUXTAPID
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin, rosuvastatin), fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colestesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated LDL-C greater than 100 mg/dl (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points.

<b>Prior Authorization Group</b>	KALYDECO
<b>Drug Names</b>	KALYDECO
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	The patient has one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation.
<b>Age Restrictions</b>	Granules: 12 months of age or older. Tablets: 6 years of age or older.
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	The requested drug will not be used in combination with lumacaftor/ivacaftor or tezacaftor/ivacaftor.
<b>Prior Authorization Group</b>	KETOCONAZOLE
<b>Drug Names</b>	KETOCONAZOLE
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, Cushing's syndrome.
<b>Exclusion Criteria</b>	Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, alprazolam or simvastatin.
<b>Required Medical Information</b>	1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis, OR 2) The requested drug is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	KEYTRUDA
<b>Drug Names</b>	KEYTRUDA
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D, malignant pleural mesothelioma, Merkel cell carcinoma.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-