How do I request an exception to the Central Health Plan’s Formulary?

You can ask Central Health Plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Central Health Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our non-preferred tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. “Also, you may not ask us to provide a higher level of coverage for drugs that are in the specialty tier.”

Generally, Central Health Plan will only approve your request for an exception if the alternative drugs included on the plan’s formulary, the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request. Generally, we must make our decision within 72 hours of getting your prescribing physician’s supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician’s supporting statement.

Your physician must submit a statement supporting your coverage determination or exception request. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

What if I have additional questions?

You can call us at: 1-800-546-5677 (seven days a week, 24 hours a day) if you have any additional questions. If you have a hearing or speech impairment, please call us at TTY 1-866-706-4757.
ABELCET

| COVERED USES: | All FDA-Approved indications not otherwise excluded from Part D. Aspergillosis, Blastomycosis, Candidiasis, Cryptococcal meningitis, Leishmaniasis and Systemic mycosis. |
| EXCLUSION CRITERIA: | |
| REQUIRED INFO: | |
| AGE RESTRICTIONS: | |
| MD RESTRICTIONS: | |
| COVERAGE DURATION: | End of plan year |
| OTHER CRITERIA: | **Note: THIS FORMULATION IS NOT INTERCHANGEABLE WITH OTHER FORMULATIONS, SUCH AS CONVENTIONAL AMPHOTERICIN B, AMPHOTERICIN B CHOLESTERYL SULFATE COMPLEX, OR AMPHOTERICIN B LIPOSOME |
ADAGEN

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adagen® is indicated for enzyme replacement therapy for adenosine deaminase (ADA) deficiency in patients with severe combined immunodeficiency disease (SCID) who are not suitable candidates for or who have failed bone marrow transplantation. Adagen® is not intended as a replacement for HLA identical bone marrow transplant therapy.

EXCLUSION CRITERIA:

REQUIRED INFO: ADAGEN® (pegademase bovine) Injection is recommended for use in infants from birth or in children of any age at the time of diagnosis. Pregnancy category C.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ADAPALENE

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Safety and efficacy have not been established in children less than 12 years of age

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ADCIRCA

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patient must be at least 18 years old

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA

Current as of: Thursday, August 24, 2017
ADEMPAS

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

 EXCLUSION CRITERIA:  Pregnancy category X—Patient must not be pregnant.

 REQUIRED INFO:

 AGE RESTRICTIONS:  Patient is 18 years of age or older.

 MD RESTRICTIONS:

 COVERAGE DURATION:  End of plan year

 OTHER CRITERIA:  NA
AFINITOR

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include advanced renal cell cancer in patients who have failed treatment with sunitinib or sorafenib, subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis in patients who require therapeutic intervention but are not candidates for curative surgical resection, and progressive pancreatic neuroendocrine tumor (PNET) in patients with unresectable, locally advanced or metastatic disease.

EXCLUSION CRITERIA:

REQUIRED INFO: 1) If treating advanced renal cell cancer, the patient needs to have failed sunitinib or sorafenib. 2) Patient needs a baseline complete blood count and liver function tests. 3) Patient should not be allergic to everolimus or any other rapamycin derivatives.

AGE RESTRICTIONS: Patients must be at least 1 year old.

MD RESTRICTIONS: Medication must be prescribed by an oncologist.

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include advanced renal cell cancer in patients who have failed treatment with sunitinib or sorafenib, subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis in patients who require therapeutic intervention but are not candidates for curative surgical resection, and progressive pancreatic neuroendocrine tumor (PNET) in patients with unresectable, locally advanced or metastatic disease.

EXCLUSION CRITERIA:

REQUIRED INFO: 1) If treating advanced renal cell cancer, the patient needs to have failed sunitinib or sorafenib. 2) Patient needs a baseline complete blood count and liver function tests. 3) Patient should not be allergic to everolimus or any other rapamycin derivatives.

AGE RESTRICTIONS: Patients must be at least 1 year old.

MD RESTRICTIONS: Medication must be prescribed by an oncologist.

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ALDURAZYME

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Mucopolysaccharidosis Type I

EXCLUSION CRITERIA:

REQUIRED INFO: Pregnancy Category: B--Patients should receive antipyretics and/or antihistamines prior to infusion

AGE RESTRICTIONS: Patient must be at least 6 months of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ALORA

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
AMPHOTERICIN B

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. FUNGIZONE INTRAVENOUS (Amphotericin B for injection) will be covered for: Patient has a potentially life-threatening fungal infection such as one of the following: ASPERGILLOSIS, BLASTOMYCOSIS, SYSTEMIC CANDIDIASIS, COCCIDIOIDOMYCOSIS, CRYPTOCOCCOSIS, HISTOPLASMOSIS, ZYGOMYCOSIS, LEISHMANIASIS, SPOROTRICHOSIS

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: This medication must not meet coverage criteria under Medicare Part B

Current as of: Thursday, August 24, 2017
AMPYRA

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include treatment of multiple sclerosis to improve walking.

EXCLUSION CRITERIA: 1) Patients with renal insufficiency and a creatinine clearance less than or equal to 50mL per min. 2) Patients with a history of seizures or a seizure disorder.

REQUIRED INFO: 1) Patient must be ambulatory. 2) A baseline serum creatinine must be obtained prior to initiation of medication. 3) Patient must be concurrently receiving a disease modifying agent such as Avonex, Betaseron, Copaxone, Rebif, or Tysabri.

AGE RESTRICTIONS: Patients must be greater than or equal to 18 years of age.

MD RESTRICTIONS: Medication must be prescribed by a neurologist or MS specialist.

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ANADROL-50

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

EXCLUSION CRITERIA: In patients with nephrosis or the nephrotic phase of nephritis. In patients with severe hepatic dysfunction. Carcinoma of the prostate or breast in male patients. Carcinoma of the breast in females with hypercalcemia. Pregnancy in females of reproductive potential.

REQUIRED INFO: Anadrol-50 will not be used as replacement of other supportive measures, e.g., correction of iron, folic acid, vitamin B12 or pyridoxine deficiency, etc., if any

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA:
APOKYN

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

EXCLUSION CRITERIA:

REQUIRED INFO: Apomorphine is used to treat "off" episodes when they occur. It is not used to prevent "off" episodes. The safety and efficacy has not been established for use in pediatrics. Pregnancy category is C. The patient must have a diagnosis of Parkinson’s disease, Acute, intermittent treatment of hypomobility "off" episodes.

AGE RESTRICTIONS: Patient must be at least 18 years old

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ARALAST NP

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Alpha-1-antitrypsin deficiency

EXCLUSION CRITERIA:

REQUIRED INFO: Patients must be immunized against Hepatitis B prior to receiving Aralast.

AGE RESTRICTIONS: Patient must be at least 18 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ARANESP ALBUMIN FREE

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

EXCLUSION CRITERIA: Treatment of patients who require immediate correction of severe anemia - Treatment of anemia in cancer or HIV-infected patients caused by other factors such as iron or folate deficiencies, hemolysis or GI bleeding. In these cases the underlying cause of the anemia should be managed appropriately - Treatment of anemia in rheumatoid arthritis - Treatment of pruritis associated with renal failure - Treatment of anemia in Gaucher’s disease - Treatment of anemia in Castleman’s disease - Treatment of anemia in paroxysmal nocturnal hemoglobinuria (PNH) - Treatment of sickle cell anemia - Treatment of symptomatic anemia related to zidovudine therapy in HIV-infected patients where the dose of zidovudine is -Less Than- 4200 mg/week - Treatment of anemic patients scheduled to undergo elective, noncardiac, nonvascular surgery or patients at high risk for perioperative transfusions with significant, anticipated blood loss - Myelodysplastic syndrome in patients whose pre-treatment endogenous erythropoietin level is -Less Than- 500 mU/ml - Anemia of prematurity, when the patient has either a birthweight -Less Than- 1500 grams or a gestational age of -Less Than- 33 weeks - Special circumstance patients (such as Jehovah Witness) who will not/cannot receive whole blood or components as replacement for traumatic or surgical loss. Uncontrolled hypertension.

REQUIRED INFO: This medication must not meet the criteria for coverage under Medicare Part A or B. Treatment of symptomatic anemia associated with chronic renal failure, including patients on dialysis (end-stage renal disease) and patients not on dialysis OR anemia in cancer patients receiving chemotherapy. Pretreatment hemoglobin levels must be less than 10 g/dL. Medication is prescribed to achieve and maintain hemoglobin of 10 g/dL for adults with CKD not on dialysis or with cancer, 11 g/dL for adults with CKD on dialysis, or 12 g/dL for children with CKD.

AGE RESTRICTIONS: 

MD RESTRICTIONS: 

COVERAGE DURATION: End of plan year 

OTHER CRITERIA: NA
ARCALYST

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include the treatment of cryopyrin-associated periodic syndromes (CAPS) including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome.

EXCLUSION CRITERIA: Patient may not take Arcalyst while on etanercept, infliximab, adalimumab or anakinra.

REQUIRED INFO: 

AGE RESTRICTIONS: Patients must be greater than or equal to 12 years of age

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ASCOMP/CODEINE

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA

Current as of: Thursday, August 24, 2017
ATOVAQUONE

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Pneumocystis pneumonia - prophylaxis, Pneumocystis pneumonia, Babesiosis, Malaria, Toxoplasmosis.

EXCLUSION CRITERIA:

REQUIRED INFO: Patient with a diagnosis of pneumocystis pneumonia must have a documented allergy or intolerance to Sulfamethoxazole-Trimethoprim. Patient needing prophylaxis for pneumocystis pneumonia must have a documented failure, allergy, or intolerance to one of more of the following, Sulfamethoxazole-Trimethoprim, Dapsone, Aerosolized pentamidine.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
AUBAGIO

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

EXCLUSION CRITERIA: 1) Patient must not be using in combination with leflunomide and 2) patient must not have severe hepatic impairment.

REQUIRED INFO: 1) Baseline liver function tests or clinical notes documenting patient does not have severe hepatic impairment and 2) for female patient’s of childbearing potential only: a) patient must have a negative pregnancy test result within 2 weeks prior to start of therapy and b) documentation must be provided that patient is using reliable contraception.

AGE RESTRICTIONS: Patient is at least 18 years of age.

MD RESTRICTIONS: Prescribed by or in consult with a neurologist or MS specialist.

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
AVONEX

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

EXCLUSION CRITERIA:

REQUIRED INFO: Have had at least two acute exacerbations during the previous two years, which consisting of new symptoms or aggravation of old symptoms lasting at least 24 hours, and proceeded by stability or improvement for at least 30 days. The patient must have a diagnosis of or Multiple Sclerosis (MS), Relapsing Multiple Sclerosis, Relapsing-Remitting Multiple Sclerosis (RRMS) and Progressive - Relapsing Multiple Sclerosis.

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
AVONEX PEN

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

EXCLUSION CRITERIA:

REQUIRED INFO: Have had at least two acute exacerbations during the previous two years, which consisting of new symptoms or aggravation of old symptoms lasting at least 24 hours, and proceeded by stability or improvement for at least 30 days. The patient must have a diagnosis of or Multiple Sclerosis (MS), Relapsing Multiple Sclerosis, Relapsing-Remitting Multiple Sclerosis (RRMS) and Progressive - Relapsing Multiple Sclerosis.

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
AZACTAM

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Beta-lactam agents, other will be covered for: Endometritis, Female genital infection, Infection of skin and/or subcutaneous tissue, Infection of abdomen, Lower respiratory tract infection, Septicemia, Urinary tract infection disease, Community acquired pneumonia, Operation of intestine.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
BARACLUDE

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Active type B viral hepatitis, chronic

EXCLUSION CRITERIA:

REQUIRED INFO: LFTs must be monitored

AGE RESTRICTIONS: Patient must be at least 2 years old

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
BENLYSTA

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
BENZTROPINE MESYLATE

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
BETASERON

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

EXCLUSION CRITERIA:

REQUIRED INFO: Have had at least two acute exacerbations during the previous two years, which consisting of new symptoms or aggravation of old symptoms lasting at least 24 hours, and preceded by stability or improvement for at least 30 days. The patient must have a diagnosis of or Multiple Sclerosis (MS) or Relapsing-Remitting Multiple Sclerosis (RRMS).

AGE RESTRICTIONS: Patient must be at least 18 years old

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
BUPRENORPHINE HCL

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: NA

COVERAGE DURATION: End of plan year

OTHER CRITERIA:
BUPRENORPHINE HCL/NALOXONE

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: NA

COVERAGE DURATION: End of plan year

OTHER CRITERIA:
BUTALBITAL/ACETAMINOPHEN

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
BUTALBITAL/ASPIRIN/CAFFEINE

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

Exclusion Criteria:

Required Info: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

Age Restrictions: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD Restrictions:

Coverage Duration: End of plan year

Other Criteria: NA

Current as of: Thursday, August 24, 2017
BYETTA

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include type 2 diabetes mellitus.

EXCLUSION CRITERIA: 1) Patients with a type 1 diabetes mellitus diagnosis. 2) Patients with renal dysfunction and a creatinine clearance less than or equal to 30mL per min. 3) Patient has a personal or family history of thyroid cancer. 4) Patients currently taking prandial, short acting insulin.

REQUIRED INFO: 1) Patient has not achieved adequate glycemic control on metformin, sulfonylureas, thiazolidinediones, or a combination of sulfonylureas or thiazolidinediones with metformin. 2) Byetta may be used as monotherapy if patient has an intolerance or contraindication to metformin, sulfonylureas, and thiazolidinediones.

AGE RESTRICTIONS: Patients must be at least 18 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
CARBAGLU

COVERED USES:
All FDA-Approved indications not otherwise excluded from Part D. Covered indications include the treatment of hyperammonemia in patients with N-acetylglutamate synthase deficiency both as an adjunctive therapy for the treatment of acute hyperammonemia and as maintenance therapy for chronic hyperammonemia.

EXCLUSION CRITERIA:

REQUIRED INFO:
Obtain baseline ammonia levels prior to treatment initiation. Lab values or chart notes confirming deficiency of the hepatic enzyme N-acetylglutamate synthase.

AGE RESTRICTIONS:

MD RESTRICTIONS:
Medication must be prescribed by an endocrinologist, geneticist, metabolic specialist, or other prescriber with experience in N-acetylglutamate synthase deficiency.

COVERAGE DURATION:
End of plan year

OTHER CRITERIA:
NA
CARIMUNE NANOFILTERED

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
**CAYSTON**

**COVERED USES:** All FDA-Approved indications not otherwise excluded from Part D. Covered indications include to improve respiratory symptoms in cystic fibrosis patients with *Pseudomonas aeruginosa*.

**EXCLUSION CRITERIA:**

**REQUIRED INFO:** Documentation must be provided with evidence of *Pseudomonas aeruginosa* lung infection.

**AGE RESTRICTIONS:** Patients must be at least 7 years of age.

**MD RESTRICTIONS:** Medication is being prescribed by a pulmonologist, endocrinologist, or infectious disease specialist.

**COVERAGE DURATION:** End of plan year

**OTHER CRITERIA:** NA
CEREZYME

COVERED USES:  All FDA-Approved indications not otherwise excluded from Part D.  
Non-neuropathic Gaucher's disease, chronic

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION:  End of plan year

OTHER CRITERIA:  NA
CHANTIX

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Aid to smoking cessation

EXCLUSION CRITERIA:

REQUIRED INFO: Chantix should be started one week before the target date to quit smoking.

AGE RESTRICTIONS: The patient must be at least 18 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: Treatment should last for 12 weeks.
CHANTIX STARTING MONTH PA

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Aid to smoking cessation

EXCLUSION CRITERIA:

REQUIRED INFO: Chantix should be started one week before the target date to quit smoking.

AGE RESTRICTIONS: The patient must be at least 18 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: Treatment should last for 12 weeks.
COVERED USES: All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: NA

COVERAGE DURATION: End of plan year

OTHER CRITERIA:
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
CYCLOBENZAPRINE HCL

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA

Current as of: Thursday, August 24, 2017
COVERED USES: All FDA-approved indications not otherwise excluded from Part D. Covered indications include type 2 diabetes mellitus.

EXCLUSION CRITERIA:

REQUIRED INFO: Patient must have documented failure, contraindication, or intolerance to two of the following: metformin, sulfonylurea, or thiazolidinedione.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:  

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:  

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include the prevention of COPD exacerbations in patients with severe chronic obstructive pulmonary disease (COPD) associated with chronic bronchitis and a history of exacerbations.

EXCLUSION CRITERIA: 1) Patients with moderate to severe hepatic impairment. 2) Patients experiencing acute bronchospasms. Daliresp is not a bronchodilator and is not indicated for the relief of acute bronchospasm.

REQUIRED INFO: Baseline liver function tests should be obtained prior to treatment initiation.

AGE RESTRICTIONS: Patients must be greater than or equal to 18 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
DEXTRO AMPHETAMINE SULFATE

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: NA

COVERAGE DURATION: End of plan year

OTHER CRITERIA:
DIGITEK

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
DIGOXIN

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
DISOPYRAMIDE PHOSPHATE

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
DRONABINOL

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ELAPRASE

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. The patient must have a diagnosis of Mucopolysaccharidosis, MPS-II.

EXCLUSION CRITERIA: 

REQUIRED INFO: Pregnancy category is C.

AGE RESTRICTIONS: Patient must be at least 16 months of age.

MD RESTRICTIONS: 

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ELIDEL

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. The patient has a diagnosis of mild to moderate atopic dermatitis.

EXCLUSION CRITERIA:

REQUIRED INFO: The patient is not immunocompromised. The patient has a documented failure or inadequate response with at least two topical corticosteroids, or a contraindication to topical corticosteroids.

AGE RESTRICTIONS: The patient is two years of age or older.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ENBREL

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

EXCLUSION CRITERIA: shall not be granted for use Wegener’s granulomatosis.

REQUIRED INFO: patient with a diagnosis of plaque psoriasis must have had an inadequate response or a documented failure due to lack of efficacy to one or more of the following, Topical corticosteroid, Tazarotene, Anthralin. Patient with a diagnosis of either rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis or psoriatic arthritis must have had an inadequate response or a documented failure due to lack of efficacy to one or more of the following disease modifying antirheumatic drugs (DMARDs), Methotrexate, Hydroxychloroquine, D-penicillamine, Sulfasalazine, Leflunomide, Azathioprine, Oral/Injectable Gold Compounds.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ENBREL SURECLICK

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

EXCLUSION CRITERIA: shall not be granted for use Wegener’s granulomatosis.

REQUIRED INFO: patient with a diagnosis of plaque psoriasis must have had an inadequate response or a documented failure due to lack of efficacy to one or more of the following, Topical corticosteroid, Tazarotene, Anthralin. Patient with a diagnosis of either rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis or psoriatic arthritis must have had an inadequate response or a documented failure due to lack of efficacy to one or more of the following disease modifying antirheumatic drugs (DMARDs), Methotrexate, Hydroxychloroquine, D-penicillamine, Sulfasalazine, Leflunomide, Azathioprine, Oral/Injectable Gold Compounds.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ENTECAVIR

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Active type B viral hepatitis, chronic

EXCLUSION CRITERIA:

REQUIRED INFO: LFTs must be monitored

AGE RESTRICTIONS: Patient must be at least 2 years old

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
EPOGEN

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

EXCLUSION CRITERIA: 1. Treatment of patients who require immediate correction of severe anemia.

REQUIRED INFO: 1. Treatment of symptomatic anemia associated with chronic renal failure, including patients on dialysis (end-stage renal disease) and patients not on dialysis. 2. Treatment of symptomatic anemia where erythropoietin level is Less Than 500 mU/ml, related to zidovudine therapy in HIV-infected patients where the dose of zidovudine is Less Than 4200 mg/week. 3. Treatment of symptomatic anemia in patients with non-myeloid malignancies and anemia is caused by the effect of administered chemotherapy and the patient must be on chemotherapy concomitantly for a minimum of 2 months. 4. Treatment of anemic patients scheduled to undergo elective, noncardiac, nonvascular surgery.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: Special circumstance patients (such as Jehovah Witness) who will not/cannot receive whole blood or components as replacement for traumatic or surgical loss will be taken into consideration.
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. The patient must have a diagnosis of Candidemia, Candidiasis of the esophagus, disseminated candidiasis, intra-abdominal and peritonitis.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patients must be at least 17 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ESBRIET

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

EXCLUSION CRITERIA: Esbriet is not used in patients on Ofev. Patient must not have severe hepatic impairment (Child-Pugh Class C) and end stage renal disease (ESRD) requiring dialysis.

REQUIRED INFO: Confirmed diagnosis of idiopathic pulmonary fibrosis (e.g., via high-resolution computed tomography (HRCT) demonstrating usual interstitial pneumonia (UIP), etc.). Baseline liver function tests: ALT, AST, bilirubin.

AGE RESTRICTIONS:

MD RESTRICTIONS: Pulmonologist

COVERAGE DURATION: The PA will be approved through the remainder of the contract year.

OTHER CRITERIA:
ESGIC

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA: 

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS: 

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ESTROPIPATE

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
EXJADE

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. 1. Chronic iron toxicity. 2. Chronic iron toxicity secondary to transfusional iron overload.

EXCLUSION CRITERIA: Exjade will not be covered if the serum creatinine is greater than 2 times the age-appropriate upper limit of normal (ULN), creatinine clearance is less than 40 mL/min, patient has poor performance status, patient has high-risk myelodysplastic syndrome (MDS), patient has advanced malignancy, or patient has a platelet count less than 50 x 10^9/L.

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: Have had at least two acute exacerbations during the previous two years, which consisting of new symptoms or aggravation of old symptoms lasting at least 24 hours, and preceded by stability or improvement for at least 30 days. The patient must have a diagnosis of or Multiple Sclerosis (MS) or Relapsing-Remitting Multiple Sclerosis (RRMS).

AGE RESTRICTIONS: Patient must be at least 18 years old

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
FABRAZYME

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.
Fabry’s disease

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patient must be at least 8 years old

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Breakthrough cancer pain in opioid tolerant patients with malignancies currently taking chronic pain medications

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
FERRIPROX

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

EXCLUSION CRITERIA:

REQUIRED INFO: 1) Serum iron studies confirming iron overload. 2) Patient has tried Exjade with inadequate response.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
**FIRAZYR**

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

**EXCLUSION CRITERIA:**

**REQUIRED INFO:**

**AGE RESTRICTIONS:**

**MD RESTRICTIONS:**

**COVERAGE DURATION:** End of Plan year

**OTHER CRITERIA:** NA
<table>
<thead>
<tr>
<th>COVERED USES:</th>
<th>All FDA-Approved indications not otherwise excluded from Part D. Arthroplasty of knee, Total - Postoperative deep vein thrombosis - Prophylaxis. Deep venous thrombosis, acute, In conjunction with warfarin sodium. Postoperative deep vein thrombosis - Prophylaxis - Repair of hiP. Postoperative deep vein thrombosis - Prophylaxis - Total replacement of hip. Pulmonary embolism, acute, In conjunction with warfarin sodium when initial therapy is administered in a hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXCLUSION CRITERIA:</td>
<td>Active major bleeding - risk of uncontrollable hemorrhage--Bacterial endocarditis--Body weight less than 50 kg for prophylactic therapy of hip fracture, hip replacement or knee replacement surgery, or abdominal surgery - increased risk for major bleeding episodes--Fondaparinux-related thrombocytopenia--Hypersensitivity to fondaparinux--Severe renal impairment (creatinine clearance less than 30 milliliters/minute) - increased risk for major bleeding episodes</td>
</tr>
<tr>
<td>REQUIRED INFO:</td>
<td></td>
</tr>
<tr>
<td>AGE RESTRICTIONS:</td>
<td>Patient must be at least 18 years old</td>
</tr>
<tr>
<td>MD RESTRICTIONS:</td>
<td></td>
</tr>
<tr>
<td>COVERAGE DURATION:</td>
<td>End of plan year</td>
</tr>
<tr>
<td>OTHER CRITERIA:</td>
<td>NA</td>
</tr>
</tbody>
</table>
FORTEO

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Postmenopausal osteoporosis in women who are at a high risk for fracture, Primary osteoporosis in men, Hypogondal osteoporosis in men, glucocorticoid-induced osteoporosis in patients at high risk of fracture.

EXCLUSION CRITERIA: Forteo shall not be approved for any of the following reasons: in children or adolescents, Paget’s disease of the bone, hypercalcemia, patients with bone cancer or other cancers that have metastasized to the bones.

REQUIRED INFO: The patient should also meet National Osteoporosis Foundation guidelines for treatment and have one of the following: 1. Bone Mineral Density (BMD) 2.5 or more standard deviations below the mean value (ie T-score less than 2.5) with no risk factors OR 2. BMD T-score below 1.5 (1.5 or more standard deviations below the mean value) with one or more risk factors 3. Prior vertebral or hip fracture 4. Patients must also have a prior failure or intolerance to at least one of the following therapies: Bisphosphonate (Fosamax, Actonel, Boniva), Miacalcin, Evista (SERM)

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
FRAGMIN

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

EXCLUSION CRITERIA:

REQUIRED INFO: The patient must have a diagnosis of ANY of the following: acute deep venous thrombosis (DVT), pulmonary embolism (PE), venous thromboembolism (VTE) prophylaxis, unstable angina (UA), non-ST-segment elevation myocardial infarction (NSTEMI), or non-Q-wave myocardial infarction, acute myocardial infarction with ST-segment elevation (STemi).

AGE RESTRICTIONS: Patients must be at least 18 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
GAMASTAN S/D

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
GAMMAGARD LIQUID

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
GAMMAGARD S/D

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
GARDASIL 9

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Indicated for patients 9-26 years of age

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
GATTEX

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

EXCLUSION CRITERIA:

REQUIRED INFO: 1) Patient is dependent on parenteral support. 2) Colonoscopy of the entire colon has been performed within 6 months prior to starting initial treatment.

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43), Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9), Patients with Turner’s syndrome (758.6). GH therapy for patients with Turner’s syndrome, Patients with AIDS (042) related wasting with involuntary weight loss, Children with Russel – Silver syndrome (759.89), Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.
GENOTROPIN MINIQUICK

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43), Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9), Patients with Turner’s syndrome (758.6). GH therapy for patients with Turner’s syndrome, Patients with AIDS (042) related wasting with involuntary weight loss, Children with Russel – Silver syndrome (759.89), Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include the treatment of relapsing forms of multiple sclerosis to reduce the frequency of clinical exacerbations and to delay the accumulation of physical disability.

EXCLUSION CRITERIA:

REQUIRED INFO: A baseline ophthalmologic evaluation should be performed prior to the initiation of treatment. Baseline liver function tests should be obtained.

AGE RESTRICTIONS: Patients must be greater than or equal to 18 years of age.

MD RESTRICTIONS: Medication must be prescribed by a neurologist or MS specialist.

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
GILOTRIF

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

EXCLUSION CRITERIA: N/A

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: Oncologist

COVERAGE DURATION: The PA will be approved through the remainder of the contract year.

OTHER CRITERIA: A documented diagnosis of metastatic non-small cell lung cancer (NSCLC) with EGFR exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.
GLATOPA

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

EXCLUSION CRITERIA:

REQUIRED INFO: The patient must have had an inadequate response or a documented failure due to lack of efficacy to interferon beta 1. The patient must have a diagnosis of Relapsing-Remitting Multiple Sclerosis (RRMS).

AGE RESTRICTIONS: Patient must be at least 18 years old

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
GUANFACINE HCL

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
HARVONI

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

EXCLUSION CRITERIA: Patient has severe renal impairment (eGFR less than 30ml/min) or end stage renal disease requiring dialysis. Coadministration with sofosbuvir or simeprevir.

REQUIRED INFO: Documentation of chronic hepatitic C infection and genotype. Documentation of quantitative baseline HCV RNA load.

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
HETLIOZ

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
HUMATROPE

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43). Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9), Patients with Turner’s syndrome (758.6). GH therapy for patients with Turner’s syndrome, Patients with AIDS (042) related wasting with involuntary weight loss, Children with Russel – Silver syndrome (759.89), Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.
HUMATROPE COMBO PACK

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43), Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9), Patients with Turner’s syndrome (759.6). GH therapy for patients with Turner’s syndrome, Patients with AIDS (042) related wasting with involuntary weight loss, Children with Russel – Silver syndrome (759.89), Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.

Current as of: Thursday, August 24, 2017
HUMIRA

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

EXCLUSION CRITERIA:

REQUIRED INFO: Patient must not have an active infection (chronic or acute). The patient has a negative TB test result prior to therapy. The patient is not receiving anakinra (Kineret), etanercept (Enbrel), or infliximab (Remicade) in combination with Humira (adalimumab).

AGE RESTRICTIONS: Patient must be at least 2 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
HUMIRA PEDIATRIC CROHNS D

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

EXCLUSION CRITERIA:

REQUIRED INFO: Patient must not have an active infection (chronic or acute). The patient has a negative TB test result prior to therapy. The patient is not receiving anakinra (Kineret), etanercept (Enbrel), or infliximab (Remicade) in combination with Humira (adalimumab).

AGE RESTRICTIONS: Patient must be at least 2 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
HUMIRA PEN

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

Exclusion Criteria:

Required Info: Patient must not have an active infection (chronic or acute). The patient has a negative TB test result prior to therapy. The patient is not receiving anakinra (Kineret), etanercept (Enbrel), or infliximab (Remicade) in combination with Humira (adalimumab).

Age Restrictions: Patient must be at least 2 years of age.

MD Restrictions:

Coverage Duration: End of plan year

Other Criteria: NA
HUMIRA PEN-CROHNS DISEASE

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

EXCLUSION CRITERIA:

REQUIRED INFO: Patient must not have an active infection (chronic or acute). The patient has a negative TB test result prior to therapy. The patient is not receiving anakinra (Kineret), etanercept (Enbrel), or infliximab (Remicade) in combination with Humira (adalimumab).

AGE RESTRICTIONS: Patient must be at least 2 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: Patient must not have an active infection (chronic or acute). The patient has a negative TB test result prior to therapy. The patient is not receiving anakinra (Kineret), etanercept (Enbrel), or infliximab (Remicade) in combination with Humira (adalimumab).

AGE RESTRICTIONS: Patient must be at least 2 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
HYDROXYZINE HCL

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
IBANDRONATE SODIUM

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
IBRANCE

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

EXCLUSION CRITERIA: N/A

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: Oncologist, Hematologist

COVERAGE DURATION: The PA will be approved through the remainder of the contract year.

OTHER CRITERIA: Estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced breast cancer confirmed via testing in postmenopausal women. Ibrance will be used in combination with letrozole or will be used with fulvestrant in women with disease progression following endocrine therapy. Baseline CBC.
IMATINIB MESYLATE

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

EXCLUSION CRITERIA: N/A

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: The prescription must be initially written or recommended by the Oncologist.

COVERAGE DURATION: The PA will be approved through the remainder of the contract year.

OTHER CRITERIA: Documented Philadelphia chromosome positive status is required for 1) chronic myeloid leukemia (Ph+ CML), and 2) acute lymphoblastic leukemia (Ph+ ALL).
IMBRUVICA

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

EXCLUSION CRITERIA: N/A

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: The prescription must be initially written or recommended by the Oncologist.

COVERAGE DURATION: The PA will be approved through the remainder of the contract year.

OTHER CRITERIA: Documented Philadelphia chromosome positive status is required for 1) chronic myeloid leukemia (Ph+ CML), and 2) acute lymphoblastic leukemia (Ph+ ALL).
INCRELEX

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.
1. Long term treatment of growth failure in children with primary IGF-1 deficiency or with growth hormone gene deletion who have developed neutralizing antibodies to GH.

EXCLUSION CRITERIA: Patients with closed epiphyses. Active or suspected neoplasia, and therapy should be discontinued if neoplasia develops. GH deficiency, Malnutrition, Hypothyroidism, Chronic anti-inflammatory steroids.

REQUIRED INFO: Severe Primary IGFD is defined with the following criteria: Height standard deviation score -Less Than -3.0 AND Basal IGF-1 standard deviation score -Less Than -3.0 AND Normal or elevated Growth Hormone GH OR Mutations in the GH receptor Post GHR signaling pathway mutations IGF-1 gene defects 0.12mg/kg twice daily is maximum dose—doses higher than this have not been evaluated for safety.

AGE RESTRICTIONS: 

MD RESTRICTIONS: 

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
INDOMETHACIN

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
INDOMETHACIN ER

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

Exclusion Criteria:

Required Info: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

Age Restrictions: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD Restrictions:

Coverage Duration: End of plan year

Other Criteria: NA
INFLECTRA

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

EXCLUSION CRITERIA:

REQUIRED INFO:  Active Crohn's Disease, Ankylosing Spondylitis, Plaque Psoriasis, Fistulizing Crohn's Disease, Rheumatoid Arthritis, Psoriatic Arthritis, Psoriasis, Ulcerative colitis, In patients with an inadequate response to conventional therapy: induction dose: 5 mg/kg IV at 0, 2, and 6 weeks, Ulcerative colitis, In patients with an inadequate response to conventional therapy: maintenance dose: 5 mg/kg IV every 8 weeks. Rheumatoid Arthritis 3mg/kg IV at weeks 0, 2, 6 then every 8 weeks incomplete response dosing may vary per label.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION:  End of plan year

OTHER CRITERIA:  NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
JUXTAPIPD

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

EXCLUSION CRITERIA: 1) Patient has moderate or severe hepatic impairment (Child-Pugh category B or C) or active hepatic disease. 2) Patient is pregnant.

REQUIRED INFO: 1) Patient has a clinical or laboratory diagnosis consistent with homozygous familial hypercholesterolemia defined as a) documented functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality OR b) skin fibroblast LDL receptor activity <20% normal, OR c) untreated TC >500 mg/dL and TG <300 mg/dL and both parents with documented untreated TC >250 mg/dL. 2) Baseline liver function tests.

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
KALYDECO

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

EXCLUSION CRITERIA: Patient is homozygous for the F508del mutation in the CFTR gene.

REQUIRED INFO: Patient has one of the following confirmed CFTR gene mutations: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, or R117H.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
KINERET

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

EXCLUSION CRITERIA:
Prior authorization requests shall not be granted for use in multiple sclerosis, lupus erythematosus, juvenile rheumatoid arthritis, inflammatory bowel diseases, sepsis syndrome or graft-versus-host disease. Kineret should not be used in combination with Tumor Necrosis Factor (TNF) blocking agents (Enbrel, Remicade). Kineret should also not be used in patients with active infections.

REQUIRED INFO:
For the diagnosis of RA, the patient must have had an inadequate response or a documented failure due to lack of efficacy to one or more of the following disease modifying antirheumatic drugs (DMARDs), such as: Methotrexate--Hydroxychloroquine--D-penicillamine--Sulfasalazine--Leflunomide--Azathioprine--Oral/Injectable Gold Compounds (auranofin, aurothioglucose, gold sodium thiomalate). The patient must not be using Kineret in combination with Enbrel, Remicade, or Humira. For the diagnosis of RA, the patient must have a diagnosis of moderately to severely active rheumatoid arthritis (RA) as defined by the American College of Rheumatology (ACR).

AGE RESTRICTIONS:
For the diagnosis of RA, the patient must be at least 18 years of age.

MD RESTRICTIONS:

COVERAGE DURATION:
End of plan year

OTHER CRITERIA:
NA

Current as of: Thursday, August 24, 2017
KORLYM

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

EXCLUSION CRITERIA: Patient is pregnant.

REQUIRED INFO:

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS: Medication is being prescribed by an endocrinologist.

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
KUVAN

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include the treatment of hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU) in conjunction with a phenylalanine (Phe)-restricted diet.

EXCLUSION CRITERIA:

REQUIRED INFO: 1) A baseline phenylalanine level must be obtained prior to treatment initiation.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
KYNAMRO

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

EXCLUSION CRITERIA: Patient has moderate or severe hepatic impairment (Child-Pugh category B or C) or active hepatic disease.

REQUIRED INFO: 1) Patient has a clinical or laboratory diagnosis consistent with homozygous familial hypercholesterolemia defined as either a) LDLR DNA sequence analysis showing two mutant alleles OR b) history of untreated LDL cholesterol over 500 mg/dL with either tendinous and/or cutaneous xanthoma prior to age 10 years or documentation of elevated LDL cholesterol over 190 mg/dL prior to lipid-lowering therapy consistent with HeFH in both parents. In cases where a parent is not available, a history of coronary artery disease in a first degree male relative of the parent younger than 55 years or first degree female relative of the parent younger than 60 years is acceptable. 2) Baseline liver function tests. 3) Patient is on other lipid-lowering treatment.

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
LETAIRIS

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Pulmonary aterial hypertension, WHO Group I.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Safety and effectiveness not established in pediatric patients

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: Available only through the Letairis Education Access Program (LEAP) by calling 1-866-664-LEAP (5327) or by logging on to www.letairis.com.
LEUKINE


EXCLUSION CRITERIA: Concomitant chemo- or radiotherapy (or within 24 hours before or after). Excess leukemic myeloid blasts in the blood/bone marrow (greater than 10%). Hypersensitivity to GM-CSF or yeast-derived products

REQUIRED INFO: Patient must have biweekly CBC with differential

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
LIDOCAINE

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
LINEZOLID

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Patient has Vancomycin-resistant Enterococcus faceium infection including patients with concurrent bacteremia. Patient has nosocomial pneumonia caused by Staphylococcus aureus (methicillin-resistant or methicillin-sensitive strains) or Streptococcus pneumoniae (including multi-drug resistant strains: ie penicillin, second-generation cephalosporins, macrolides, tetracycline, and trimethoprim/sulfamethoxazole.) Patient has a complicated skin and skin structure infection caused by Staphylococcus aureus (methicillin-resistant or methicillin-sensitive strains), Streptococcus pyogenes, or streptococcus agalactiae (including diabetic foot infections without concomitant osteomyelitis).

EXCLUSION CRITERIA:

REQUIRED INFO: Patient requires a weekly CBC.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
METHOCARBAMOL

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
METHYLDOPA

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
MIACALCIN

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Hypercalcemia: initial. Paget's disease. Postmenopausal osteoporosis

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
MINIVELLE

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
MODAFINIL

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

EXCLUSION CRITERIA:

REQUIRED INFO: Diagnosis of narcolepsy confirmed by a sleep study. Diagnosis of Idiopathic Hypersomnia confirmed by a sleep study as defined by the International Classification of Sleep Disorders.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
NAGLAZYME

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Maroteaux-Lamy syndrome

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patients must be at least 3 months of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
NATPARA

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

EXCLUSION CRITERIA: Patient is well-controlled on calcium supplements and vitamin D alone.

REQUIRED INFO: 1) Baseline serum calcium level. 2) Patient is also receiving calcium and vitamin D supplementation.

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
NEBUPENT

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Patient has pneumocystis jiroveci pneumonia, high-risk, HIV patients prophylaxis

EXCLUSION CRITERIA:

REQUIRED INFO: Documentation of history of previous PJP. A peripheral CD4+ lymphocyte count less than or equal to 200 per mm3.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
NEULASTA

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


REQUIRED INFO: The patient must have had an inadequate response or a documented failure due to lack of efficacy to one or more of the following colony stimulating factors. Such as: Filgrastim. Neulasta must not be administered in the period between 14 days before and 24 hours after administration of cytotoxic chemotherapy. Neulasta 6mg fixed-dose formulation must not be used in infants, children, and adolescents weighing less than 45 kg. Febrile neutropenia in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs. 6mg subcutaneous injection once per chemotherapy cycle.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
NEUPOGEN

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Neutropenia secondary to chemotherapy—Bone marrow transplantation—Idiopathic, cyclic, or congenital neutropenia, Peripheral blood progenitor cell (PBPC) mobilization or Post-PBPC transplantation, AIDS-associated neutropenia, Drug-induced neutropenia, Myelodysplastic syndromes complicated with infection

EXCLUSION CRITERIA:

REQUIRED INFO: Prior authorizations will only be approved for patients who will be self-administering filgrastim. Patients that receive their injections in the provider’s office or from home health care should have the filgrastim covered under their medical benefit. Appropriate lab tests - CBC and platelet count, must be conducted to necessitate the continuation of therapy.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
NEXAVAR

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

EXCLUSION CRITERIA: Patient must not be pregnant. (Category D).

REQUIRED INFO:

AGE RESTRICTIONS: Patient must be -Greater Than-18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: 400 mg ORALLY twice daily at least 1 hour before or 2 hours after eating - continue until patient no longer benefits or until unacceptable toxicity

Thursday, August 24, 2017
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
NORDITROPIN FLEXPRO

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43), Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9), Patients with Turner’s syndrome (758.6). GH therapy for patients with Turner’s syndrome, Patients with AIDS (042) related wasting with involuntary weight loss, Children with Russel – Silver syndrome (759.89), Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: Neurogenic orthostatic hypotension is caused by primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy.

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43). Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9), Patients with Turner’s syndrome (758.6). GH therapy for patients with Turner’s syndrome, Patients with AIDS (042) related wasting with involuntary weight loss, Children with Russel – Silver syndrome (759.89), Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43), Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9), Patients with Turner’s syndrome (758.6). GH therapy for patients with Turner’s syndrome, Patients with AIDS (042) related wasting with involuntary weight loss, Children with Russel – Silver syndrome (759.89), Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43), Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9), Patients with Turner’s syndrome (758.6). GH therapy for patients with Turner’s syndrome, Patients with AIDS (042) related wasting with involuntary weight loss, Children with Russel – Silver syndrome (759.89), Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.
OCTREOTIDE ACETATE

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Acromegaly, Carcinoid tumors, Vasoactive Intestinal Peptide Tumors (VIPomas).

EXCLUSION CRITERIA:

REQUIRED INFO: The patient must tolerate an initial treatment of Sandostatin® Injectable for a minimum of 2 weeks.

AGE RESTRICTIONS: The patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
OLYSIO

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
OMNITROPE

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43), Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9), Patients with Turner’s syndrome (758.6). GH therapy for patients with Turner’s syndrome, Patients with AIDS (042) related wasting with involuntary weight loss, Children with Russel – Silver syndrome (759.89), Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.
OPSUMIT

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

EXCLUSION CRITERIA:  Patient is pregnant.

REQUIRED INFO:

AGE RESTRICTIONS:  Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION:  End of plan year

OTHER CRITERIA:  NA
ORENCIA

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

EXCLUSION CRITERIA:

REQUIRED INFO: May use drug as monotherapy or concomitantly with DMARD except TNF antagonist (eg. Anakinra). With a diagnosis of moderate to severe rheumatoid arthritis, Juvenile Idiopathic Arthritis.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ORENCIA CLICKJECT

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

EXCLUSION CRITERIA:

REQUIRED INFO: May use drug as monotherapy or concomitantly with DMARD except TNF antagonist (e.g., Anakinra). With a diagnosis of moderate to severe rheumatoid arthritis, Juvenile Idiopathic Arthritis.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ORENITRAM

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

EXCLUSION CRITERIA: Patient must not have severe hepatic impairment (Child Pugh class C).

REQUIRED INFO: 1) Baseline liver function tests or clinical notes documenting patient does not have severe hepatic impairment and 2) patient has a diagnosis of pulmonary arterial hypertension (PAH: WHO group I) verified by right sided heart catheterization.

AGE RESTRICTIONS: Patient is at least 18 years of age.

MD RESTRICTIONS: 

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ORKAMBI

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

EXCLUSION CRITERIA:

REQUIRED INFO: 1) Patient has cystic fibrosis and 2) patient is homozygous for the F508del mutation in the CFTR gene as detected by an FDA-cleared CF mutation test showing the presence of the F508del mutation on both alleles of the CFTR gene.

AGE RESTRICTIONS: Patient is at least 12 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: Patients with Hepatitis B should be treated for 48 weeks. Patients with Chronic Hepatitis C, who are also receiving sofosbuvir and ribavirin, should be treated for 12 weeks for initial treatment of genotypes 3, 4, 5 or 6 and for 12 weeks. Patients with Chronic Hepatitis C, who are also receiving sofosbuvir and ribavirin, should be treated for 12 weeks for retreatment of genotypes 2, 3, 4, 5 or 6. Patients with Chronic Hepatitis C, who are receiving Peg-Intron or Pegasys as monotherapy, should be treated for 48 weeks.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: Patients with Hepatitis B should be treated for 48 weeks. Patients with Chronic Hepatitis C, who are also receiving sofosbuvir and ribavirin, should be treated for 12 weeks for initial treatment of genotypes 3, 4, 5 or 6 and for 12 weeks. Patients with Chronic Hepatitis C, who are also receiving sofosbuvir and ribavirin, should be treated for 12 weeks for retreatment of genotypes 2, 3, 4, 5 or 6. Patients with Chronic Hepatitis C, who are receiving Peg-Intron or Pegasys as monotherapy, should be treated for 48 weeks.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
**COVERED USES:** All FDA-Approved indications not otherwise excluded from Part D.

**EXCLUSION CRITERIA:**

**REQUIRED INFO:** Patients with Hepatitis B should be treated for 48 weeks. Patients with Chronic Hepatitis C, who are also receiving sofosbuvir and ribavirin, should be treated for 12 weeks for initial treatment of genotypes 3, 4, 5 or 6 and for 12 weeks. Patients with Chronic Hepatitis C, who are also receiving sofosbuvir and ribavirin, should be treated for 12 weeks for retreatment of genotypes 2, 3, 4, 5 or 6. Patients with Chronic Hepatitis C, who are receiving Peg-Intron or Pegasys as monotherapy, should be treated for 48 weeks.

**AGE RESTRICTIONS:**

**MD RESTRICTIONS:**

**COVERAGE DURATION:** End of plan year

**OTHER CRITERIA:** NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: Patients with Hepatitis B should be treated for 48 weeks. Patients with Chronic Hepatitis C, who are also receiving sofosbuvir and ribavirin, should be treated for 12 weeks for initial treatment of genotypes 3, 4, 5 or 6 and for 12 weeks. Patients with Chronic Hepatitis C, who are also receiving sofosbuvir and ribavirin, should be treated for 12 weeks for retreatment of genotypes 2, 3, 4, 5 or 6. Patients with Chronic Hepatitis C, who are receiving Peg-Intron or Pegasys as monotherapy, should be treated for 48 weeks.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Pneumocystis carinii pneumonia. Pneumocystis carinii pneumonia, high-risk, HIV patients - prophylaxis

EXCLUSION CRITERIA: Contraindications: hypersensitivity to pentamidine or diamidine compounds.

REQUIRED INFO: Pregnancy category C. Monitoring of the following is necessary prior to and during treatment: CBC, platelet counts, serum calcium concentrations, hepatic function, and ECG. Daily BUN, serum creatinine, and blood glucose levels

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
PIPERACILLIN SODIUM/TAZOBACTAM

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Appendicitis, Complicated by rupture or abscess, Community acquired pneumonia, Infection of skin and subcutaneous tissue, including diabetic foot infections, Nosocomial pneumonia, Pelvic inflammatory disease, Peritonitis, Puerperal endometritis.

EXCLUSION CRITERIA: Zosyn is contraindicated in patients with a history of allergic reactions to any of the penicillins, cephalosporins, or (beta)-lactamase inhibitors.

REQUIRED INFO: To reduce the development of drug-resistant bacteria and maintain the effectiveness of Zosyn (piperacillin and tazobactam) injection and other antibacterial drugs, Zosyn (piperacillin and tazobactam) should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
**PROCRIT**

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

**EXCLUSION CRITERIA:**
1. Treatment of patients who require immediate correction of severe anemia.

**REQUIRED INFO:**
1. Treatment of symptomatic anemia associated with chronic renal failure, including patients on dialysis (end-stage renal disease) and patients not on dialysis.  
2. Treatment of symptomatic anemia where erythropoietin level is -Less Than- 500 mU/ml, related to zidovudine therapy in HIV-infected patients where the dose of zidovudine is -Less Than- 4200 mg/week.  
3. Treatment of symptomatic anemia in patients with non-myeloid malignancies and anemia is caused by the effect of administered chemotherapy and the patient must be on chemotherapy concomitantly for a minimum of 2 months.  
4. Treatment of anemic patients scheduled to undergo elective, noncardiac, nonvascular surgery.

**AGE RESTRICTIONS:**

**MD RESTRICTIONS:**

**COVERAGE DURATION:** End of plan year

**OTHER CRITERIA:** Special circumstance patients (such as Jehovah Witness) who will not/cannot receive whole blood or components as replacement for traumatic or surgical loss will be taken into consideration.
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Alpha-1-antitrypsin deficiency

EXCLUSION CRITERIA:

REQUIRED INFO: Patients must be immunized against Hepatitis B prior to receiving Zemaira.

AGE RESTRICTIONS: Approved in patients 18 years of age and older for alpha-1 proteinase inhibitor (A1PI) deficiency.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
PROLIA

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

EXCLUSION CRITERIA:  Prolia is not used in patients on Xgeva. Hypocalcemia.

REQUIRED INFO:  N/A

AGE RESTRICTIONS:  

MD RESTRICTIONS:  

COVERAGE DURATION:  The PA will be approved through the remainder of the contract year.

OTHER CRITERIA:  Documented history of one of the following: 1. The patient is at high risk for fractures (BMD T score below -2.5, steroids use) or has a history of an osteoporotic fracture. 2. The patient had a fracture and/or experienced a decrease in BMD T score while on either Alendronate (Fosamax), Atelvia, Ibandronate (Boniva). 3. The patient is not a candidate for bisphosphonates or intolerant to them. Prolia is subject to Part B versus Part D determination.

Current as of: Thursday, August 24, 2017
PROMACTA

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patients must be greater than or equal to 1 year of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
PULMOZYME

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include the management of cystic fibrosis in conjunction with standard therapies, to improve pulmonary function.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patients must be greater than or equal to 5 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
QUININE SULFATE

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:  NA

COVERAGE DURATION:  End of plan year

OTHER CRITERIA:
RANEXA

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
RAVICTI

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

EXCLUSION CRITERIA: RAVICTI is prescribed for treatment of acutely elevated ammonia concentrations in a patient with urea cycle disorders.

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
REBETOL

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

EXCLUSION CRITERIA:

REQUIRED INFO: The patient must have a diagnosis of one of the following: Chronic Hepatitis B, Chronic Hepatitis C, Chronic Hepatitis C, in patients with compensated liver disease--HIV infection.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
REBIF

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

EXCLUSION CRITERIA:

REQUIRED INFO: The patient must have the ability to self-administer the medication. Have had at least two acute exacerbations during the previous two years, which consisting of new symptoms or aggravation of old symptoms lasting at least 24 hours, and proceeded by stability or improvement for at least 30 days. Has had baseline CBC and LFT lab tests. The patient must have a diagnosis of Relapsing-Remitting Multiple Sclerosis (RRMS).

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
REBIF TITRATION PACK

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

EXCLUSION CRITERIA:

REQUIRED INFO:  The patient must have the ability to self-administer the medication. Have had at least two acute exacerbations during the previous two years, which consisting of new symptoms or aggravation of old symptoms lasting at least 24 hours, and proceeded by stability or improvement for at least 30 days. Has had baseline CBC and LFT lab tests. The patient must have a diagnosis of Relapsing-Remitting Multiple Sclerosis (RRMS).

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION:  End of plan year

OTHER CRITERIA:  NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: 1) Patient is receiving opioids. 2) Patient has an advanced illness and receiving palliative care OR patient has chronic noncancer pain. 3) For patients with advanced illness receiving palliative care, patient has failed or has an intolerance to one other conventional laxative therapy.

AGE RESTRICTIONS: Patients must be greater than or equal to 18 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: Active Crohn's Disease, Ankylosing Spondylitis, Plaque Psoriasis, Fistulizing Crohn's Disease, Rheumatoid Arthritis, Psoriatic Arthritis, Psoriasis, Ulcerative colitis. In patients with an inadequate response to conventional therapy: induction dose 5 mg/kg IV at 0, 2, and 6 weeks. Ulcerative colitis. In patients with an inadequate response to conventional therapy: maintenance dose 5 mg/kg IV every 8 weeks. Rheumatoid Arthritis 3mg/kg IV at weeks 0, 2, 6 then every 8 weeks. Incomplete response dosing may vary per label.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
REMODULIN

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. The patient must have a diagnosis of pulmonary arterial hypertension with World Health Organization (WHO) Class II, III, or IV symptoms

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
**REPATHA**

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

**EXCLUSION CRITERIA:** A history of serious hypersensitivity reaction to Repatha (e.g., hypersensitivity vasculitis, hypersensitivity reactions requiring hospitalization, etc.).

**REQUIRED INFO:**

**AGE RESTRICTIONS:**

**MD RESTRICTIONS:** Cardiologist, endocrinologist, or physician who focuses in the treatment of cardiovascular (CV) risk management and/or lipid disorders.

**COVERAGE DURATION:** The PA will be approved through the remainder of the contract year.

**OTHER CRITERIA:** ASCVD/HeFH: 18 years old or older, HoFH: 13 years old or older. Repatha is being used as an adjunct to the LDL-lowering therapy containing a high potency statin in patients with one of the following diagnoses: 1) homozygous familial hypercholesterolemia (HoFH) confirmed by genetic testing or clinical diagnosis (based on a history of an untreated LDL-C greater than 500mg/dL together with either xanthoma before 10 years of age or evidence of HeFH in both parents) or 2) heterozygous familial hypercholesterolemia (HeFH) confirmed by genotyping or clinical criteria (using either the Simon Broome or WHO/Dutch Lipid Network criteria with documented baseline LDL-C greater than or equal to 160 mg/dL) or 3) clinical atherosclerotic cardiovascular disease (ASCVD) with documented LDL-C greater than or equal to 70 mg/dL while being treated with previous lipid lowering therapy AND documentation of one of the following conditions: MI, history of ACS, ischemic stroke, unstable/stable angina, revascularization (e.g., PCI or CABG), TIA, carotid stenosis, or PVD/PAD. In members with HeFH or ASCVD: documentation that the member has tried at least one high-intensity statin (e.g., atorvastatin greater than or equal to 40 mg/d) for greater than or equal to 8 weeks continuously and LDL-C remains greater than or equal to 70 mg/dL (unless there is documentation that the member is statin intolerant as demonstrated by experiencing statin-associated rhabdomyolysis OR the member experienced skeletal-muscle related symptoms while receiving a high-intensity statin). In members with HoFH: documentation that the member has tried at least one high-intensity statin (e.g., atorvastatin greater than or equal to 40 mg/d) for greater than or equal to 8 weeks continuously and requires additional lowering of LDL-C (unless there is documentation that the member is statin intolerant as demonstrated...
by experiencing statin-associated rhabdomyolysis OR the member experienced skeletal-muscle related symptoms while receiving a high-intensity statin).
REPATHA SURECLICK

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

EXCLUSION CRITERIA: A history of serious hypersensitivity reaction to Repatha (e.g., hypersensitivity vasculitis, hypersensitivity reactions requiring hospitalization, etc.).

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: Cardiologist, endocrinologist, or physician who focuses in the treatment of cardiovascular (CV) risk management and/or lipid disorders.

COVERAGE DURATION: The PA will be approved through the remainder of the contract year.

OTHER CRITERIA: ASCVD/HeFH: 18 years old or older, HoFH: 13 years old or older. Repatha is being used as an adjunct to the LDL-lowering therapy containing a high potency statin in patients with one of the following diagnoses: 1) homozygous familial hypercholesterolemia (HoFH) confirmed by genetic testing or clinical diagnosis (based on a history of an untreated LDL-C greater than 500mg/dL together with either xanthoma before 10 years of age or evidence of HeFH in both parents) or 2) heterozygous familial hypercholesterolemia (HeFH) confirmed by genotyping or clinical criteria (using either the Simon Broome or WHO/Dutch Lipid Network criteria with documented baseline LDL-C greater than or equal to 160 mg/dL) or 3) clinical atherosclerotic cardiovascular disease (ASCVD) with documented LDL-C greater than or equal to 70 mg/dL while being treated with previous lipid lowering therapy AND documentation of one of the following conditions: MI, history of ACS, ischemic stroke, unstable/stable angina, revascularization (e.g., PCI or CABG), TIA, carotid stenosis, or PVD/PAD. In members with HeFH or ASCVD: documentation that the member has tried at least one high-intensity statin (e.g., atorvastatin greater than or equal to 40 mg/d) for greater than or equal to 8 weeks continuously and LDL-C remains greater than or equal to 70 mg/dL (unless there is documentation that the member is statin intolerant as demonstrated by experiencing statin-associated rhabdomyolysis OR the member experienced skeletal-muscle related symptoms while receiving a high-intensity statin). In members with HoFH: documentation that the member has tried at least one high-intensity statin (e.g., atorvastatin greater than or equal to 40 mg/d) for greater than or equal to 8 weeks continuously and requires additional lowering of LDL-C (unless there is documentation that the member is statin intolerant as demonstrated
by experiencing statin-associated rhabdomyolysis OR the member experienced skeletal-muscle related symptoms while receiving a high-intensity statin).
REVLIMID

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

EXCLUSION CRITERIA: Pregnancy in females of reproductive potential.

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: Oncologist, Hematologist

COVERAGE DURATION: The PA will be approved through the remainder of the contract year.

OTHER CRITERIA: Revlimid will not be used in patients with chronic lymphocytic leukemia (CLL) outside of controlled clinical trials. In patients with transfusion-dependent anemia due to low-or intermediate-1-risk myelodysplastic syndromes (MDS), disease is associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities confirmed by testing. In patients with mantle cell lymphoma (MCL), documented disease relapse or progression on at least two prior therapies including bortezomib (Velcade) is required prior to the initiation of Revlimid.

Current as of: Thursday, August 24, 2017
SAIZEN

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43). Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9), Patients with Turner’s syndrome (758.6). GH therapy for patients with Turner’s syndrome, Patients with AIDS (042) related wasting with involuntary weight loss, Children with Russel – Silver syndrome (759.89), Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.
SAIZEN CLICK.EASY

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43). Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9), Patients with Turner’s syndrome (758.6). GH therapy for patients with Turner’s syndrome, Patients with AIDS (042) related wasting with involuntary weight loss, Children with Russel – Silver syndrome (759.89), Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Acromegaly, Carcinoid tumors, Vasoactive Intestinal Peptide Tumors (VIPomas).

EXCLUSION CRITERIA:

REQUIRED INFO: The patient must tolerate an initial treatment of Sandostatin® Injectable for a minimum of 2 weeks.

AGE RESTRICTIONS: The patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. 
Adolescent Growth Failure (783.43). Growth Failure. Adult patients 
with documented GHD (253.2, 253.3, 253.7) secondary to 
destructive lesions of the pituitary or the peripituitary area (e.g., 
pituitary adenoma), or as a result of treatment (e.g., cranial 
irradiation) or surgery. Adult patients with idiopathic growth 
hormone deficiency (783.43), Growth retardation in children with 
chronic renal insufficiency (593.9, 585.2-585.9), Patients with 
Turner’s syndrome (758.6). GH therapy for patients with Turner’s 
syndrome, Patients with AIDS (042) related wasting with involuntary 
weight loss, Children with Russel – Silver syndrome (759.89), Short 
Stature in Children with Noonan’s syndrome—Norditropin® 
(759.89), Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, 
patient is currently on antiretroviral therapy.
COVERED USES: All FDA approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: Cushing's disease - pituitary surgery is not an option or has not been curative. Acromegaly - patient had an inadequate response to surgery and/or surgery is not an option.

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
SILDENAFIL

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

EXCLUSION CRITERIA: 1. NPS will not grant any PAs for sildenafil 20mg tablet if the diagnosis is for erectile dysfunction. Blood pressure must be greater than 90/50 mm hg. Member must not be concurrently taking a nitrate, ritonavir, or an alpha adrenergic blocker (i.e. doxazosin, prazosin, terazosin, phenoxybenzamine, tamsulosin).

REQUIRED INFO:

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: A caution was issued for Revatio use with any alpha blocker.
SIRTURO

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: NA

COVERAGE DURATION: End of plan year

OTHER CRITERIA:
SOMAVERNT

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

EXCLUSION CRITERIA:

REQUIRED INFO: Patients have had a documented inadequate response to surgery and/or radiation therapy. Patient must have baseline LFTs (AST and ALT less than 3 times upper limit). Patients must have failed ONE or MORE of the following treatments: Transsphenoidal surgery, Radiation therapy, Octreotide, Lanreotide, Bromocriptine. Diagnosis of acromegaly documented by elevated GH levels (GH level -Greater Than- 5ng/mL)

AGE RESTRICTIONS: Patient must be at least 18 years old

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
SOVALDI

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
SPRYCEL

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

EXCLUSION CRITERIA: N/A

REQUIRED INFO: N/A

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: The PA will be approved through the remainder of the contract year.

OTHER CRITERIA: Diagnosis of chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) or diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia or newly diagnosed Philadelphia chromosome positive chronic myeloid leukemia in chronic phase. The documented use of Gleevec is required prior to the initiation of Sprycel in patients who are not intolerant to Gleevec for all FDA-approved indications, except for the following: in the treatment of newly-diagnosed patients with Ph+ CML in chronic
SUTENT

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

EXCLUSION CRITERIA: Acute Liver failure.

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: The prescription must be initially written or recommended by the Oncologist.

COVERAGE DURATION: The PA will be approved through the remainder of the contract year.

OTHER CRITERIA: ALT or AST is equal to or less than 2.5X ULN or, if due to liver metastases, is equal to or less than 5.0X ULN. In patients restarting Sutent, absence of severe changes in liver function tests and absence of other signs and symptoms of liver failure with the previous use of Sutent. In patients with gastrointestinal stromal tumors (GIST), the documented use of Gleevec is required prior to the initiation of Sutent.
SYNAGIS

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
SYNAREL

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Central Precocious Puberty In Children of Both Sexes, Endometriosis

EXCLUSION CRITERIA: Patient must not be pregnant (cat. X)

REQUIRED INFO:

AGE RESTRICTIONS: Patient must be at least 18 years old for diagnosis of endometriosis.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
TECFIDERA

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patient is at least 18 years of age.

MD RESTRICTIONS: Prescribed by or in consult with a neurologist or MS specialist.

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
TECFIDERA STARTER PACK

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patient is at least 18 years of age.

MD RESTRICTIONS: Prescribed by or in consult with a neurologist or MS specialist.

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
<table>
<thead>
<tr>
<th><strong>COVERED USES:</strong></th>
<th>All FDA-Approved indications not otherwise excluded from Part D. Covered indications include the treatment of chorea associated with Huntington's Disease (Huntington's Chorea).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXCLUSION CRITERIA:</strong></td>
<td>Patients with hepatic impairment.</td>
</tr>
<tr>
<td><strong>REQUIRED INFO:</strong></td>
<td>Baseline liver function tests should be obtained prior to treatment initiation.</td>
</tr>
<tr>
<td><strong>AGE RESTRICTIONS:</strong></td>
<td>Patients must be greater than or equal to 18 years of age.</td>
</tr>
<tr>
<td><strong>MD RESTRICTIONS:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>COVERAGE DURATION:</strong></td>
<td>End of plan year</td>
</tr>
<tr>
<td><strong>OTHER CRITERIA:</strong></td>
<td>NA</td>
</tr>
</tbody>
</table>
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. A complicated skin infection by one of the following: E. coli, Enterococcus faecalis (vancomycin-susceptible only), Staphylococcus aureus (methicillin-susceptible and methicillin-resistant), Streptococcus agalactiae, Streptococcus anginosus (including S. anginosus, S. intermedia, and S. constellatus), Streptococcus pyogenes and Bacteroides fragilis. A complicated intra-abdominal infection as a result from one of the following: Citrobacter freundii, Enterobacter cloacae, E. coli, Klebsiella oxytoca, Klebsiella pneumonias, Enterococcus faecalis (vancomycin-susceptible only), Staphylococcus aureus (vancomycin-susceptible only), Streptococcus anginosus (including S. anginosus, S. intermedia, and S. constellatus), Bacteroides fragilis, Bacteroides thetaiotaomicron, Bacteroides uniformis, Bacteroides vulgatus, Clostridium perfringens, and Peptostreptococcus micros. A community-acquired pneumonia caused by Streptococcus pneumoniae (penicillin-susceptible isolates), including cases with concurrent bacteremia, Haemophilus influenzae (beta-lactamase negative isolates), and Legionella pneumophila.

EXCLUSION CRITERIA:

REQUIRED INFO: If the patient has severe hepatic impairment (Child Pugh C), an initial dose of 100 mg of Tygacil™ should be given followed by a maintenance dose of 25 mg every 12 hours. The patient should be closely monitored for treatment response.

AGE RESTRICTIONS: The patient must be at least 18 years old

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: The patient is not currently taking glyburide or cyclosporine. The patient has had baseline liver function tests (ALT, AST) performed prior to the initiation of therapy. For female patients of childbearing potential (12-50 years of age), a baseline negative pregnancy test is performed prior to the initiation of therapy. Patient must have a diagnosis of pulmonary arterial hypertension with World Health Organization (WHO) Class II to IV symptoms.

AGE RESTRICTIONS: Patients must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
TRIHEXYPHENIDYL HCL

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
**TYGACIL**

**COVERED USES:** All FDA-Approved indications not otherwise excluded from Part D. A complicated skin infection by one of the following: E. coli, Enterococcus faeclis (vancomycin-susceptible only), Staphylococcus aureus (methicillin-susceptible and methicillin-resistant), Streptococcus agalactiae, Streptococcus anginosus (including S. anginosus, S. intermedius, and S. constellatus), Streptococcus pyogenes and Bacteroides fragilis. A complicated intra-abdominal infection as a result from one of the following: Citrobacter freundii, Enterobacter cloacae, E. coli, Klebsiella oxytoca, Klebsiella pneumoniae, Enterococcus faecalis (vancomycin-susceptible only), Staphylococcus aureus (methicillin-susceptible only), Streptococcus anginosus (including S. anginosus, S. intermedius, and S. constellatus), Bacteroides fragilis, Bacteroides thetaiotaomicron, Bacteroides uniformis, Bacteroides vulgatus, Clostridium perfringens, and Peptostreptococcus micros. A community-acquired pneumonia caused by Streptococcus pneumoniae (penicillin-susceptible isolates), including cases with concurrent bacteremia, Haemophilus influenzae (beta-lactamase negative isolates), and Legionella pneumophila.

**EXCLUSION CRITERIA:**

**REQUIRED INFO:** If the patient has severe hepatic impairment (Child Pugh C), an initial dose of 100 mg of Tygacil™ should be given followed by a maintenance dose of 25 mg every 12 hours. The patient should be closely monitored for treatment response.

**AGE RESTRICTIONS:** The patient must be at least 18 years old

**MD RESTRICTIONS:**

**COVERAGE DURATION:** End of plan year

**OTHER CRITERIA:** NA

Current as of: Thursday, August 24, 2017
TYSABRI

COVERED USES:  All FDA-Approved indications not otherwise excluded from Part D. Relapsing Multiple Sclerosis, Crohn's Disease.

EXCLUSION CRITERIA:

REQUIRED INFO:  Pregnancy Category:  C.

AGE RESTRICTIONS:  Patient Must Be At Least 18 Years Old.

MD RESTRICTIONS:

COVERAGE DURATION:  End of plan year

OTHER CRITERIA:  Tysabri is available only through a special restricted distribution program called the TOUCH Prescribing Program and must be administered only to patients enrolled in this program.
UPTRAVI

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

EXCLUSION CRITERIA:

REQUIRED INFO: Patient has a diagnosis of pulmonary arterial hypertension (PAH: WHO group I) verified by right sided heart catheterization.

AGE RESTRICTIONS: Patient is at least 18 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
VANCOMYCIN HCL

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include the treatment of pseudomembranous colitis due to Clostridium difficile and the treatment of enterocolitis due to Staphylococcus aureus.

EXCLUSION CRITERIA:

REQUIRED INFO: Must obtain stool culture report within the previous 30 days indicating positive C. difficile toxin.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
VORICONAZOLE

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Aspergillosis, Invasive, Candidemia, Candidiasis of the esophagus, Disseminated candidiasis, of the skin and infections in abdomen, kidney, bladder wall, and wounds, Mycosis, Serious infections due to Scedosporium apiospermum and Fusarium species.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patient must be at least 12 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include long-term enzyme replacement therapy in patients with type 1 Gaucher’s disease.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS: Patients must be greater than or equal to 4 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA:

REQUIRED INFO: For treatment of allergic asthma: 1) The patient must have a history of positive skin or RAST test (IgE Level) to a perennial aeroallergen AND 2) The patient must have IgE levels -Greater Than-30 IU/ml AND 3) The patient must have a diagnosis of moderate to severe persistent asthma as defined by the NAEPP guidelines (nocturnal symptoms -Greater Than-1 time/week, FEV1 or PEV-Less Than-60% predicted and PEF variability -Greater Than-30%).

AGE RESTRICTIONS: The patient must be 6 years of age or greater

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
COVERED USES: All FDA-approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA: In women who are or may become pregnant. Absence of concomitant use of Xtandi with drugs metabolized by CYP3A4 (e.g., alfentanil, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus or tacrolimus, etc.), CYP2C9 (e.g., phenytoin, etc.), or CYP2C19 (e.g., S-mephenytoin, etc.).

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: Oncologist

COVERAGE DURATION: The PA will be approved through the remainder of the contract year.

OTHER CRITERIA:
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Cataplexy associated with narcolepsy

EXCLUSION CRITERIA: The patient is not concurrently taking any sedative hypnotic agents at the time of the prior authorization review

REQUIRED INFO:

AGE RESTRICTIONS: Patient must be at least 18 years old.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ZALEPLON

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ZAVESCA

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Covered indications include the treatment of mild to moderate type 1 Gaucher's disease in patients for whom enzyme replacement therapy is not an option.

EXCLUSION CRITERIA: 1) Patients with renal dysfunction and a creatinine clearance less than or equal to 30mL per min.

REQUIRED INFO: 1) A baseline serum creatinine must be obtained prior to treatment initiation.

AGE RESTRICTIONS: Patients must be greater than or equal to 18 years of age.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ZEBUTAL

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

EXCLUSION CRITERIA:

REQUIRED INFO: For patients less than or equal to 64 years, claim will automatically pay. For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D, AND prescriber must acknowledge that medication benefit outweighs potential risks.

AGE RESTRICTIONS: Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ZEMAIRA

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Alpha-1-antitrypsin deficiency

EXCLUSION CRITERIA:

REQUIRED INFO: Patients must be immunized against Hepatitis B prior to receiving Zemaira.

AGE RESTRICTIONS: Approved in patients 18 years of age and older for alpha-1 proteinase inhibitor (A1PI) deficiency.

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ZENZEDI

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

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS: NA

COVERAGE DURATION: End of plan year

OTHER CRITERIA:
**ZINBRYTA**

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

**EXCLUSION CRITERIA:** Use in types of multiple sclerosis other than relapsing. Current or prior history of autoimmune hepatitis, other autoimmune condition involving the liver, hepatic disease, or hepatic impairment (AST or ALT 2 times the upper limit of normal or greater). Patient has untreated or current tuberculosis or other serious active infection. Individual who has not had a tuberculin skin test or equivalent test for tuberculosis.

**REQUIRED INFO:** Individual is using for relapsing forms of multiple sclerosis who has had an inadequate response to at least two drugs indicated for the treatment of multiple sclerosis.

**AGE RESTRICTIONS:** Individual is 17 years of age or older

**MD RESTRICTIONS:** Prescribed by or in consultation with a neurologist or multiple sclerosis specialist.

**COVERAGE DURATION:** End of plan year

**OTHER CRITERIA:** NA
COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Adolescent Growth Failure (783.43). Growth Failure. Adult patients with documented GHD (253.2, 253.3, 253.7) secondary to destructive lesions of the pituitary or the peripituitary area (e.g., pituitary adenoma), or as a result of treatment (e.g., cranial irradiation) or surgery. Adult patients with idiopathic growth hormone deficiency (783.43). Growth retardation in children with chronic renal insufficiency (593.9, 585.2-585.9). Patients with Turner’s syndrome (758.6). GH therapy for patients with Turner’s syndrome. Patients with AIDS (042) related wasting with involuntary weight loss. Children with Russel – Silver syndrome (759.89). Short Stature in Children with Noonan’s syndrome—Norditropin® (759.89). Children with Prader – Willi syndrome.

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: For patients with AIDS related wasting with involuntary weight loss, patient is currently on antiretroviral therapy.
ZORBATIVE

COVERED USES: All FDA-Approved indications not otherwise excluded from Part D. Cachexia associated with AIDS, Growth hormone deficiency, Short Bowel Syndrome

EXCLUSION CRITERIA:

REQUIRED INFO:

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA
ZOSYN

COVERED USES:
All FDA-Approved indications not otherwise excluded from Part D. Appendicitis, Complicated by rupture or abscess, Community acquired pneumonia, Infection of skin and subcutaneous tissue, including diabetic foot infections, Nosocomial pneumonia, Pelvic inflammatory disease, Peritonitis, Puerperal endometritis.

EXCLUSION CRITERIA:
- Zosyn is contraindicated in patients with a history of allergic reactions to any of the penicillins, cephalosporins, or (beta)-lactamase inhibitors.

REQUIRED INFO:
To reduce the development of drug-resistant bacteria and maintain the effectiveness of Zosyn (piperacillin and tazobactam) injection and other antibacterial drugs, Zosyn (piperacillin and tazobactam) should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy.

AGE RESTRICTIONS:

MD RESTRICTIONS:

COVERAGE DURATION: End of plan year

OTHER CRITERIA: NA