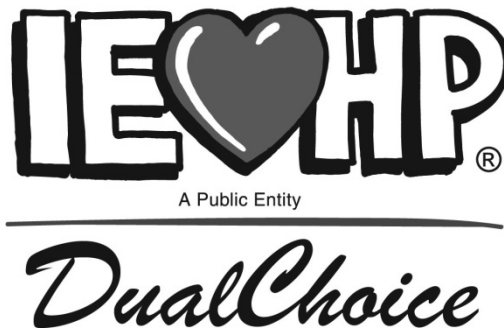


Prior Authorization Criteria
Last Updated: March 20, 2019
Effective Date: April 1, 2019



2019 Prior Authorizations (List of Prior Authorizations)

PLEASE READ CAREFULLY: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE PRIOR AUTHORIZATIONS ON DRUGS THAT WE COVER IN THIS PLAN.

Note to existing members: Beneficiaries must use network pharmacies to access their prescription drug benefit. “Benefits, List of Covered Drugs, pharmacy and provider networks and copayments may change from time to time throughout the year and on January 1 of each year.”

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. You can get this information for free in other languages. Call 1-877-273-IEHP (4347), 8am – 8pm (PST) 7 days a week, including holidays. TTY/TDD users should call 1-800-718-4347. The call is free.

Usted puede obtener esta información gratis en otros idiomas. Llame al 1-877-273-IEHP (4347), 8am – 8pm (Hora del Pacífico), los 7 días de la semana, incluidos días festivos. Los usuarios de TTY/TDD deben llamar al 1-800-718-4347. La llamada es gratuita.

ABELCET

Products Affected

- ABELCET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.

ABILIFY MAINTENA

Products Affected

- **ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG, 400 MG**
- **ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.

ABIRATERONE

Products Affected

- *abiraterone*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of concurrent treatment with prednisone.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: calcipotriene, clobetasol, cyclosporine, fluocinonide, methotrexate, or Tazorac.

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist, Orthopedist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

ADEFOVIR

Products Affected

- *adefovir*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of nitrates and PDE5 inhibitors.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year
Other Criteria	For Pulmonary Arterial Hypertension only: Failure or clinically significant adverse effects to the formulary alternative: sildenafil. Other indication(s) do not require failure or clinically significant adverse effects to sildenafil.

ADHD

Products Affected

- *dexmethylphenidate oral tablet*
- *dextroamphetamine oral tablet*
- *dextroamphetamine-amphetamine oral tablet*
- *methylphenidate hcl oral capsule, er biphasic 30-70*
- *methylphenidate hcl oral capsule, er biphasic 50-50 10 mg, 20 mg, 30 mg, 40 mg*
- *methylphenidate hcl oral solution*
- *methylphenidate hcl oral tablet*
- *methylphenidate hcl oral tablet extended release*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Advanced renal cell carcinoma: Failure or clinically significant adverse effects to one of the formulary alternatives: Nexavar or Sutent. Advanced hormone receptor-positive, HER2 negative breast cancer in postmenopausal women: Use in combination with exemestane and failure or clinically significant adverse effects to one of the formulary alternatives: anastrozole or letrozole.

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of anaplastic lymphoma kinase (ALK) positive.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ALLI

Products Affected

- ALLI 60 MG CAPSULE STARTER PACK

PA Criteria	Criteria Details
Covered Uses	Obesity management including weight loss and weight maintenance when used in conjunction with a reduced-calorie diet.
Exclusion Criteria	N/A
Required Medical Information	BMI greater than or equal to 27 kg/m ² with one or more comorbidity (e.g. coronary heart disease, dyslipidemia, hypertension, type 2 diabetes mellitus, sleep apnea), OR BMI greater than or equal to 30 kg/m ² . Reauthorization: Documented weight loss of 5% during the first 6 month period and lack of side effects. Therapy beyond the first year can be authorized every 6 months with documentation of weight maintenance and lack of side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months.
Other Criteria	N/A

ALUNBRIG

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of anaplastic lymphoma kinase (ALK) positive.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Xalkori.

ALYQ

Products Affected

- *alyq*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of nitrates and PDE5 inhibitors.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: sildenafil.

AMBISOME

Products Affected

- AMBISOME

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.

AMITRIPTYLINE

Products Affected

- *amitriptyline*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

AMOXAPINE

Products Affected

- *amoxapine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.

AMPHOTERICIN B

Products Affected

- *amphotericin b*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

ANADROL

Products Affected

- ANADROL-50

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ANDROGENS

Products Affected

- **ANDRODERM**
- *testosterone transdermal gel in metered-dose pump*
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)*
- *testosterone transdermal solution in metered pump w/app*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

APOKYN

Products Affected

- APOKYN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: antiparkinson drugs such as amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline.

APREPITANT

Products Affected

- *aprepitant*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to one of the formulary 5-HT3 antagonist alternatives: ondansetron or granisetron except when the member is on any chemotherapy.

APTIOM

Products Affected

- APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrently taking any tumor necrosis factor (TNF)-blocking agents such as Enbrel, Humira, or Remicade.
Required Medical Information	N/A
Age Restrictions	Approve if 12 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ARIKAYCE

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of treatment failure with a combination antibacterial drug regimen for at least 6 months, as evidenced by not achieving negative sputum cultures.
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

ARIPIPIRAZOLE

Products Affected

- *aripiprazole oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Bipolar and Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

ARIPIPIRAZOLE ODT

Products Affected

- *aripiprazole oral tablet, disintegrating*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Bipolar and Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

ARIPIPIRAZOLE SOLUTION

Products Affected

- *aripiprazole oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of difficulty or inability to swallow.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Bipolar and Schizophrenia: Failure or clinically significant adverse effects to one of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone. Depression: Failure or clinically significant adverse effects to one of the formulary alternatives: bupropion, citalopram, desvenlafaxine, duloxetine, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

ATOVAQUONE

Products Affected

- *atovaquone*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Pneumocystic pneumonia: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim/sulfamethoxazole.

AUBAGIO

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

AUSTEDO

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with an MAOI.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist, Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

AVONEX

Products Affected

- AVONEX (WITH ALBUMIN)
- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.

BENZNIDAZOLE

Products Affected

- BENZNIDAZOLE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	60 days.
Other Criteria	N/A

BENZTROPINE

Products Affected

- *benztropine oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Parkinsonism: Failure or clinically significant adverse effects to two of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline. Medication-induced movement disorder - extrapyramidal disease: Failure or clinically significant adverse effects to the formulary alternative: amantadine.

BERINERT

Products Affected

- **BERINERT INTRAVENOUS KIT**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	N/A
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.

BOSULIF

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

BRAFTOVI

Products Affected

- BRAFTOVI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Documentation of history of prior treatment with BRAF inhibitors or MEK inhibitors
Required Medical Information	Concurrent use with binimetinib. Documentation of BRAF V600E or V600K mutation as detected by a FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

BRIVIACT

Products Affected

- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

CABOMETYX

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

CALQUENCE

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of at least one prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CAPRELSA

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Congenital long QT syndrome.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CARBAGLU

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N-acetylglutamate synthase deficiency must be confirmed by FDA approved testing
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CARBINOXAMINE

Products Affected

- *carbinoxamine maleate oral liquid*
- *carbinoxamine maleate oral tablet 4 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Allergic rhinitis: Failure or clinically significant adverse effects to two of the formulary alternatives: azelastine, cetirizine, cromolyn, flunisolide, or levocetirizine. Cutaneous hypersensitivity, urticaria, or angioedema: Failure or clinically significant adverse effects to all of the formulary alternatives: cetirizine and levocetirizine.

CARISOPRODOL

Products Affected

- *carisoprodol oral tablet 350 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk.

CASPOFUNGIN

Products Affected

- *caspofungin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

CAYSTON

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	4 weeks.
Other Criteria	Subject to Part B vs Part D determination.

CERDELGA

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of CYP2D6 metabolism as an extensive metabolizer (EM), intermediate metabolizer (IM) or poor metabolizer (PM) determined by a FDA-cleared test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CHOLBAM

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CINRYZE

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	N/A
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: danazol.

CLEMASTINE

Products Affected

- *clemastine oral tablet 2.68 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Allergic rhinitis: Failure or clinically significant adverse effects to two of the formulary alternatives: azelastine, cetirizine, cromolyn, flunisolide, or levocetirizine. Cutaneous hypersensitivity, urticaria, or angioedema: Failure or clinically significant adverse effects to all of the formulary alternatives: cetirizine and levocetirizine.

CLOBAZAM

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

CLOMIPRAMINE

Products Affected

- *clomipramine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: fluoxetine, fluvoxamine, paroxetine, or sertraline.

CLONIDINE ER

Products Affected

- *clonidine hcl oral tablet extended release 12 hr*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: guanfacine ER.

CLOZAPINE ODT

Products Affected

- *clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: clozapine tablet.

COMETRIQ

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Recent history of hemorrhage or hemoptysis.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

COPIKTRA

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of at least 2 prior systemic therapies.
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CORLANOR

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented New York Association (NYHA) class II to IV heart failure with an ejection fraction of less than or equal to 35% and sinus rhythm with a resting heart rate greater than or equal to 70 beats per minute. Documentation that patient is on maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication or a hypersensitivity to beta blocker. Documented concurrent use with an ACE inhibitor or ARB, unless both are not tolerated or contraindicated.
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of BRAF V600E or V600K mutation by a FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CYCLOBENZAPRINE

Products Affected

- *cyclobenzaprine oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk

CYCLOSET

Products Affected

- CYCLOSET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: glipizide, glimepiride, metformin, or pioglitazone.

CYPROHEPTADINE

Products Affected

- *cyproheptadine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Allergic rhinitis: Failure or clinically significant adverse effects to two of the formulary alternatives: azelastine, cetirizine, cromolyn, flunisolide, or levocetirizine. Pruritus or urticaria: Failure or clinically significant adverse effects to all of the formulary alternatives: cetirizine and levocetirizine.

CYSTAGON

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

CYSTARAN

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Concurrently on a disease-modifying agent for multiple sclerosis. Documentation of difficulty walking (such as timed 25-foot walk test: Patient must be able to walk 25 feet within 8-45 sec).
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

DALIRESP

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Advair Diskus, Anoro Ellipta, Serevent, Spiriva or Tudorza.

DAPTOMYCIN

Products Affected

- *daptomycin intravenous recon soln 500 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination

DARAPRIM

Products Affected

- DARAPRIM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, HIV specialist, Infectious Disease specialist, Oncologist, Transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Primary prophylaxis of toxoplasmic encephalitis: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim-sulfamethoxazole.

DAURISMO

Products Affected

- Daurismo Oral Tablet 100 mg, 25 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented concurrent use with low-dose cytarabine. Documentation of 75 years of age or older, or comorbidities that preclude use of intensive induction chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

DEMSEER

Products Affected

- DEMSEER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Essential hypertension.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

DESIPRAMINE

Products Affected

- *desipramine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline or venlafaxine.

DIAZEPAM SOLUTION

Products Affected

- *diazepam intensol*
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

DICLOFENAC TOPICAL GEL

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: fluorouracil topical cream, fluorouracil topical solution or imiquimod topical.

DIGOXIN

Products Affected

- *digitek*
- *digox*
- *digoxin oral solution 50 mcg/ml*
- *digoxin oral tablet*
- **LANOXIN ORAL TABLET 125 MCG, 250 MCG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Average daily doses greater than 0.125mg require a clinical justification. Approve for average daily doses of 0.125mg or less.

DISOPYRAMIDE

Products Affected

- *disopyramide phosphate oral capsule*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: acebutolol, amiodarone, flecainide, mexiletine, propafenone, quinidine, or sotalol.

DOXEPIN

Products Affected

- *doxepin oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	For the average daily dose of doxepin that is greater than 6 mg: Anxiety: Failure or clinically significant adverse effects to two of the formulary alternatives: buspirone, escitalopram, paroxetine, or venlafaxine. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

DRONABINOL

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Chemotherapy-induced nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, metoclopramide, ondansetron, or prochlorperazine.

DUAVEE

Products Affected

- DUAVEE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to two of the formulary alternatives: alendronic acid, ibandronic acid, or risedronate. Other indication(s): Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol transdermal patch, estradiol tablet or estropipate.

ELIGARD

Products Affected

- **ELIGARD**
- **ELIGARD (3 MONTH)**
- **ELIGARD (4 MONTH)**
- **ELIGARD (6 MONTH)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

EMFLAZA

Products Affected

- EMFLAZA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: prednisone.

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: phenelzine and tranylcypromine.

ENBREL

Products Affected

- ENBREL
- ENBREL SURECLICK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to two of the following: acitretin, cyclosporine, methotrexate or phototherapy.

ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented concurrent use with hydroxyurea. Documentation of two or more painful sickle cell crises within the past 12 months.
Age Restrictions	N/A
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ENTECAVIR

Products Affected

- BARACLUDGE ORAL SOLUTION
- *entecavir*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ENTRESTO

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of Chronic Heart Failure (NYHA Class II-IV) and reduced ejection fraction less than or equal to 40%.
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

EPCLUSA

Products Affected

- EPCLUSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status.
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	12 weeks.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. Failure or clinically significant adverse effects to the formulary alternative: Mavyret.

EPIDIOLEX

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

EPOGEN

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled hypertension.
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodysplastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

ERGOLOID

Products Affected

- *ergoloid*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members with acute and chronic psychosis.
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: donepezil, galantamine, or rivastigmine.

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ERLEADA

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ERTAPENEM

Products Affected

- *ertapenem*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	14 days.
Other Criteria	Subject to Part B vs Part D determination.

ESBRIET

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ESTROGENS

Products Affected

- *estradiol oral*
- *estradiol transdermal patch weekly*
- *estropipate oral tablet 0.75 mg*
- *jinteli*
- *norethindrone ac-eth estradiol oral tablet 1-5 mg-mcg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects all of the formulary alternatives: alendronic acid and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol cream or Premarin Cream.

EXJADE

Products Affected

- EXJADE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

FANAPT

Products Affected

- FANAPT ORAL TABLET
- FANAPT ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone or ziprasidone.

FARYDAK

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

FENTANYL LOZENGE

Products Affected

- *fentanyl citrate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute, intermittent, or postoperative pain.
Required Medical Information	Documentation of opioid tolerance taking around-the-clock opioid therapy consisting of at least 60mg of oral morphine daily, at least 25mg transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8mg oral hydromorphone daily, at least 25mg oral oxymorphone daily or an equianalgesic dose of another opioid daily for a week or longer for breakthrough pain of cancer. Patients must remain on around-the clock opioids when taking transmucosal immediate release fentanyl.
Age Restrictions	N/A
Prescriber Restrictions	Pain Specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

FERRIPROX

Products Affected

- FERRIPROX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Exjade.

FETZIMA

Products Affected

- FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK
- FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

FIRAZYR

Products Affected

- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	N/A
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

FIRMAGON

Products Affected

- FIRMAGON KIT W DILUENT SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

FIRVANQ

Products Affected

- FIRVANQ ORAL RECON SOLN 25 MG/ML, 50 MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	C diff diarrhea: Reauthorization: Documentation of C. Difficile positive stool
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	N/A

FORTEO

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone mineral density (BMD) T score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and a history of fractures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: alendronic acid or risedronate. Medical justification required for treatment duration beyond 24 months.

FYCOMPA

Products Affected

- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

GATTEX

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented dependence on parenteral nutrition support for at least 12 months
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GENOTROPIN

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	AGHD(initial): diagnosis confirmed as a result of past diagnosis of childhood-onset GHD, or adult-onset GHD with documentation of hormone deficiency due to hypothalamic-pituitary disease from organic or known causes (eg: damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and documentation of one growth-hormone stimulant test (eg: insulin tolerance test, arginine/GHRH,glucagon,arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or documented deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IFG-1/somatomedinC below age and gender adjusted normal range as provided by physicians lab. AGHD(reauthorization): Documentation of positive experience by the patient.
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GEODON SOLUTION

Products Affected

- GEODON INTRAMUSCULAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

GILENYA

Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Class III or IV heart failure, decompensated heart failure requiring hospitalization, myocardial infarction, stroke, transient ischemic attack or unstable angina within the last 6 months. Concomitant use of Class Ia or Class III anti-arrhythmic drugs. Mobitz type II second-degree or third-degree atrioventricular block, or sick-sinus syndrome unless the patient has a functional pacemaker. QT interval at baseline 500 ms or greater.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Metastatic non-small cell lung cancer: documentation of epidermal growth factor receptor (EGFR) mutation status
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GLATIRAMER

Products Affected

- *glatiramer*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GLATOPA

Products Affected

- *glatopa*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GLYBURIDE

Products Affected

- *glyburide micronized*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: glipizide and glimepiride.

GOCOVRI

Products Affected

- GOCOVRI ORAL CAPSULE, EXTENDED RELEASE 24HR 137 MG, 68.5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of concurrent levodopa therapy.
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

GUANFACINE

Products Affected

- *guanfacine oral tablet*
- *guanfacine oral tablet extended release 24 hr*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Hypertension: Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide. ADHD: Failure or clinically significant adverse effects to two of the formulary alternatives: amphetamine/dextroamphetamine, dexamethylphenidate, dextroamphetamine, or methylphenidate.

HAEGARDA

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	N/A
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: danazol.

HETLIOZ

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist, Sleep specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

HP ACTHAR

Products Affected

- ACTHAR H.P.

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist for infantile spasm and exacerbation of multiple sclerosis
Coverage Duration	Multiple sclerosis: 21 days. For other approved indications: 28 days.
Other Criteria	For acute exacerbations of multiple sclerosis, patients must be receiving concurrent immunomodulator therapy, such as Aubagio, glatiramer, or interferon beta 1a. For all other non-neurological indications, failure or clinically significant adverse effects to other first line or standard of care therapies must be submitted.

HUMIRA

Products Affected

- HUMIRA
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA(CF)
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Gastroenterologist, Ophthalmologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to two of the formulary alternatives: acitretin, cyclosporine, methotrexate or phototherapy. Crohn's disease and Ulcerative colitis: Failure or clinically significant adverse effects to two of the formulary alternatives: budesonide, mesalamine or sulfasalazine.

HUMIRA PEDIATRIC CROHNS

Products Affected

- HUMIRA PEDIATRIC CROHNS START
- HUMIRA(CF) PEDI CROHNS STARTER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Greater or equal to 6 years of age
Prescriber Restrictions	Gastroenterologist, Pediatrician
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

HUMIRA PSORIASIS

Products Affected

- HUMIRA PEN PSOR-UVEITS-ADOL HS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Rheumatologist, Ophthalmologist, Gastroenterologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Plaque psoriasis: Failure or clinically significant adverse effects to two of the following: acitretin, cyclosporine, methotrexate or phototherapy.

HYDROXYZINE

Products Affected

- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Urticaria: Failure or clinically significant adverse effects to all of the formulary alternatives: cetirizine and levocetirizine. Nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, ondansetron, or prochlorperazine. Anxiety: Failure or clinically significant adverse effects to two of the formulary alternatives: buspirone, escitalopram, paroxetine, or venlafaxine. Pruritus: Failure or clinically significant adverse effects to one of the formulary topical alternatives: betamethasone or triamcinolone.

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ICLUSIG

Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	All requests: Documentation of T315I mutation status. Acute Lymphoblastic Leukemia (ALL): Documentation of Philadelphia Chromosome Positive (Ph+)
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of formulary alternatives: Bosulif, imatinib, Sprycel or Tasigna except when the member has a diagnosis of Chronic Myeloid Leukemia T315I-positive or Ph+ALL T315-positive.

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of isocitrate dehydrogenase-2 (IDH2) mutation as detected by a FDA approved test
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

IMATINIB

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

IMBRUVICA

Products Affected

- **IMBRUVICA ORAL CAPSULE**
- **IMBRUVICA ORAL TABLET 280 MG, 420 MG, 560 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist, Transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

IMIPRAMINE

Products Affected

- *imipramine hcl*
- *imipramine pamoate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	For Depression Only: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, desvenlafaxine, duloxetine, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

IMMUNOGLOBULIN

Products Affected

- **CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM**
- **GAMMAGARD LIQUID**
- **GAMMAPLEX**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Approve under Part B for these types of Primary Humoral Immunodeficiency: Congenital agammaglobulinemia, Common variable immunodeficiency, Wiskott-Aldrich syndrome, X-linked agammaglobulinemia, Severe combined immunodeficiency. Subject to Part B vs Part D determination.

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

INDOMETHACIN

Products Affected

- *indomethacin oral capsule*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, ibuprofen, meloxicam, nabumetone, naproxen, or sulindac.

INLYTA

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

INTRALIPID

Products Affected

- INTRALIPID INTRAVENOUS EMULSION
30 %

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Subject to Part B vs Part D determination.

INVEGA SUSTENNA

Products Affected

- INVEGA SUSTENNA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: oral paliperidone or oral risperidone.

INVEGA TRINZA

Products Affected

- INVEGA TRINZA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: oral paliperidone or oral risperidone and failure or clinically significant adverse effects to the formulary alternative: Invega Sustenna.

IRESSA

Products Affected

- IRESSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of EGFR exon 19 deletion or exon 21 (L858R) substitution mutation detected by a FDA approved genetic test
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ISOTRETINOIN

Products Affected

- *claravis*
- *isotretinoin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist
Coverage Duration	20 weeks.
Other Criteria	N/A

ITRACONAZOLE

Products Affected

- *itraconazole oral solution*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Polycythemia Vera: Failure or clinically significant adverse effects to the formulary alternative: hydroxyurea.

JUXTAPID

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate or severe hepatic impairment (Child-Pugh B or C) or active liver disease.
Required Medical Information	Concurrent use with other lipid-lowering treatments
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: atorvastatin, ezetimibe, ezetimibe-simvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin.

JYNARQUE

Products Affected

- JYNARQUE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Nephrologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Cystic Fibrosis mutation must be confirmed by DNA testing
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

KEVEYIS

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

KINERET

Products Affected

- KINERET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Pediatrician, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.

KISQALI

Products Affected

- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of HER2 negative. Documentation of hormone receptor positive.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

KISQALI FEMARA

Products Affected

- KISQALI FEMARA CO-PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of HER2 negative. Documentation of hormone receptor positive.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use of simvastatin, lovastatin and CYP3A substrates with narrow therapeutic ranges (e.g. cyclosporine, fentanyl, sirolimus, etc.). History of unexplained vaginal bleeding or endometrial hyperplasia with atypia or endometrial carcinoma.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

KUVAN

Products Affected

- KUVAN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

KYNAMRO

Products Affected

- KYNAMRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate or severe hepatic impairment (Child-Pugh B or C) or active liver disease.
Required Medical Information	Concurrent use with other lipid-lowering treatments
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: atorvastatin, ezetimibe, ezetimibe-simvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin.

LATUDA

Products Affected

- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone or ziprasidone.

LAZANDA

Products Affected

- LAZANDA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute or postoperative pain, including headache/migraine or dental pain.
Required Medical Information	Documentation of opioid tolerance taking around-the-clock opioid therapy consisting of at least 60 mg of oral morphine daily, at least 25 mg transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8 mg oral hydromorphone daily, at least 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid daily for a week or longer for breakthrough pain of cancer.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Pain specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LEDIPASVIR-SOFOSBUVIR

Products Affected

- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status.
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	12 weeks.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

LENVIMA

Products Affected

- LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LETAIRIS

Products Affected

- LETAIRIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: sildenafil.

LEUKINE

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Excessive leukemia myeloid blasts in the bone marrow or peripheral blood equal to or greater than 10%.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	3 months.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Zarxio.

LEUPROLIDE ACETATE

Products Affected

- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LEVALBUTEROL

Products Affected

- *levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml, 1.25 mg/3 ml*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: albuterol inhalant solution.

LIDOCAINE PATCH

Products Affected

- *lidocaine topical adhesive patch, medicated*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternatives: gabapentin.

LINEZOLID

Products Affected

- *linezolid in dextrose 5%*
- *linezolid oral suspension for reconstitution*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LINZESS

Products Affected

- LINZESS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: 1) Amitiza and 2) lactulose or polyethylene glycol.

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of KRAS mutation status.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LORBRENA

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of anaplastic lymphoma kinase (ALK) positive.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternative: Alecensa, Zykadia, Xalkori, or Alunbrig.

LUPRON DEPOT

Products Affected

- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Endometriosis: Patient has had surgical ablation to prevent recurrence, or history of failure, contraindication, or intolerance to oral contraceptives.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LYNPARZA TABLET

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Deleterious or suspected deleterious germline BRCA-mutated advanced ovarian cancer only: Documentation of BRCA gene mutation detected by a FDA approved genetic test.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

LYRICA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Postherpetic neuralgia: Failure or clinically significant adverse effects to the formulary alternative: gabapentin. Diabetic neuropathy: Failure or clinically significant adverse effects to all of the formulary alternatives: duloxetine and gabapentin. Fibromyalgia: Failure or clinically significant adverse effects to two of the formulary alternatives: duloxetine, gabapentin or Savella.

MATULANE

Products Affected

- MATULANE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

MAVYRET

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status.
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	8 to 16 weeks.
Other Criteria	N/A

MEGESTROL

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Cachexia associated with AIDS: Failure or clinically significant adverse effects to all of the formulary alternatives: dronabinol and oxandrolone.

MEKINIST

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of BRAF V600E or V600K mutation by a FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

MEKTOVI

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Documentation of history of prior treatment with BRAF inhibitors or MEK inhibitors
Required Medical Information	Concurrent use with encorafenib. Documentation of BRAF V600E or V600K mutation as detected by a FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

MEPROBAMATE

Products Affected

- *meprobamate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to at least two of the formulary alternatives: buspirone, duloxetine, escitalopram, paroxetine, or venlafaxine.

METHOCARBAMOL

Products Affected

- *methocarbamol oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk

METHOXSALLEN

Products Affected

- *methoxsalen*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: calcipotriene, clobetasol, cyclosporine, fluocinonide, methotrexate, or tazarotene.

METHYLDOPA

Products Affected

- *methyldopa*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide.

METHYLDOPA/HYDROCHLOROTHIAZIDE

Products Affected

- *methyldopa-hydrochlorothiazide*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide.

MIGLUSTAT

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that enzyme replacement therapy is not a therapeutic option (e.g. due to allergy, hypersensitivity or poor venous access)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

MODAFINIL

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Narcolepsy: Failure or clinically significant adverse effects to all of the formulary alternatives: dextroamphetamine and methylphenidate.

MOLINDONE

Products Affected

- *molindone oral tablet 10 mg, 25 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone.

MULTAQ

Products Affected

- MULTAQ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

MYCAMINE

Products Affected

- MYCAMINE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of serum calcium greater than 7.5 mg/dL and 25-hydroxyvitamin D above 10 ng/mL
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

NERLYNX

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

NEULASTA

Products Affected

- NEULASTA SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to formulary alternative: Zarxio

NEUPOGEN

Products Affected

- NEUPOGEN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to formulary alternative: Zarxio

NEUPRO

Products Affected

- NEUPRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Parkinson's Disease: Failure or clinically significant adverse effects to two of the formulary alternatives: carbidopa/levodopa, pramipexole, ropinirole, or selegiline. Restless Legs Syndrome: Failure or clinically significant adverse effects to all of the formulary alternatives: pramipexole and ropinirole.

NEXAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

NITROFURANTOIN

Products Affected

- *nitrofurantoin*
- *nitrofurantoin macrocrystal*
- *nitrofurantoin monohyd/m-cryst*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	CrCL less than 60ml/min.
Required Medical Information	Documentation of culture and sensitivity indicating that nitrofurantoin is the only drug of choice for all reauthorizations.
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Initial request: 90 days of the cumulative day supply. Reauthorization: Length of therapy.
Other Criteria	Prophylaxis of UTI: Failure or clinically significant adverse effects to the formulary alternative: sulfamethoxazole/trimethoprim.

NORTHERA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

NOXAFIL

Products Affected

- NOXAFIL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: fluconazole, itraconazole, or voriconazole.

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Allergist, Immunologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Asthma: Failure or clinically significant adverse effects to two of the formulary alternatives: fluticasone-salmeterol dry powder inhaler, Asmanex, budesonide, Flovent, or Qvar.

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

NUPLAZID

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG, 17 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

NUTRILIPID

Products Affected

- NUTRILIPID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Subject to Part B vs Part D determination.

OCALIVA

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Documented inadequate response to ursodiol monotherapy for greater than or equal to 1 year. Use in combination with ursodiol

OCTREOTIDE

Products Affected

- *octreotide acetate injection solution*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of idiopathic pulmonary fibrosis confirmed by the presence of usual interstitial pneumonia on high resolution computed tomography (HRCT) and/or surgical lung biopsy.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Will not be used in combination with Esbriet.

OLANZAPINE SOLUTION

Products Affected

- *olanzapine intramuscular*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

OMNITROPE

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	AGHD (initial): diagnosis confirmed as a result of past diagnosis of childhood-onset GHD, or adult-onset GHD with documentation of hormone deficiency due to hypothalamic-pituitary disease from organic or known causes (eg: damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and documentation of one growth-hormone stimulant test (eg: insulin tolerance test, arginine/GHRH, glucagon, arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or documented deficiency of 3 anterior pituitary hormones (prolactin, ACTH, TSH, FSH/LH) and IFG-1/somatomedin C below age and gender adjusted normal range as provided by physicians lab. AGHD (reauthorization): Documentation of positive experience by the patient.
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: sildenafil.

ORENCIA

Products Affected

- **ORENCIA CLICKJECT**
- **ORENCIA SUBCUTANEOUS SYRINGE
125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7
ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.

ORFADIN

Products Affected

- ORFADIN ORAL CAPSULE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ORKAMBI

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

OXANDROLONE

Products Affected

- *oxandrolone*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

PALIPERIDONE

Products Affected

- *paliperidone oral tablet extended release 24hr*
1.5 mg, 3 mg, 6 mg, 9 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone or ziprasidone.

PALYNZIQ

Products Affected

- PALYNZIQ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented blood phenylalanine level greater than 600 micromol/L and documentation of at least one prior treatment (e.g. medical food, protein-restricted diet, Kuvan, etc.)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

PANRETIN

Products Affected

- PANRETIN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, HIV specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

PEGASYS

Products Affected

- **PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML**
- **PEGASYS SUBCUTANEOUS SOLUTION**
- **PEGASYS SUBCUTANEOUS SYRINGE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Hepatitis C: Treatment length is determined by FDA labeling or AASLD recommendation
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

PHENOBARBITAL

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

PHENTERMINE

Products Affected

- *phentermine 15 mg capsule*
- *phentermine 30 mg capsule*
- *phentermine 37.5 mg tablet*

PA Criteria	Criteria Details
Covered Uses	Short-term use, adjunct in a regimen of weight reduction based on exercise, behavioral modification and caloric restriction in the management of exogenous obesity for patients with an initial body mass index (BMI) greater than or equal to 30kg/m ² , or greater or equal to 27 kg/m ² in the presence of other risk factors (e.g. hypertension, diabetes, hyperlipidemia).
Exclusion Criteria	N/A
Required Medical Information	BMI greater than or equal to 27 kg/m ² with one or more comorbidity (e.g. coronary heart disease, dyslipidemia, hypertension, type 2 diabetes mellitus, sleep apnea), OR BMI greater than or equal to 30 kg/m ² . Reauthorization: Documented weight loss of 5% during the first 3 month period and lack of side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	N/A

PIMECROLIMUS

Products Affected

- *pimecrolimus*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the topical formulary alternatives: clobetasol, betamethasone, fluocinolone or fluocinonide and failure or clinically significant adverse effects to the formulary alternative: tacrolimus ointment.

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

PREMARIN TABLETS

Products Affected

- PREMARIN ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to the formulary alternative: estradiol cream. Other indication(s): Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol transdermal patch, estradiol tablet or estropipate.

PREMPRO TABLETS

Products Affected

- PREMPRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid, and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to the formulary alternative: estradiol cream. Other indication(s): Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol transdermal patch, estradiol tablet or estropipate.

PREVYMIS

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist, Transplant specialist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

PROCRT

Products Affected

- **PROCRT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled hypertension.
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodysplastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

PROLIA

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Postmenopausal osteoporosis: Bone mineral density (BMD) T score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and a history of fractures
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Osteoporosis: Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate.

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of platelet count. Thrombocytopenia in hepatitis C infection: Documentation of concurrent or planned interferon-based treatment of chronic hepatitis C.
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hematologist, Hepatologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Chronic immune (idiopathic) thrombocytopenia: Failure or clinically significant adverse effects to one of the formulary alternatives: dexamethasone, methylprednisolone, prednisolone or prednisone.

PROMETHAZINE

Products Affected

- *promethazine oral*
- *promethazine rectal suppository 12.5 mg, 25 mg*
- *promethegan rectal suppository 25 mg, 50 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Allergy: Failure or clinically significant adverse effects to one of the formulary alternatives: cetirizine and levocetirizine. Nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, ondansetron, or prochlorperazine.

PROTRIPTYLINE

Products Affected

- *protriptyline*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.

PURIXAN

Products Affected

- PURIXAN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of difficulty or inability to swallow.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: mercaptopurine tablet.

QUININE

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Prevention or treatment of nocturnal leg cramps.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	10 days.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: chloroquine or hydroxychloroquine.

RANEXA

Products Affected

- RANEXA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with strong CYP3A inhibitors or CYP3A inducers.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

RAYALDEE

Products Affected

- RAYALDEE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Stage 5 chronic kidney disease or end stage renal disease on dialysis.
Required Medical Information	Documented serum total 25-hydroxyvitamin D levels less than 30 ng/mL
Age Restrictions	N/A
Prescriber Restrictions	Nephrologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

REBIF

Products Affected

- **REBIF (WITH ALBUMIN)**
- **REBIF REBIDOSE**
- **REBIF TITRATION PACK**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.

RECTIV

Products Affected

- RECTIV

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 weeks.
Other Criteria	N/A

RELISTOR

Products Affected

- **RELISTOR ORAL**
- **RELISTOR SUBCUTANEOUS SOLUTION**
- **RELISTOR SUBCUTANEOUS SYRINGE
12 MG/0.6 ML, 8 MG/0.4 ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of opioid use for at least 4 weeks prior to the initiation of therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: 1) Amitiza and 2) lactulose or polyethylene glycol.

REPATHA

Products Affected

- **REPATHA PUSHTRONEX**
- **REPATHA SURECLICK**
- **REPATHA SYRINGE**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of current LDL levels and the concurrent use of a maximally tolerated statin therapy, unless intolerant or contraindicated to statin therapy.
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Endocrinologist, Lipid specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Primary Hyperlipidemia: Clinically significant adverse effects, contraindication, intolerance or failure to high-intensity statin: atorvastatin 40-80 mg or rosuvastatin 20-40 mg.

RESTASIS

Products Affected

- RESTASIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of test results confirming the diagnosis, such as: Tear break-up test (TBUT), Ocular surface disease index (OSDI), Schirmer's test, Visual analog scale (VAS), Symptom assessment in dry eye (SANDE), McMonnies questionnaire, etc.
Age Restrictions	N/A
Prescriber Restrictions	Ophthalmologist, Optometrist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

RETACRIT

Products Affected

- RETACRIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled hypertension.
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodysplastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

REVLIMID

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

REXULTI

Products Affected

- REXULTI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.

RIBAVIRIN

Products Affected

- *ribavirin oral capsule*
- *ribavirin oral tablet 200 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Hepatitis C: Treatment length is determined by FDA labeling or AASLD recommendation
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

RISPERDAL CONSTA

Products Affected

- RISPERDAL CONSTA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: oral risperidone.

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For acute myeloid leukemia: Documentation of FLT3 mutation positive and concurrent use with cytarabine and daunorubicin.
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SABRIL

Products Affected

- SABRIL ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Refractory Complex Partial Seizures only: Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide

SAPHRIS

Products Affected

- SAPHRIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone, or ziprasidone.

SAVELLA

Products Affected

- SAVELLA ORAL TABLET
- SAVELLA ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: duloxetine and gabapentin.

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

SILDENAFIL

Products Affected

- *sildenafil (antihypertensive) oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of nitrates and PDE5 inhibitors.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SOFOSBUVIR-VELPATASVIR

Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status.
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	12 weeks.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

SOMATULINE DEPOT

Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: octreotide.

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: octreotide.

SPRITAM

Products Affected

- SPRITAM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: levetiracetam oral solution.

SPRYCEL

Products Affected

- **SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

STELARA

Products Affected

- STELARA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Gastroenterologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Crohn's Disease: Failure or clinically significant adverse effects to the formulary alternative: Humira. Plaque Psoriasis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira. Psoriatic arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Metastatic colon cancer: Failure or clinically significant adverse effects to the alternatives: fluoropyrimidine containing chemotherapy and anti-VEGF therapy. If KRAS wild type, documented previous use of an anti-EGFR therapy. Gastrointestinal stromal tumor (GIST): Failure or clinically significant adverse effects to all the formulary alternatives: imatinib and Sutent. Liver cancer: Failure or clinically significant adverse effects to formulary alternative: sorafenib.

SUTENT

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Gastrointestinal stromal tumor (GIST): Failure or clinically significant adverse effects to the formulary alternative: imatinib.

SYLATRON

Products Affected

- SYLATRON

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of homozygous F508del mutation or at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor.
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SYMLIN

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Confirmed gastroparesis.
Required Medical Information	Documentation of a history of HbA1C scores of 7% or higher after at least 3 months of optimal therapy with insulin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of difficulty or inability to swallow.
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

SYNAREL

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

SYNRIBO

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Bosulif, imatinib, Iclusig, Sprycel or Tassigna.

TABLOID

Products Affected

- TABLOID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TACROLIMUS OINTMENT

Products Affected

- *tacrolimus topical*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the topical formulary alternatives: clobetasol, betamethasone, fluocinolone, or fluocinonide.

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of BRAF V600E mutation by a FDA approved test when Tafinlar is used as monotherapy. Documentation of BRAF V600E or V600K mutation by a FDA approved test when Tafinlar is used with Mekinist.
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TAGRISO

Products Affected

- TAGRISO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of epidermal growth factor receptor (EGFR) mutation
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: Gilotrif, Iressa or Tarceva.

TAKHZYRO

Products Affected

- TAKHZYRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	N/A
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: danazol.

TALZENNA

Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of germline BRCA mutation as detected by a FDA-approved test. Documentation of previous treatment with an anthracycline and/or a taxane unless contraindicated.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TARCEVA

Products Affected

- TARCEVA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	NSCLC: Documentation of epidermal growth factor receptor (EGFR) mutation
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TAVALISSE

Products Affected

- TAVALISSE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Promacta.

TAZORAC

Products Affected

- *tazarotene*
- **TAZORAC TOPICAL CREAM 0.05 %**
- **TAZORAC TOPICAL GEL**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Plaque psoriasis: Failure or clinically significant adverse effects to one of the topical formulary alternatives: calcipotriene, clobetasol or fluocinonide. Acne vulgaris: Failure or clinically significant adverse effects to two of the formulary alternatives: benzoyl peroxide/clindamycin topical, benzoyl peroxide/erythromycin topical, clindamycin topical, doxycycline oral, erythromycin topical, minocycline oral, tetracycline oral or tretinoin topical.

TECFIDERA

Products Affected

- **TECFIDERA**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.

TESTOSTERONE

Products Affected

- *testosterone cypionate*
- *testosterone enanthate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism: Documentation of testosterone levels below the lab reference range.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TESTOSTERONE PUMP

Products Affected

- *testosterone transdermal gel in metered-dose pump*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Androderm, testosterone cypionate, testosterone enanthate or testosterone transdermal gel.

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

THALOMID

Products Affected

- THALOMID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Hematologist, Oncologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

THIORIDAZINE

Products Affected

- *thioridazine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone.

TIBSOVO

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of susceptible isocitrate dehydrogenase-1 mutation.
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TIGECYCLINE

Products Affected

- *tigecycline*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

TOBI PODHALER

Products Affected

- TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TOBRAMYCIN SOLUTION

Products Affected

- *tobramycin in 0.225 % nacl*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

TOLCAPONE

Products Affected

- *tolcapone*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of concurrent use with levodopa and carbidopa.
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline.

TRACLEER

Products Affected

- TRACLEER ORAL TABLET
- TRACLEER ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TRIENTINE

Products Affected

- *trientine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Biliary cirrhosis, rheumatoid arthritis.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Depen.

TRIHXYPHENIDYL

Products Affected

- *trihexyphenidyl*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Parkinsonism: Failure or clinically significant adverse effects to one of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline. Medication-induced movement disorder - extrapyramidal disease: Failure or clinically significant adverse effects to the formulary alternative: amantadine.

TRIMIPRAMINE

Products Affected

- *trimipramine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.

TRINTELLIX

Products Affected

- TRINTELLIX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, or sertraline.

TYKERB

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone mineral density (BMD) T score of -2.5 or less based on BMD measurements from lumbar spine or hip (including femoral neck).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate. Medical justification required for treatment duration beyond 24 months.

UDENYCA

Products Affected

- UDENYCA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to formulary alternative: Zarxio

UPTRAVI

Products Affected

- UPTRAVI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VANCOMYCIN CAPSULE

Products Affected

- *vancomycin oral capsule 125 mg, 250 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	C diff diarrhea: Reauthorization: Documentation of C. Difficile positive stool
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	N/A

VEMLIDY

Products Affected

- VEMILIDY

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hepatologist, Gastroenterologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VENCLEXTA

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of 17p deletion and documentation of at least one prior therapy
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of Hormone Receptor (HR) positive. Documentation of HER2 negative.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VIBERZI

Products Affected

- VIBERZI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Irritable bowel syndrome with diarrhea: Failure or clinically significant adverse effects to the all of the formulary alternatives: dicyclomine and loperamide.

VIGABATRIN

Products Affected

- *vigabatrin oral powder in packet*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Refractory Complex Partial Seizures only: Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide

VIIBRYD

Products Affected

- VIIBRYD ORAL TABLET
- VIIBRYD ORAL TABLETS,DOSE PACK
10 MG (7)- 20 MG (23)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, paroxetine, or sertraline.

VIMPAT

Products Affected

- VIMPAT ORAL SOLUTION
- VIMPAT ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.

VITRAKVI

Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation. Documentation of no satisfactory alternative treatments or that disease has progressed following previous treatment.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

VIZIMPRO

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of EGFR exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VORICONAZOLE

Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VOSEVI

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status.
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	12 weeks.
Other Criteria	Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

VRAYLAR

Products Affected

- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE,DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Bipolar and Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, or ziprasidone.

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of anaplastic lymphoma kinase (ALK) or ROS1 positive mutation detected by an FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

XATMEP

Products Affected

- XATMEP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist, Pediatrician, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

XERMELO

Products Affected

- XERMELO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of four or more bowel movements daily despite the use of octreotide
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist, Gastroenterologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

XIFAXAN

Products Affected

- XIFAXAN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Hepatic encephalopathy: Failure or clinically significant adverse effects to the formulary alternative: lactulose. Irritable bowel syndrome with diarrhea: Failure or clinically significant adverse effects to the formulary alternative: loperamide. Traveler's diarrhea: Failure or clinically significant adverse effects to the formulary alternative: ciprofloxacin.

XIIDRA

Products Affected

- XIIDRA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of test results confirming the diagnosis, such as: Tear break-up test (TBUT), Ocular surface disease index (OSDI), Schirmer's test, Visual analog scale (VAS), Symptom assessment in dry eye (SANDE), McMonnies questionnaire, etc.
Age Restrictions	N/A
Prescriber Restrictions	Ophthalmologist, Optometrist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

XOLAIR

Products Affected

- XOLAIR SUBCUTANEOUS RECON SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Asthma (Initial): Forced expiratory volume in one second or peak expiratory flow less than or equal to 80% of predicted level, or measures of asthma control indicate uncontrolled asthma (eg, Asthma Control Test [ACT] score 19 or less). Baseline (pre-Xolair treatment) serum total IgE level greater than or equal to 30 IU/mL. Positive skin test or in vitro reactivity to a perennial aeroallergen.
Age Restrictions	N/A
Prescriber Restrictions	Allergist, Dermatologist, Immunologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.

XOSPATA

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented FLT3 mutation detected by an FDA-approved test
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year
Other Criteria	N/A

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	Daytime excessive sleepiness in patients with narcolepsy: Failure or clinically significant adverse effects to the formulary alternative: modafinil.

YONSA

Products Affected

- YONSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented concurrent use with methylprednisolone
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ZALEPLON

Products Affected

- *zaleplon*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: lorazepam, Rozerem, temazepam, trazodone, or triazolam.

ZEJULA

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented completion of two or more platinum-based chemotherapy regimens and are in a complete or partial response.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Wild-type BRAF melanoma.
Required Medical Information	Malignant melanoma: Documentation of BRAF V600E mutation by a FDA approved test, Erdheim-Chester Disease: Documentation of BRAF V600 mutation by a FDA approved test
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ZEPATIER

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status.
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	12 to 16 weeks dependent on genotype and polymorphism, cirrhosis, or previous treatment.
Other Criteria	For genotype 1a: Documentation for NS5A polymorphism testing. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. Failure or clinically significant adverse effects to the formulary alternative: Mavyret.

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two prior systemic therapies.

ZOLPIDEM

Products Affected

- *zolpidem oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	N/A
Coverage Duration	3 months.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: lorazepam, Rozerem, temazepam, trazodone, or triazolam.

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two prior systemic therapies.

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of Anaplastic Lymphoma Kinase (ALK) Positive.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

ZYPREXA RELPREVV

Products Affected

- **ZYPREXA RELPREVV
INTRAMUSCULAR SUSPENSION FOR
RECONSTITUTION 210 MG**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Until the end of calendar year.
Other Criteria	The member has a documented history of receiving oral olanzapine without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.

ZYTIGA

Products Affected

- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of concurrent treatment with prednisone.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- *acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg/3 ml (0.083 %), 5 mg/ml*
- **AMINOSYN II 8.5 %-ELECTROLYTES INTRAVENOUS PARENTERAL SOLUTION 8.5 %**
- **AMINOSYN-HBC 7% INTRAVENOUS PARENTERAL SOLUTION 7 %**
- *azathioprine oral tablet 50 mg*
- *budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml*
- *calcitriol oral capsule 0.25 mcg, 0.5 mcg*
- *calcitriol oral solution 1 mcg/ml*
- *chlorpromazine oral tablet 25 mg*
- **CLINIMIX 4.25%/D10W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- **CLINIMIX 4.25%/D5W SULFIT FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- **CLINIMIX 4.25%-D25W SULF-FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- **CLINIMIX E 4.25%/D10W SUL FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- **CLINIMIX E 4.25%/D25W SUL FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- **CLINIMIX E 4.25%/D5W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %**
- *clinisol sf 15 % intravenous parenteral solution 15 %*
- *colistin (colistimethate na) injection recon soln 150 mg*
- *cromolyn inhalation solution for nebulization 20 mg/2 ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *dextrose 10 % in water (d10w) intravenous parenteral solution 10 %*
- **DURAMORPH (PF) INJECTION SOLUTION 0.5 MG/ML, 1 MG/ML**
- **ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML**
- **ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML**
- *granisetron hcl oral tablet 1 mg*
- *heparin (porcine) injection solution 1,000 unit/ml, 10,000 unit/ml, 20,000 unit/ml, 5,000 unit/ml*
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml*
- **ISOLYTE-S INTRAVENOUS PARENTERAL SOLUTION**
- *levocarnitine oral tablet 330 mg*
- *methotrexate sodium (pf) injection solution 25 mg/ml*
- *methotrexate sodium injection solution 25 mg/ml*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension for reconstitution 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet, delayed release (dr/ec) 180 mg, 360 mg*
- **NEBUPENT INHALATION RECON SOLN 300 MG**
- *ondansetron hcl oral solution 4 mg/5 ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet, disintegrating 4 mg, 8 mg*

- **PLASMA-LYTE 148 INTRAVENOUS PARENTERAL SOLUTION**
- **PLASMA-LYTE A INTRAVENOUS PARENTERAL SOLUTION**
- *prednisone oral tablet 50 mg*
- **PROSOL 20 % INTRAVENOUS PARENTERAL SOLUTION**
- **PULMOZYME INHALATION SOLUTION 1 MG/ML**
- **RAPAMUNE ORAL SOLUTION 1 MG/ML**
- **RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML**
- **RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML**
- **SENSIPAR ORAL TABLET 30 MG, 60 MG, 90 MG**
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- **TRAVASOL 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %**
- *vancomycin intravenous recon soln 1,000 mg, 10 gram, 250 mg, 500 mg, 750 mg*
- **ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG**
- **ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG, 1 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.

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