# ACTHAR

## Products Affected

- HP ACTHAR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of multiple sclerosis AND patient is currently on a disease modifying drug (interferon beta 1a, peginterferon beta1a, interferon beta1b, glatiramer, natlizumab, mitoxatrone, dimethyl fumarate, teriflunomide, alemtuzumab) to control disease progression, OR has tried and failed, contraindicated or intolerant to all DMDs AND the patient has failed corticosteroid therapy within the last 30 days or has an FDA labeled contraindication to corticosteroid therapy. |
| **Age Restrictions** | for infantile spasms patient must be less than 24 months of age |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# ADCIRCA

## Products Affected

- ADCIRCA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Concurrent use of organic nitrate or guanylate cyclase stimulators (includes intermittent use) |
| **Required Medical Information** | Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization AND Patient has tried and had an insufficient response to at least one other PAH agent (e.g., sildenafil) therapy. |
| **Age Restrictions** | 18 years and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# ADEMPAS

**Products Affected**

- ADEMPAS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form. Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline). Pregnancy. |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension (WHO group I) AND diagnosis was confirmed by right heart catheterization OR Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) AND patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable AND female patients are enrolled in the ADEMPAS REMS program. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 6 months - initial. 12 months - renewal |
| **Other Criteria** | For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.) |

# ALIQOPA

## Products Affected

- ALIQOPA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Follicular Lymphoma: Diagnosis of relapsed follicular lymphoma in patients who have received at least 2 prior systemic therapies |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Must be prescribed by, or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approve for continuation of therapy |

# ALUNBRIG

## Products Affected

- ALUNBRIG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of metastatic, ALK positive non-small cell lung cancer and have progressed or are intolerant to crizotinib. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# AMPYRA

## Products Affected

- AMPYRA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute). |
| **Required Medical Information** | Diagnosis of multiple sclerosis. Patient must demonstrate sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting Ampyra. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial - 3 months. Renewal - 12 months |
| **Other Criteria** | None |

# ARANESP

## Products Affected

- ARANESP (ALBUMIN FREE)

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | cancer patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure |
| **Required Medical Information** | Diagnosis Hgb ferritin EPO level and Tsats.Aranesp may be considered medically necessary when following criteria met for diagnosis of anemia associated with CKD nonmyeloid malignancies due to chemotherapy or myelodysplastic syndromes. Initial and maintenance requests must have iron stores evaluated (serum ferritin greater or equal to 100ng/mL and transferrin saturation greater or equal to 20%) and receive iron therapy if needed. Initial request: other causes of anemia ruled out and inadequate response to epoetin alfa for at least 2 consecutive months with appropriate dose adjustment. CKD and MDS:Must have Hb less than or equal to 10g/dL.MDS only:EPO level less than or equal to 500mUnits/mL. Chemo treated: Must have Hb less than10g/dL (within last 4 wks) and anticipated need for greater or equal to 8 wks. Continuing Therapy-CKD:Current (within last 4 wks) Hb less than 12g/dL OR documented dose adjustment of therapy with corresponding Hb levels to indicate maintenance therapy. MDS (must meet ALL):No response after 6-8 wks of therapy (or after 3-4 months if 5Q deletion MDS on Revlimid) and after trial of concomitant g-csf discontinue DPO and consider other options response defined as 1.5g/dL rise in Hb or decrease in RBC transfusion requirement) AND current Hb less than or equal 12g/dL. Chemo treated (after first 4-6 wks): response of no less than 1g/dL increase in Hb levels in any prior use of DPO. There cannot be a documented failure on previous DPO with a similar regimen. The member must meet ALL of the |

| PA Criteria | Criteria Details |
|---|---|
| | following criteria:Current (within the last 4 wks) Hb level is low enough (or declining rapidly enough) to necessitate transfusion (and Hb less than11g/dL) DPO stopped if after 6-8 wks (assuming appropriate dose increase has been attempted in non-responders as per FDA approved label) not experienced greater or equal to1 g/dL rise in Hb (per ASCO guidelines 2007) AND DPO should not be continued after completion of myelosuppressive chemotherapy. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 3 months for chemo induced anemia and 6 months for CKD/MDS |
| **Other Criteria** | None |

# AUBAGIO

## Products Affected

- AUBAGIO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Severe hepatic impairment. Current treatment with leflunomide. Patients who are pregnant or women of childbearing potential not using reliable contraception. |
| **Required Medical Information** | Diagnosis of relapsing forms of multiple sclerosis (e.g., relapsing-remitting MS or progressive-relapsing MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease) |

# AURYXIA

## Products Affected

- AURYXIA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | For the management of hyperphosphatemia in patients with chronic kidney disease on dialysis |
| **Age Restrictions** | 18 years and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# BCG

## Products Affected

- *bcg vaccine*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# BEXAROTENE

## Products Affected

- *bexarotene*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Patient must meet one of following criteria: received prior systemic therapy for CTCL OR advanced-stage MF (stage IIB, III or IV) or SS OR early-stage MF (stage IA, IB or IIA) with folliculotropic/large cell transformation OR early-stage MF (stage IA, IB or IIA) refractory to skin directed therapy. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | Definite diagnosis of cutaneous T-cell lymphoma (CTCL) AND refractory to any prior systemic therapy (such as methotrexate) |

# BOSUTINIB

**Products Affected**

- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Signed statement of diagnosis from the physician, hepatic panel and CBC, trial and failure of imatinib or dasatinib and documentation of a 90 day response OR newly diagnosed chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia (Ph + CML) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# BRIVIACT

## Products Affected

- BRIVIACT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of partial-onset seizures, member must have history of inadequate response, contraindication, or intolerance to levetiracetam prior to approval. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# CALQUENCE

## Products Affected

- CALQUENCE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | MANTLE CELL LYMPHOMA (MCL) (1) Patient must have a diagnosis of MCL AND (2) Patient has tried one other therapy |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Must be prescribed by, or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approve for continuation of therapy |

# CAPRELSA

## Products Affected

- CAPRELSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Congenital long QT syndrome |
| **Required Medical Information** | Diagnosis of medullary thyroid cancer (MTC), and disease is one of the following: A) unresectable, locally advanced, or B) metastatic AND one of the following: patient has symptomatic disease or patient has progressive disease. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 3 months |
| **Other Criteria** | None |

# CARIMUNE

## Products Affected

- CARIMUNE NF

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome X-linked immunodeficiency with hyperimmunoglobulin etc.).Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30 000/uL) To increase platelet counts prior major surgical procedures Severe thrombocytopenia (platelets less than 20 000/uL) at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met: Prior treatment has included corticosteroids and splenectomy Duration of illness less than 6 months No concurrent illness explaining thrombocytopenia Platelets persistently at or below 20 000/uL. Chronic Lymphocytic Leukemia (CLL B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL) Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease. IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms. Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogenic hematopoeietic stem cell transplantation. Is |

| PA Criteria | Criteria Details |
|---|---|
| | experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3 To prevent maternal transmission of HIV infection IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# EMEND

## Products Affected

- *aprepitant*
- EMEND INTRAVENOUS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Fosaprepitant is contraindicated in patients with a hypersensitivity to aprepitant or any other component of the formulation concurrent use with cisapride or pimozide. |
| **Required Medical Information** | Emend IV (fosaprepitant) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Prophylaxis of Chemotherapy-induced nausea and vomiting due to moderately-highly emetogenic chemotherapy. Patient must be on concomitant corticosteroid and a 5HT3 agonist (ondansetron dolasetron palonosetron or granisetron) if no contraindication. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# EMPLICITI

## Products Affected

- EMPLICITI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of multiple myeloma and used in combination with lenalidomide and dexamethasone in patients who have received 1 to 3 prior therapies. |
| **Age Restrictions** | 18 years and older |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# ENDARI

## Products Affected

- ENDARI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of acute sickle cell disease AND Must have A) trial history of Hydroxyurea OR B) intolerance to Hydroxyurea OR C) contraindication to Hydroxyurea |
| **Age Restrictions** | 5 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# ENTRESTO

**Products Affected**

- ENTRESTO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Statement of diagnosis indicating Heart Failure (NYHA Class II  IV) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# ERLEADA

## Products Affected

- ERLEADA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Pregnancy |
| **Required Medical Information** | Diagnosis of nonmetastatic, castration-resistant prostate cancer |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or urologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# ERWINAZE

## Products Affected

- ERWINAZE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# ESBRIET

**Products Affected**

- ESBRIET

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | 1)Diagnosis of Idiopathic pulmonary fibrosis (IPF) as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (e.g., domestic and occupational environmental exposures, connective tissue disease, drug toxicity), AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF, AND 2) not used in combination with Ofev (nintedanib). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Pulmonologist |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# ESRD THERAPY

**Products Affected**

- PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Epoetin alfa therapy is not considered medically necessary for members with the following concomitant conditions: Concomitant use of another Recombinant Erythropoietin Product. Anemia in cancer not related to chemotherapy OR anemia associated only with radiotherapy (without chemo).ESAs are not indicated in cancer patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure (ESAs remain indicated when myelosuppressive chemotherapy is intended for palliation. |
| **Required Medical Information** | Diagnosis Hgb ferritin EPO level Tsats. Epoetin alfa may be considered medically necessary when following criteria met for diagnosis of anemia associated with CKD Zidovudine-treated HIV-infected mbrs nonmyeloid malignancies due to chemo surgery myelodysplastic syndromes Hep C rheumatoid arthritis. Initial and maint requests except surgery use must have iron stores evaluated (ferritin greater or equal to 100ng/mL and Tsats greater or equal to 20%) and receive iron therapy if needed. CKD HIV MDS HCV:Must have Hb less or equal to 10g/dL.MDS and HIV:EPO level less or equal to 500mUnits/mL.HIV (intl / maint):Must receiving zidovudine and not exceed 4.2g/wk.HCV (intl / maint):Receiving combo IFN/RBV or PEGIFN/RBV. Chemo treated and RA:Must have Hb less than10g/dL (within last 4 wks).Chemo treated: Need for greater than or equal to 8wks.RA (intl / maint):Receiving therapy known to cause anemia. Surg:elective noncardiace novasculary surg with Hb greater than 10 less than or equal to 13g/dL.Maint |

| PA Criteria | Criteria Details |
|---|---|
| | Therapy-CKD HIV HCV:Current Hb less than 12g/dL OR documented dose adj. of therapy with corresponding Hb levels to indicate maint therapy. HCV:Able to maintain previous RBV dosing without dose reduction dt anemia.RA:Current Hb less than11g/dL.MDS (must meet ALL):No response after 6-8 wks of therapy (or after 3-4 months if 5Q deletion MDS on Revlimid) and after trial of concomitant g-csf discontinue EPO and consider other options response defined as 1.5g/dL rise in Hb or decrease in RBC transfusion requirement AND current Hb less or equal to 12g/dL.Chemo treated (after first 4-6 wks): response of no less than 1g/dL increase in Hb levels in any prior use of EPO. Mbr must meet ALL :Current (within last 4 wks) Hb level is low enough to necessitate transfusion (and Hb less than11g/dL) EPO stopped if after 6-8 wks not experienced greater or equal to1g/dL rise in Hb AND EPO shouldn't be continued after completion of myelosuppressive chemotherapy. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 3 months |
| **Other Criteria** | None |

# FARYDAK

## Products Affected

- FARYDAK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of Multiple Myeloma (MM) Used in combination with both of the following: Velcade (bortezomib) and dexamethasone. Patient has received at least two prior treatment regimens which included both of the following: Velcade (bortezomib) and an immunomodulatory agent [e.g., Revlimid (lenalidomide), Thalomid (thalidomide)]. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# FENTORA

## Products Affected

- FENTORA BUCCAL TABLET 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- LAZANDA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Fentanyl Buccal Tablet (Fentora) may be considered medically necessary when the following criteria are met: The member is currently diagnosed with cancer OTFC is required to manage breakthrough pain member is currently taking opioid therapy and is opioid tolerant and member has tried and failed generic Actiq (fentanyl citrate lozenge). Tolerance is defined as any of the following: greater than or equal to 60mg morphine/day for greater than or equal than 1 week or greater than or equal to 50 mcg transdermal fentanyl/hour for greater than or equal 1 week or an equianalgesic dose of another opioid for greater than or equal 1 week. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# FLECTOR

**Products Affected**

- FLECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Previously experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. Use for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery. Application to non-intact or damaged skin. |
| **Required Medical Information** | Patient is experiencing acute localized pain due to minor strains, sprains and contusions AND the intended duration of therapy is 3 months or less AND patient had experienced treatment failure with at least 2 prescription strength oral NSAIDs or patient has a documented swallowing disorder OR has a history of peptic ulcer disease/gastrointestinal bleeding OR patient is more than 65 years of age with one additional risk factor for gastrointestinal adverse event (e.g., use of anticoagulants or chronic corticosteroids) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# GILENYA

## Products Affected

- GILENYA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500 ms. Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (quinidine, procainamide, amiodarone, sotalol). |
| **Required Medical Information** | Diagnosis of a relapsing form of multiple sclerosis or diagnosis of first clinical episode with MRI features consistent with MS AND Patient will be observed for signs and symptoms of bradycardia in a controlled setting for at least 6 hours after the first dose |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial - 6 months. Renewal - 12 months |
| **Other Criteria** | None |

# GILOTRIF

## Products Affected

- GILOTRIF

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician in patients with: 1) metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test or 2) metastatic squamous NSCLC, progressing after platinum-based chemotherapy. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# GOCOVRI

**Products Affected**

- GOCOVRI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Patients with ESRD (CrCl below 15 ml/min/m2) |
| **Required Medical Information** | INITIAL: Diagnosis of Parkinson's disease AND (1) Patient is experiencing dyskinesia AND (2) Patient is receiving levodopa based therapy AND (3) Must have documented trial and failure to amantadine immediate release. RENEWAL: (1) must meet the initial criteria above AND (2) Documentation of positive clinical response to Gocovri (e.g., decreased "off" periods, decreased "on" time with troublesome dyskinesia) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescribed by or in consultation with a neurologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# GROWTH HORMONE

## Products Affected

- NORDITROPIN FLEXPRO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Closed epiphyses. Acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma or acute respiratory failure. Active malignancy. Active proliferative or severe non-proliferative diabetic retinopathy. For PWS only: sever obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment. |
| **Required Medical Information** | Diagnosis of pediatric indication: A) GHD and bone age at least 1 year or 2 standard deviations (SD) delayed compared with chronological age and 2 stim tests with peak GH secretion below 10 ng/mL or IGF-1/IGFBP3 level more than 2 SDS below mean if CNS pathology, h/o irradiation, or proven genetic cause, B) SGA and birth weight or length 2 or more SDS below mean for gestational age and fails to manifest catch up growth by age 2 (height 2 or more SDS below mean for age and gender), C) CRI and nutritional status has been optimized, metabolic abnormalities have been corrected, and patient has not had renal transplant D) SHOX deficiency or Noonan syndrome E) PWS confirmed by genetic testing, F) Turner Syndrome confirmed by chromosome analysis. For GHD, CRI, SHOX deficiency, Noonan syndrome, and PWS one of the following: height more than 3 SDS below mean for age and gender, or height more than 2 SDS below mean with GV more than 1 SDS below mean, or GV over 1 year 2 SDS below mean. OR Diagnosis of an adult indication: A) childhood- or adult-onset GHD confirmed by 2 standard GH stim tests (provide assay): 1 test must be insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L). If contraindicated, use a standardized stim test (i.e. arginine plus GH releasing |

| PA Criteria | Criteria Details |
|---|---|
| | hormone [preferred], glucagon, arginine), B) GHD with at least 1 other pituitary hormone deficiency and failed at least 1 GH stim test (ITT preferred), C) GHD with panhypopituitarism (3 or more pituitary hormone deficiencies), D) GHD with irreversible hypothalamic-pituitary structural lesions due to tumors, surgery or radiation of pituitary or hypothalamus region AND a subnormal IGF-1 (after at least 1 month off GH therapy) AND Objective evidence of GHD complications, such as: low bone density, increased visceral fat mass, or cardiovascular complications AND Completed linear growth (GV less than 2 cm/year) AND GH has been discontinued for at least 1 month (if previously receiving GH). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# HEPATITIS C

## Products Affected

- EPCLUSA
- HARVONI
- MAVYRET
- ZEPATIER

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Must submit documentation of chronic hepatitis C genotype (confirmed by HCV RNA level within the last 6 months). Must submit laboratory results within 6 weeks of initiating therapy including: 1) CBC w Platelets, 2) AST/ALT, 3) Total Bilirubin, 4) Serum Albumin, 5) PT/INR, 6) Serum Creatinine, and 7) GFR. FOR GENOTYPES 1 and 4-Must include subtype, trial/failure, contraindication to, or intolerance to Zepatier or Mavyret prior to approval of Epclusa or Havoni. GENOTYPES 2 and 3-Must include subtype, trial/failure, contraindication to, or intolerance to Mavyret prior to approval of Epclusa. GENOTYPES 5 and 6-Must include subtype, trail/failure, contraindication to, or intolerance to Mavyret prior to approval of Epclusa or Harvoni. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist |
| **Coverage Duration** | Duration of approval per AASLD Guidelines |
| **Other Criteria** | None |

# HETLIOZ

**Products Affected**

- HETLIOZ

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of Non-24-hour-sleep-wake disorder (Non-24) AND patient has documented blindness |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 6 months (initial), 12 months (renewal) |
| **Other Criteria** | For renewal, patient experienced an objective improvement (e.g., improvement in timing of nighttime sleep, improvement in duration of nighttime sleep, or reduction in daytime sleep). |

# HRM

## Products Affected

- *guanfacine hcl er*
- *methylphenidate hcl*
- *methylphenidate hcl er*
- *methylphenidate hcl er (cd)*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk. AND The physician must document on progress notes that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication. |
| **Age Restrictions** | For patients less than or equal to 64 years claim will automatically pay. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# HRM - ANALGESICS

## Products Affected

- ASCOMP-CODEINE
- *butalbital-apap-caff-cod*
- *butalbital-asa-caff-codeine*
- *indomethacin*
- *indomethacin er*
- *ketorolac tromethamine injection*
- *ketorolac tromethamine intramuscular*
- *ketorolac tromethamine oral*
- *meperidine hcl*
- *pentazocine-naloxone hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication . |
| **Age Restrictions** | PA applies to patients 65 years or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | Mild pain: codeine. Moderate to severe pain: short-term NSAIDs, tramadol, tramadol/APAP, morphine sulfate, hydrocodone/APAP, oxycodone, oxycodone/APAP, fentanyl. |

# HRM - ANTI-ARRHYTHMICS

## Products Affected

- DIGITEK ORAL TABLET 250 MCG
- DIGOX ORAL TABLET 250 MCG
- *digoxin injection*
- *digoxin oral solution*
- *digoxin oral tablet 250 mcg*
- *disopyramide phosphate*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication. |
| **Age Restrictions** | PA applies to patients 65 years or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# HRM - ANTIEMETIC DRUGS

## Products Affected

- *promethazine hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication. |
| **Age Restrictions** | PA applies to patients 65 years or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# HRM - ANTIHISTAMINES

## Products Affected

- *carbinoxamine maleate*
- *clemastine fumarate*
- *cyproheptadine hcl*
- *promethazine vc plain*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication . |
| **Age Restrictions** | PA applies to patients 65 years or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | cetirizine, fexofenadine, loratadine, desloratadine, levocetirizine |

# HRM - ANTIHYPERTENSIVE AGENTS

## Products Affected

- *methyldopa*
- *methyldopa-hydrochlorothiazide*
- *methyldopate hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication. |
| **Age Restrictions** | PA applies to patients 65 years or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# HRM - ANTIPARKINSON AGENTS

## Products Affected

- *benztropine mesylate*
- *trihexyphenidyl hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication . |
| **Age Restrictions** | PA applies to patients 65 years or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | For the treatment of Parkinsonism, a trial of at least 1 formulary drug that is not an HRM in elderly (e.g., carbidopa/levodopa, pramipexole, ropinirole, bromocriptine, selegiline, rasagiline, entacapone, amantadine, etc.) or other type of clinical justification will be required in members 65 years of age and older. For the treatment of medication-induced movement disorder - extrapyramidal disease, a trial of at least 1 formulary drug that is not an HRM in elderly (e.g., amantadine, etc.) or other type of clinical justification will be required in members 65 years of age and older. |

# HRM - CALCIUM CHANNEL BLOCKERS, DIHYDROPYRIDINE

## Products Affected

- *nifedipine*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication . |
| **Age Restrictions** | PA applies to patients 65 years or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | extended-release nifedipine, nicardipine, amlodipine |

# HRM - ORAL AND TRANSDERMAL ESTROGENS AND PROGESTINS

## Products Affected

- CLIMARA PRO
- *estradiol oral*
- *estropipate*
- MENEST
- PREMARIN INJECTION
- PREMARIN ORAL
- PREMPHASE
- PREMPRO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication . |
| **Age Restrictions** | PA applies to patients 65 years or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | Bone Density: alendronate, risedronate, ibandronate, raloxifene (zoledronic acid for bed-bound patients or for post-hip fracture). Vaginal Symptoms: vaginal estrogen cream |

# HRM - PLATELET INHIBITORS

## Products Affected

- *dipyridamole*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication . |
| **Age Restrictions** | PA applies to patients 65 years or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | clopidogrel, aggrenox |

# HRM - SKELETAL MUSCLE RELAXANTS

## Products Affected

- *carisoprodol*
- *carisoprodol-aspirin*
- *carisoprodol-aspirin-codeine*
- *chlorzoxazone*
- *cyclobenzaprine hcl*
- *methocarbamol*
- *orphenadrine citrate*
- *orphenadrine citrate er*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication. |
| **Age Restrictions** | PA applies to patients 65 years or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# HRM - SULFONYLUREAS

## Products Affected

- *chlorpropamide*
- *glyburide*
- *glyburide micronized*
- *glyburide-metformin*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication . |
| **Age Restrictions** | PA applies to patients 65 years or older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | glimepiride, glipizide |

# HRM-MEGESTROL

**Products Affected**

- *megestrol acetate oral suspension 625 mg/5ml*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives for diagnosis of cachexia secondary to chronic illness (dronabinol, oxandrolone) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication, AND anticipated treatment course/duration. For treatment of cancer related diagnosis or endometrial hyperplasia, or endometriosis, requests will be automatically approved. |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | Applies to New Starts only |

# HYDROXYPROGESTERONE CAPROATE

## Products Affected

- *hydroxyprogesterone caproate*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Breast, cervical, hepatocellular, uterine, or vaginal cancers, hepatic or thromboembolic disease, jaundice, or vaginal bleeding |
| **Required Medical Information** | Supporting statement of diagnosis from physician |
| **Age Restrictions** | 16 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 21 weeks |
| **Other Criteria** | None |

# IBRANCE

## Products Affected

- IBRANCE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of locally advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND One of the following: 1) Used in combination with Faslodex (fulvestrant) and disease has progressed following endocrine therapy OR 2) Used in combination with an aromatase inhibitor AND One of the following: 1) patient is a postmenopausal woman OR 2) both of the following: patient is a premenopausal or perimenopausal woman and patient is receiving a luteinizing hormone-releasing hormone (LHRH) agonist [e.g., Zoladex (goserelin)]. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# ICLUSIG

**Products Affected**

- ICLUSIG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of chronic myelogenous leukemia (CML) AND One of the following: A) History of failure, resistance, relapse, contraindication, or intolerance to at least TWO other tyrosine kinase inhibitors (i.e., GLEEVEC [imatinib], SPRYCEL, TASIGNA, and BOSULIF), or B) Patient has the T315I mutation. OR Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) AND One of the following: A) History of failure, resistance relapse, contraindication, or intolerance to at least TWO other FDA-approved tyrosine kinase inhibitors (i.e., GLEEVEC [imatinib], SPRYCEL), or B) Patient has the T315I mutation. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# IDHIFA

## Products Affected

- IDHIFA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of relapsed or refractory acute myelogenous leukemia (AML) with isocitrate dehydrogenase 2 mutation expression, as detected by an FDA approved test |
| **Age Restrictions** | age 18 years and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# IMBRUVICA

## Products Affected

- IMBRUVICA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of mantle cell lymphoma (MCL) in patients who have received at least one prior therapy OR chronic lymphocytic leukemia (CLL)/Small lymphocyctic lymphoma (SLL) OR chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) with 17p deletion OR Waldenstrom's macroglobulinemia (WM) OR marginal zone lymphoma (MZL) who require systemic therapy in patients who have received at least one prior anti-CD20-based therapy OR chronic graft-versus-host disease (cGVHD) after failure of one or more lines of systemic therapy. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# IMFINZI

## Products Affected

- IMFINZI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of locally advanced or metastatic urothelial carcinoma. Patient must have progressed on or following platinum-containing chemotherapy, or within 12 months of neoadjuvant or adjuvant platinum containing chemotherapy OR Unresectable Stage III, non-small cell lung cancer without progression following concurrent platinum-based chemotherapy and radiation therapy. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# INTRAROSA

**Products Affected**

- INTRAROSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia. |
| **Required Medical Information** | Diagnosis of moderate to severe dyspareunia or atrophic vaginitis AND A) Patient must be female, B) Patient must be menopausal or postmenopausal, C) Patient has tried and failed, has a contraindication or intolerance to a low dose vaginal estrogen preparation (e.g. Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem), D) Patient does not have renal or hepatic impairment. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial: 3 months, Reauthorization: 12 months |
| **Other Criteria** | None |

# INVANZ

## Products Affected

- INVANZ

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Invanz (ertapenem sodium) is contraindicated in patients with a hypersensitivity to ertapenem or other drugs of the same class in patients with a prior anaphylactic reaction to beta-lactams and in patients with a hypersensitivity to amide-type anesthetics. |
| **Required Medical Information** | Labs with culture and sensitivity information. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# JEVTANA

**Products Affected**

- JEVTANA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Jevtana (cabazitaxel) therapy is contraindicated in patients with hypersensitivity to cabazitaxel polysorbate 80 or any component of the formulation neutrophil count = 1500/mm3. |
| **Required Medical Information** | This agent may be considered medically necessary when the following criteria are met: Hormone-Refractory Metastatic Prostate Cancer. The member must have a diagnosis of hormone-refractory metastatic prostate cancer. The member must have previously been treated with a docetaxol-containing treatment regimen. The member must be taking Jevtana in combination with prednisone. The member must BE MALE. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# JUXTAPID

## Products Affected

- JUXTAPID

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests. Pregnancy. Concomitant use with strong or moderate CYP3A4 inhibitors. |
| **Required Medical Information** | Diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (i.e., LDLRAP1 or ARH), or b) both of the following: 1) either untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. Patient has been receiving at least 12 consecutive weeks of ONE LDL-C lowering prescription therapy and will continue to receive an LDL-C lowering prescription therapy. History of failure after 12 consecutive weeks or intolerance to PCSK9 inhibitor therapy. One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 30 days: LDL-C greater than or equal to 100 mg/dL with ASCVD OR LDL-C greater than or equal to 130 mg/dL without ASCVD. Not used in combination with Kynamro (mipomersen). Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient is not pregnant. Patient does not have moderate or severe hepatic impairment (i.e., Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests. Patient is not concomitantly on moderate or strong CYP 3A4 inhibitors (e.g., clarithromycin). |
| **Age Restrictions** | None |

| PA Criteria | Criteria Details |
|---|---|
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# KALYDECO

## Products Affected

- KALYDECO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of cystic fibrosis AND the patient has 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# KEYTRUDA

**Products Affected**

- KEYTRUDA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of unresectable or metastatic melanoma OR first-line treatment of metastatic non-small cell lung cancer (NSCLC) in patients with high PD-L1 expressing tumors and with no EGFR or ALK genomic tumor aberrations OR treatment of metastatic NSCLC in patients with PD-L1 expression who have disease progression on or after platinum-containing chemotherapy (patients with EGFR or ALK genomic tumor aberrations should have disease progression on approved therapy for these aberrations prior to receiving Keytruda) OR recurrent or metastatic cervical cancer with tumor PD-L1 expression and disease progression on or after previous chemotherapy OR recurrent or metastatic squamous cell carcinoma of the head and neck in patients with disease progression on or after platinum-containing chemotherapy OR treatment of adult or pediatric patients with classical Hodgkin lymphoma (in patients who are refractory or who have relapsed after 3 or more prior lines of therapy) OR first-line treatment (in combination with pemetrexed plus carboplatin) of metastatic nonsquamous NSCLC OR locally advanced or metastatic urothelial carcinoma (in patients who are not eligible for cisplatin-containing chemotherapy, or who have had disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy) OR unresectable or metastatic solid tumors that have been identified as having a biomarker referred to as microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) (solid |

| PA Criteria | Criteria Details |
|---|---|
| | tumors and colorectal cancer) OR treatment of recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma and tumors express PD-L1 (as determined by an FDA-approved test) with disease progression on or after 2 (or more) prior lines of therapy including fluoropyrimidine and platinum-containing chemotherapy (and if appropriate HER2/neu-targeted therapy) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# KISQALI

## Products Affected

- KISQALI 200 DOSE
- KISQALI 400 DOSE
- KISQALI 600 DOSE
- KISQALI FEMARA 200 DOSE
- KISQALI FEMARA 400 DOSE
- KISQALI FEMARA 600 DOSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of endocrine-based treatment of hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer in combination with an aromatase inhibitor in postmenopausal women |
| **Age Restrictions** | Age 18 years and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or gastroenterologist |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# KORLYM

## Products Affected

- KORLYM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Pregnancy |
| **Required Medical Information** | Supporting statement of diagnosis and relevant medical information from physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# KYNAMRO

## Products Affected

- KYNAMRO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests. |
| **Required Medical Information** | Diagnosis of homozygous familial hypercholesterolemia AND Patient has tried and had an inadequate response or intolerance to statins |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial - 6 months. Renewal - 12 months |
| **Other Criteria** | For renewal, patient has responded to therapy with a decrease in LDL levels. |

# LARTRUVO

**Products Affected**

- LARTRUVO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of soft tissue sarcoma (STS), histologic subtype for which an anthracycline-containing regimen is appropriate, previous treatment failure with radiotherapy or surgery and must document being used in combination with doxorubicin for the first 8 cycles. |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 month |
| **Other Criteria** | None |

# LIDOCAINE

## Products Affected

- *lidocaine external patch*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# MS INTERFERONS

## Products Affected

- BETASERON

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# MYLOTARG

## Products Affected

- MYLOTARG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | INITIAL: A. Newly- diagnosed, CD33 positive acute myeloid leukemia (AML) or B. Relapsed or refractory CD33 positive AML. CONTINUATION OF THERAPY: 1) patient continues to meet initial criteria and 2) patients with newly diagnosed AML have not exceeded a maximum of 8 cycles |
| **Age Restrictions** | Relapsed of refractory AML: 2 years and older, Newly diagnosed AML: 18 years and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# NERLYNX

## Products Affected

- NERLYNX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of early stage HER2-positive breast cancer. Must be used after trastuzumab-based therapy, as an adjuvant treatment. |
| **Age Restrictions** | age 18 years and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# NORTHERA

## Products Affected

- NORTHERA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Request will be approved for the following indication(s): orthostatic dizziness, light-headedness, or the feeling that you are about to black out in adults with neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure (i.e., Parkinson disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# NUEDEXTA

## Products Affected

- NUEDEXTA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Patient diagnosis of pseudobulbar affect. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# NULOJIX

## Products Affected

- NULOJIX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Kidney transplant: The medication is being used for prevention of kidney transplant organ rejection AND The patient is immune to the Epstein-Barr virus (i.e. EBV seropositive) AND The patient is prescribed concurrent therapy with mycophenolate and corticosteroids |
| **Age Restrictions** | Kidney transplant: 18 years of age or older |
| **Prescriber Restrictions** | Kidney transplant: Prescriber is experienced in immunosuppressive therapy and management of transplant patients |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# NUPLAZID

## Products Affected

- NUPLAZID

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of Parkinson’s disease psychosis including hallucinations and/or delusions |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# OPSUMIT

## Products Affected

- OPSUMIT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Pregnancy. |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension WHO group I AND diagnosis was confirmed by right heart catheterization AND female patients are enrolled in the OPSUMIT REMS program |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 6 months - initial. 12 months - renewal |
| **Other Criteria** | For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.) |

# ORKAMBI

## Products Affected

- ORKAMBI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Initial Therapy: Must have 1. Diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test. Continuation of therapy: 1. Documentation patient is tolerating and responding to medication (i.e. improved FEV1, weight gain, decreased exacerbations, etc.) |
| **Age Restrictions** | Must be greater than or equal to 12 years of age |
| **Prescriber Restrictions** | Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# OSPHENA

## Products Affected

- OSPHENA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia, acute thromboembolism or a past history of thromboembolic disease (including patients with a history of DVT, pulmonary embolism, retinal vein thrombosis, stroke, or myocardial infarction, known or suspected pregnancy. |
| **Required Medical Information** | Diagnosis of moderate to severe dyspareunia or atrophic vaginitis AND A) Patient must be female, B) Patient must be menopausal or postmenopausal, C) Patient has tried and failed, has a contraindication or intolerance to a low dose vaginal estrogen preparation (e.g. Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem), D) Dose must not exceed 1 tablet per day, E) Patient does not have hepatic impairment. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial: 2 months, Reauthorization: 12 months |
| **Other Criteria** | None |

# PCSK9 INHIBITOR

## Products Affected

- PRALUENT
- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | For PRALUENT: MUST MEET CRITERIA #1 OR #3. For REPATHA: MUST MEET CRITERIA #1, #2, OR #3. 1. Diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by genotyping OR Simon Broome criteria: Total cholesterol greater than 290mg/dL or LDL cholesterol greater than 190mg/dL, PLUS ONE OF THE FOLLOWING: Tendon xanthomas in patient or 1st degree relative (parent, sibling, child) or 2nd degree relative (grandparent, uncle, aunt) OR DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation. 2a. Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD OR 2b. Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genotyping OR diagnosis based on the following: a. History of untreated LDL-C greater than 500 mg/dL AND xanthoma before 10 years of age OR b. Documentation of HeFH in both parents. 3. Diagnosis of clinical atherosclerotic cardiovascular disease as defined as one of the following: a. acute coronary syndrome, b. history of myocardial infarction, c. stable/unstable angina, d. coronary or other arterial revascularization, e. stroke, f. transient ischemic stroke, g. peripheral arterial disease presumed to be atherosclerotic region AND MEETS CRITERIA #4, #5, and #6. 4. Provide baseline and current LDL-C. 5. LDL-C greater than or equal to 70mg/dL. 6. Used in combination with maximally tolerated high- |

| PA Criteria | Criteria Details |
|---|---|
| | intensity statin OR MEETS CRITERIA #7 AND #8. 7. Statin intolerant 8. LDL-C greater than or equal to 70mg/dL. CONTINUING THERAPY: 1. Documented response to Praluent or Repatha, defined as ONE of the following: a. The patient is tolerating medication b. Will continue to be used in combination with maximally tolerated statin (unless statin intolerant). |
| **Age Restrictions** | Repatha: 13 years of age or older for diagnosis HoFM, Diagnosis CVD or HeFH AND Praluent or Repatha : 18 years of age or older |
| **Prescriber Restrictions** | Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist |
| **Coverage Duration** | Initial approval: 8 weeks, Renewal approval: Plan Year |
| **Other Criteria** | None |

# PROVIGIL

## Products Affected

- *modafinil*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# RADICAVA

## Products Affected

- RADICAVA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Known hypersensitivity to sulfite |
| **Required Medical Information** | Diagnosis of amyotrophic lateral sclerosis (ALS) |
| **Age Restrictions** | age 18 years and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# REGRANEX

## Products Affected

- REGRANEX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diabetic Neuropathic Ulcers: Diabetic patient with ulcer wound. Treatment will be given in combination with ulcer wound care (e.g., debridement, infection control, and/or pressure relief). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Diabetic Neuropathic Ulcers: Maximum 5 months. |
| **Other Criteria** | None |

# REVATIO

## Products Affected

- *sildenafil citrate*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# RUBRACA

## Products Affected

- RUBRACA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of BRCA mutation-positive (germline and/or somatic) epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients who have received 2 or more prior chemotherapy regimens OR Diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer after a complete or partial response to platinum-based chemotherapy |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 month |
| **Other Criteria** | None |

# RYDAPT

## Products Affected

- RYDAPT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Angioedema |
| **Required Medical Information** | Diagnosis of treatment naive FLT3 mutation-positive acute myelogenous leukemia (AML) and must be used in combination with standard cytarabine and daunorubicin induction and consolidation therapy or diagnosis of systemic mastocytosis. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# SAMSCA

## Products Affected

- SAMSCA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# STIVARGA

## Products Affected

- STIVARGA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# SYMDEKO

## Products Affected

- SYMDEKO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of cystic fibrosis and patient is homozygous for the F508del mutation OR have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by an FDA-cleared CF mutation test |
| **Age Restrictions** | 12 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial-6 months. Renewal-12 months. |
| **Other Criteria** | None |

# TOBI

## Products Affected

- TOBI PODHALER

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | This agent may be considered medically necessary when the following criteria are met: Cystic Fibrosis. The patient has a diagnosis of cystic fibrosis (CF).The patient is colonized with P.aeruginosa |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# TRETINOIN

## Products Affected

- *tretinoin external cream*
- *tretinoin external gel 0.01 %, 0.025 %*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Approval will be given to all members using this agent for a medically necessary FDA approved non-cosmetic indication. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# TYMLOS

**Products Affected**

- TYMLOS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Patients at increased risk of osteogenic sarcoma. |
| **Required Medical Information** | Diagnosis of osteoporosis in post-menopausal women at high risk for fracture. Member must have failed therapy with a bisphosphonate (defined by a fracture while on therapy or worsening bone density) unless such a trial is shown to be inappropriate or contraindicated (i.e., presence of severe osteoporosis [T-scores -3.0 or worse in lumbar spine, femoral neck, or total hip region], history of major osteoporotic fracture, presence of renal insufficiency, etc.) AND member has at least one of the following: T-score equal to or worse than -2.5 in the lumbar spine, femoral neck, or total hip region OR a FRAX calculator based 10-year risk of at least 20% for a major osteoporotic fracture (spine, shoulder, hip, or wrist), or a 10-year risk of at least 3% for a hip fracture OR presence or history of osteoporotic fracture. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial: 12 months. Reauth: Treatment duration has not exceeded 24 months during patient lifetime. |
| **Other Criteria** | None |

# VENCLEXTA

## Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of chronic lymphocytic leukemia (CLL) OR small lymphocytic lymphoma, with or without 17p deletion and patient has had at least 1 prior therapy |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# VERZENIO

**Products Affected**

- VERZENIO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | BREAST CANCER (1) Patient must have a diagnosis of advanced or metastatic breast cancer AND (2a) must be used in combination with fulvestrant for the treatment of disease progression following endocrine therapy OR (2b) used as monotherapy for treatment of disease progression following endocrine therapy and patient has already received at least one prior chemotherapy regimen of Ibrance or Kisqali OR (2c) used as initial endocrine-based treatment in combination with an aromatase inhibitor AND (3) disease is hormone receptor positive AND human epidermal growth factor 2 (HER2)- negative |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approve for continuation of therapy |

# VYXEOS

## Products Affected

- VYXEOS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of therapy-related acute myelogenous leukemia (AML) OR acute myelogenous leukemia (AML) with myelodysplasia-related changes. If the patient has the diagnosis of therapy-related AML, it must be newly diagnosed. |
| **Age Restrictions** | age 18 years and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# XADAGO

**Products Affected**

- XADAGO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Concurrent use of MAOI therapy, including linezolid |
| **Required Medical Information** | Diagnosis of Parkinson's Disease AND will be used as an adjunctive treatment to levodopa/carbidopa |
| **Age Restrictions** | age 18 years and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a neurologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# XALKORI

## Products Affected

- XALKORI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Documented diagnosis of locally advanced or metastatic non-small cell lung cancer. Member has the anaplastic lymphoma receptor tyrosine kinase (ALK) genetic mutation as detected by an FDA-approved test. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | must be prescribed by an oncologist |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# XTANDI

## Products Affected

- XTANDI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# XURIDEN

## Products Affected

- XURIDEN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of Hereditary orotic aciduria |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescribed by or in consultation with a specialist that treats metabolic defects |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# YONDELIS

## Products Affected

- YONDELIS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of unresectable or metastatic soft tissue sarcoma (liposarcoma or leiomyosarcoma) in patients who have received a prior anthracycline-containing regimen |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Must be prescribed by an oncologist |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# YONSA

## Products Affected

- YONSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of metastatic castration-resistant prostate cancer, and used in combination with methylprednisolone AND Documented history of trial with, inadequate treatment response, adverse event, or contraindication to Zytiga |
| **Age Restrictions** | 18 years of age or older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or urologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# ZEJULA

## Products Affected

- ZEJULA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer and patient had a complete or partial response to platinum-based chemotherapy. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or gynecologist |
| **Coverage Duration** | 12/31/2018 |
| **Other Criteria** | None |

# PART B VERSUS PART D

## Products Affected

- ABRAXANE INTRAVENOUS SUSPENSION RECONSTITUTED 100 MG
- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- ADRIAMYCIN INTRAVENOUS SOLUTION 2 MG/ML
- *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml*
- ALDURAZYME INTRAVENOUS SOLUTION 2.9 MG/5ML
- ALIMTA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 500 MG
- AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG
- AMINOSYN II INTRAVENOUS SOLUTION 10 %, 8.5 %
- AMINOSYN II/ELECTROLYTES INTRAVENOUS SOLUTION 8.5 %
- AMINOSYN/ELECTROLYTES INTRAVENOUS SOLUTION 7 %, 8.5 %
- AMINOSYN-HBC INTRAVENOUS SOLUTION 7 %
- AMINOSYN-PF INTRAVENOUS SOLUTION 10 %, 7 %
- AMINOSYN-RF INTRAVENOUS SOLUTION 5.2 %
- *amiodarone hcl intravenous solution 150 mg/3ml*
- *amphotericin b injection solution reconstituted 50 mg*
- *ampicillin-sulbactam sodium injection solution reconstituted 15 (10-5) gm, 3 (2-1) gm*
- ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG
- ARRANON INTRAVENOUS SOLUTION 5 MG/ML
- ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
- ATGAM INTRAVENOUS INJECTABLE 50 MG/ML
- AVASTIN INTRAVENOUS SOLUTION 100 MG/4ML
- *azacitidine injection suspension reconstituted 100 mg*
- AZASAN ORAL TABLET 100 MG, 75 MG
- *azathioprine oral tablet 50 mg*
- *azathioprine sodium injection solution reconstituted 100 mg*
- BAVENCIO INTRAVENOUS SOLUTION 200 MG/10ML
- BELEODAQ INTRAVENOUS SOLUTION RECONSTITUTED 500 MG
- BENLYSTA INTRAVENOUS SOLUTION RECONSTITUTED 120 MG
- BICNU INTRAVENOUS SOLUTION RECONSTITUTED 100 MG
- BIVIGAM INTRAVENOUS SOLUTION 10 GM/100ML
- *bleomycin sulfate injection solution reconstituted 30 unit*
- *bortezomib intravenous solution reconstituted 3.5 mg*
- *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml*
- *busulfan intravenous solution 6 mg/ml*
- *calcitonin (salmon) nasal solution 200 unit/act*
- *calcitriol intravenous solution 1 mcg/ml*

Formulary ID: 18319
Last Updated: 10/18/2018
Version: 17 - Effective: 11/01/2018

- *calcitriol oral capsule 0.25 mcg, 0.5 mcg*
- *calcitriol oral solution 1 mcg/ml*
- CAPASTAT SULFATE INJECTION SOLUTION RECONSTITUTED 1 GM
- *carboplatin intravenous solution 150 mg/15ml*
- *caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg*
- CELLCEPT INTRAVENOUS INTRAVENOUS SOLUTION RECONSTITUTED 500 MG
- CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT
- *chlorpromazine hcl injection solution 50 mg/2ml*
- *chlorpromazine hcl oral tablet 10 mg, 25 mg*
- *chorionic gonadotropin intramuscular solution reconstituted 10000 unit*
- *cisplatin intravenous solution 50 mg/50ml*
- *cladribine intravenous solution 10 mg/10ml*
- CLINIMIX E/DEXTROSE (2.75/10) INTRAVENOUS SOLUTION 2.75 %
- CLINIMIX E/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION 2.75 %
- CLINIMIX E/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (4.25/25) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %
- CLINIMIX E/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %
- CLINIMIX E/DEXTROSE (5/25) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION 2.75 %
- CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (4.25/20) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (4.25/25) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (5/25) INTRAVENOUS SOLUTION 5 %
- CLINISOL SF INTRAVENOUS SOLUTION 15 %
- *clofarabine intravenous solution 1 mg/ml*
- *colistimethate sodium (cba) injection solution reconstituted 150 mg*
- *cromolyn sodium inhalation nebulization solution 20 mg/2ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclosporine intravenous solution 50 mg/ml*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- CYRAMZA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML
- *cytarabine (pf) injection solution 100 mg/ml*
- *cytarabine injection solution 20 mg/ml*
- *dacarbazine intravenous solution reconstituted 200 mg*
- *dactinomycin intravenous solution reconstituted 0.5 mg*

- *daptomycin intravenous solution reconstituted 500 mg*
- *daunorubicin hcl intravenous injectable 5 mg/ml*
- *decitabine intravenous solution reconstituted 50 mg*
- DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML
- *dexrazoxane intravenous solution reconstituted 250 mg*
- *dextrose intravenous solution 10 %, 5 %*
- *diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml*
- *docetaxel intravenous concentrate 80 mg/4ml*
- *docetaxel intravenous solution 160 mg/16ml*
- *doripenem intravenous solution reconstituted 500 mg*
- *doxercalciferol intravenous solution 4 mcg/2ml*
- *doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg*
- *doxorubicin hcl intravenous solution 2 mg/ml*
- *doxorubicin hcl liposomal intravenous injectable 2 mg/ml*
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- ELAPRASE INTRAVENOUS SOLUTION 6 MG/3ML
- ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG
- ELITEK INTRAVENOUS SOLUTION RECONSTITUTED 1.5 MG, 7.5 MG
- EMEND ORAL SUSPENSION RECONSTITUTED 125 MG
- ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML
- ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG
- *epirubicin hcl intravenous solution 200 mg/100ml*
- ERBITUX INTRAVENOUS SOLUTION 100 MG/50ML
- ETOPOPHOS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG
- *etoposide intravenous solution 100 mg/5ml*
- FABRAZYME INTRAVENOUS SOLUTION RECONSTITUTED 35 MG, 5 MG
- FASLODEX INTRAMUSCULAR SOLUTION 250 MG/5ML
- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG, 80 MG
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 5 GM/50ML
- *fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%*
- *fludarabine phosphate intravenous solution reconstituted 50 mg*
- *fluorouracil intravenous solution 5 gm/100ml*
- FOLOTYN INTRAVENOUS SOLUTION 40 MG/2ML
- FREAMINE HBC INTRAVENOUS SOLUTION 6.9 %
- GAMASTAN S/D INTRAMUSCULAR INJECTABLE (10ML), (2ML)
- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM
- GAMMAKED INJECTION SOLUTION 1 GM/10ML

- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- *ganciclovir sodium intravenous solution reconstituted 500 mg*
- *gemcitabine hcl intravenous solution reconstituted 1 gm*
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- GENGRAF ORAL SOLUTION 100 MG/ML
- *granisetron hcl intravenous solution 0.1 mg/ml, 1 mg/ml*
- *granisetron hcl oral tablet 1 mg*
- HALAVEN INTRAVENOUS SOLUTION 1 MG/2ML
- *heparin (porcine) in d5w intravenous solution 40-5 unit/ml-%*
- *heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml*
- HEPATAMINE INTRAVENOUS SOLUTION 8 %
- HERCEPTIN INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 440 MG
- *idarubicin hcl intravenous solution 10 mg/10ml*
- *ifosfamide intravenous solution reconstituted 1 gm*
- IMOVAX RABIES INTRAMUSCULAR INJECTABLE 2.5 UNIT/ML
- INTRON A INJECTION SOLUTION 10000000 UNIT/ML, 6000000 UNIT/ML
- INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 18000000 UNIT, 50000000 UNIT
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
- *irinotecan hcl intravenous solution 100 mg/5ml*
- ISTODAX (OVERFILL) INTRAVENOUS SOLUTION RECONSTITUTED 10 MG
- KEPIVANCE INTRAVENOUS SOLUTION RECONSTITUTED 6.25 MG
- KYPROLIS INTRAVENOUS SOLUTION RECONSTITUTED 30 MG, 60 MG
- *leucovorin calcium injection solution reconstituted 100 mg, 350 mg*
- *leuprolide acetate injection kit 1 mg/0.2ml*
- *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml*
- *levocarnitine oral solution 1 gm/10ml*
- *levocarnitine oral tablet 330 mg*
- *levoleucovorin calcium intravenous solution 175 mg/17.5ml*
- *levoleucovorin calcium intravenous solution reconstituted 50 mg*
- *lincomycin hcl injection solution 300 mg/ml*
- *melphalan hcl intravenous solution reconstituted 50 mg*
- *mesna intravenous solution 100 mg/ml*
- *methotrexate oral tablet 2.5 mg*
- *methotrexate sodium (pf) injection solution 250 mg/10ml, 50 mg/2ml*
- *methotrexate sodium injection solution 250 mg/10ml*
- *methotrexate sodium injection solution reconstituted 1 gm*
- *methylprednisolone sodium succ injection solution reconstituted 1000 mg*
- *metoprolol tartrate intravenous solution 5 mg/5ml*

- *metoprolol tartrate intravenous solution cartridge 5 mg/5ml*
- *metronidazole in nacl intravenous solution 500-0.79 mg/100ml-%*
- MIACALCIN INJECTION SOLUTION 200 UNIT/ML
- MIRCERA INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.3ML, 50 MCG/0.3ML, 75 MCG/0.3ML
- *mitomycin intravenous solution reconstituted 20 mg, 40 mg, 5 mg*
- *mitoxantrone hcl intravenous concentrate 25 mg/12.5ml*
- MUSTARGEN INJECTION SOLUTION RECONSTITUTED 10 MG
- *mycophenolate mofetil hcl intravenous solution reconstituted 500 mg*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension reconstituted 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet delayed release 180 mg, 360 mg*
- NAGLAZYME INTRAVENOUS SOLUTION 1 MG/ML
- NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG
- NEPHRAMINE INTRAVENOUS SOLUTION 5.4 %
- NIPENT INTRAVENOUS SOLUTION RECONSTITUTED 10 MG
- *nutrilipid intravenous emulsion 20 %*
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML
- *ondansetron hcl injection solution 4 mg/2ml, 4 mg/2ml (2ml syringe)*
- *ondansetron hcl oral solution 4 mg/5ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet dispersible 4 mg, 8 mg*
- *oxaliplatin intravenous solution 100 mg/20ml*
- *oxaliplatin intravenous solution reconstituted 100 mg*
- *paclitaxel intravenous concentrate 100 mg/16.7ml*
- *pamidronate disodium intravenous solution 30 mg/10ml, 6 mg/ml, 90 mg/10ml*
- *paricalcitol intravenous solution 2 mcg/ml, 5 mcg/ml*
- *paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg*
- PERJETA INTRAVENOUS SOLUTION 420 MG/14ML
- *piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm*
- PLASMA-LYTE 148 INTRAVENOUS SOLUTION
- PLASMA-LYTE A INTRAVENOUS SOLUTION
- PLENAMINE INTRAVENOUS SOLUTION 15 %
- PREMASOL INTRAVENOUS SOLUTION 10 %, 6 %
- PRIVIGEN INTRAVENOUS SOLUTION 20 GM/200ML
- PROCALAMINE INTRAVENOUS SOLUTION 3 %
- *prochlorperazine maleate oral tablet 10 mg, 5 mg*
- PROGRAF INTRAVENOUS SOLUTION 5 MG/ML
- PROLEUKIN INTRAVENOUS SOLUTION RECONSTITUTED 22000000 UNIT
- PROSOL INTRAVENOUS SOLUTION 20 %
- PULMOZYME INHALATION SOLUTION 1 MG/ML

- RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED
- RAPAMUNE ORAL SOLUTION 1 MG/ML
- RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 10 MCG/ML (1ML SYRINGE), 40 MCG/ML, 5 MCG/0.5ML
- RITUXAN INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML
- SANDIMMUNE ORAL SOLUTION 100 MG/ML
- SENSIPAR ORAL TABLET 30 MG, 60 MG, 90 MG
- SIMULECT INTRAVENOUS SOLUTION RECONSTITUTED 20 MG
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML
- SYNDROS ORAL SOLUTION 5 MG/ML
- SYNERCID INTRAVENOUS SOLUTION RECONSTITUTED 150-350 MG
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- TECENTRIQ INTRAVENOUS SOLUTION 1200 MG/20ML
- TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG
- *tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml*
- *thiotepa injection solution reconstituted 15 mg*
- THYMOGLOBULIN INTRAVENOUS SOLUTION RECONSTITUTED 25 MG
- *tigecycline intravenous solution reconstituted 50 mg*
- *tobramycin inhalation nebulization solution 300 mg/5ml*
- *topotecan hcl intravenous solution reconstituted 4 mg*
- TORISEL INTRAVENOUS SOLUTION 25 MG/ML
- *tranexamic acid intravenous solution 1000 mg/10ml*
- TRAVASOL INTRAVENOUS SOLUTION 10 %
- TREANDA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 25 MG
- TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG
- TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG
- TRISENOX INTRAVENOUS SOLUTION 12 MG/6ML
- TROPHAMINE INTRAVENOUS SOLUTION 10 %
- TYSABRI INTRAVENOUS CONCENTRATE 300 MG/15ML
- VARUBI ORAL TABLET 90 MG
- VECTIBIX INTRAVENOUS SOLUTION 100 MG/5ML
- VELCADE INJECTION SOLUTION RECONSTITUTED 3.5 MG
- VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML
- *vinblastine sulfate intravenous solution 1 mg/ml*
- *vincristine sulfate intravenous solution 1 mg/ml*
- *vinorelbine tartrate intravenous solution 50 mg/5ml*
- XATMEP ORAL SOLUTION 2.5 MG/ML
- YERVOY INTRAVENOUS SOLUTION 50 MG/10ML
- ZALTRAP INTRAVENOUS SOLUTION 100 MG/4ML
- ZANOSAR INTRAVENOUS SOLUTION RECONSTITUTED 1 GM
- *zoledronic acid intravenous concentrate 4 mg/5ml*
- *zoledronic acid intravenous solution 5 mg/100ml*

- ZOMETA INTRAVENOUS SOLUTION 4 MG/100ML
- ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG

## Details

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

## Alphabetical Listing