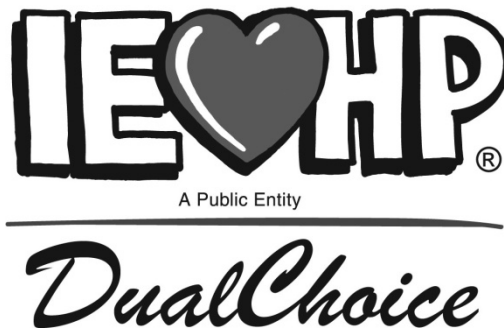


Prior Authorization Criteria  
Last Updated: June 23, 2020  
Effective Date: July 1, 2020



## 2020 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 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 deben llamar al 1-800-718-4347. La llamada es gratuita.

# ABELCET

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## Products Affected

- ABELCET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented history of receiving oral aripiprazole without any clinically significant side effects. Failure or clinically significant adverse effects to two of the formulary alternatives: Invega Sustenna, Invega Trinza or Risperdal Consta.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ACITRETIN

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## Products Affected

- *acitretin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Dermatologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: calcipotriene, clobetasol, cyclosporine, fluocinonide, methotrexate, or Tazorac.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ACTIMMUNE

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## Products Affected

- ACTIMMUNE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist, Infectious Disease specialist, Oncologist, Orthopedist, Rheumatologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ADEFOVIR

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## Products Affected

- *adefovir*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Gastroenterologist, Hepatologist, Infectious Disease specialist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ADHD

## Products Affected

- *dexmethylphenidate 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*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ALLI

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## Products Affected

- ALLI 60 MG CAPSULE STARTER PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	BMI greater than or equal to 27 kg/m <sup>2</sup> 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 <sup>2</sup> . 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# AMBISOME

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## Products Affected

- AMBISOME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# AMITRIPTYLINE

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## Products Affected

- *amitriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
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.
Indications	All FDA-approved Indications.
Off Label Uses	

# AMOXAPINE

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## Products Affected

- *amoxapine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# AMPHOTERICIN B

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## Products Affected

- *amphotericin b*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ANADROL

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## Products Affected

- ANADROL-50

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist, Oncologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ANDROGENS

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## 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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ANTICONVULSANTS 1

## Products Affected

- APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG
- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG
- EPIDIOLEX
- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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, valproic acid or zonisamide.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

## ANTICONVULSANTS 2

### Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- VIMPAT ORAL SOLUTION
- VIMPAT ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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, valproic acid or zonisamide.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# ANTIFIBROTIC AGENTS

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Esbriet: Severe hepatic impairment (Child-Pugh C). Ofev: Moderate or severe hepatic impairment (Child-Pugh B or C).
<b>Required Medical Information</b>	Initial authorization: Diagnosis of idiopathic pulmonary fibrosis confirmed by the presence of usual interstitial pneumonia on high resolution computed tomography (HRCT) and/or surgical lung biopsy. Documentation of liver function tests, documentation of baseline forced vial capacity (FVC) greater than or equal to 50 percent of the predicted value AND documentation of percent predicted diffusing capacity of the lungs for carbon monoxide (%DLCO) greater than or equal to 30 percent. Diagnosis of systemic sclerosis-associated interstitial lung disease for Ofev only. Documentation of liver function tests. Reauthorization only: Documentation of positive response to medication therapy AND documentation of liver function tests.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Pulmonologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ANTINEOPLASTIC

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## Products Affected

- *abiraterone*
- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG
- ALECENSA
- ALUNBRIG
- AYVAKIT
- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG
- BOSULIF
- BRAFTOVI ORAL CAPSULE 75 MG
- BRUKINSA
- CABOMETYX
- CALQUENCE
- CAPRELSA
- COMETRIQ
- COPIKTRA
- COTELLIC
- DAURISMO ORAL TABLET 100 MG, 25 MG
- ERIVEDGE
- ERLEADA
- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*
- FARYDAK ORAL CAPSULE 10 MG, 20 MG
- GILOTRIF
- IBRANCE
- ICLUSIG ORAL TABLET 15 MG, 45 MG
- IDHIFA
- *imatinib oral tablet 100 mg, 400 mg*
- IMBRUVICA ORAL CAPSULE
- IMBRUVICA ORAL TABLET 280 MG, 420 MG, 560 MG
- INLYTA ORAL TABLET 1 MG, 5 MG
- INREBIC
- IRESSA
- JAKAFI
- KISQALI FEMARA CO-PACK
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)
- KOSELUGO ORAL CAPSULE 10 MG, 25 MG
- 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 X 2), 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)
- LONSURF
- LORBRENA ORAL TABLET 100 MG, 25 MG
- LYNPARZA ORAL TABLET
- MATULANE
- MEKINIST ORAL TABLET 0.5 MG, 2 MG
- MEKTOVI
- NERLYNX
- NEXAVAR
- NINLARO
- NUBEQA
- ODOMZO
- PANRETIN
- PEMAZYRE
- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X 1-50 MG X 1), 300 MG/DAY (150 MG X 2)
- POMALYST
- PURIXAN
- REVLIMID
- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG
- RUBRACA
- RYDAPT
- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG
- STIVARGA
- SUTENT
- SYNRIPO
- TABLOID
- TAFINLAR

- TAGRISSO
- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG
- TASIGNA
- TAZVERIK
- THALOMID
- TIBSOVO
- TURALIO
- TYKERB
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION
- VIZIMPRO
- VOTRIENT
- XALKORI
- XOSPATA
- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 160 MG/WEEK (20 MG X 8), 60 MG/WEEK (20 MG X 3), 80 MG/WEEK (20 MG X 4)
- XTANDI
- YONSA
- ZEJULA
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET
- ZYTIGA ORAL TABLET 500 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

# APOKYN

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## Products Affected

- APOKYN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# APREPITANT

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## Products Affected

- *aprepitant*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ARCALYST

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## Products Affected

- ARCALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrently taking any tumor necrosis factor (TNF)-blocking agents such as Enbrel, Humira, or Remicade.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if 12 years old or older.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ARIPIPIRAZOLE

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## Products Affected

- *aripiprazole oral solution*
- *aripiprazole oral tablet, disintegrating*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of difficulty or inability to swallow or failure or clinically significant adverse effects to the formulary alternative: oral aripiprazole.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ATOVAQUONE

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## Products Affected

- *atovaquone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Pneumocystic pneumonia: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim/sulfamethoxazole.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# AUBAGIO

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## Products Affected

- AUBAGIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# AUSTEDO

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with an MAOI.
<b>Required Medical Information</b>	Chorea (Huntington's Disease): Failure or clinically significant adverse effects to the formulary alternative: tetrabenazine. Reauthorization only: Documentation of positive response to medication therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist, Psychiatrist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# CARISOPRODOL

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## Products Affected

- *carisoprodol oral tablet 350 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# CASPOFUNGIN

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## Products Affected

- *caspofungin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# CLOMIPRAMINE

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## Products Affected

- *clomipramine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: fluoxetine, fluvoxamine, paroxetine, or sertraline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# CLOZAPINE

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow or failure or clinically significant adverse effects to the formulary alternative: oral clozapine.
Age Restrictions	
Prescriber Restrictions	Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

# CONSTIPATION AGENTS

## Products Affected

- AMITIZA
- LINZESS
- MOVANTIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to one of the formulary alternatives: lactulose or polyethylene glycol.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

# CORLANOR

## Products Affected

- CORLANOR ORAL SOLUTION
- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Heart failure in adult patients: 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 (bpm). 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. Heart failure in pediatric patients: Documented NYHA/Ross class II to IV heart failure with an ejection fraction of less than or equal to 45% and sinus rhythm with a resting heart rate greater than or equal to 105 bpm in the age subset 6-12 months, greater than or equal to 95 bpm in the age subset 1-3 years, greater than or equal to 75 bpm in the age subset 3-5 years, greater than or equal to 70 bpm in the age subset 5-18 years
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Cardiologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# CYCLOBENZAPRINE

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## Products Affected

- *cyclobenzaprine oral tablet 10 mg, 5 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# DALFAMPRIDINE

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## Products Affected

- *dalfampridine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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). Reauthorization only: Documentation of positive response to medication therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# DALIRESP

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## Products Affected

- DALIRESP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: either Wixela or Fluticasone/Salmeterol, Anoro Ellipta, Serevent, Spiriva or Tudorza.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# DAPTOMYCIN

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## Products Affected

- *daptomycin intravenous recon soln 500 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Infectious Disease specialist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# DARAPRIM

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## Products Affected

- *pyrimethamine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist, HIV specialist, Infectious Disease specialist, Oncologist, Transplant specialist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Primary prophylaxis of toxoplasmic encephalitis: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim-sulfamethoxazole.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

# DEFERASIROX

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## Products Affected

- *deferasirox oral tablet, dispersible*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# DESIPRAMINE

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## Products Affected

- *desipramine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, venlafaxine, duloxetine, desvenlafaxine
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# DIAZEPAM SOLUTION

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## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	



# DISOPYRAMIDE

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## Products Affected

- *disopyramide phosphate oral capsule*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: acebutolol, amiodarone, flecainide, mexiletine, propafenone, quinidine, or sotalol.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# DOXEPIN

## Products Affected

- *doxepin oral capsule*
- *doxepin oral concentrate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
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.
Indications	All FDA-approved Indications.
Off Label Uses	

# DRIZALMA

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## Products Affected

- DRIZALMA SPRINKLE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of difficulty or inability to swallow an intact capsule or failure or clinically significant adverse effects to the formulary alternative: duloxetine.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# DRONABINOL

## Products Affected

- *dronabinol*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Chemotherapy-induced nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, metoclopramide, ondansetron, or prochlorperazine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# DROXIDOPA

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## Products Affected

- NORTHERA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ELIGARD

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Oncologist, Urologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# EMSAM

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## Products Affected

- EMSAM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to all of the formulary alternatives: phenelzine and tranylcypromine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ENBREL

## Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Dermatologist, Rheumatologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# ENTECAVIR

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## Products Affected

- BARACLUDE ORAL SOLUTION
- *entecavir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

# ENTRESTO

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## Products Affected

- ENTRESTO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of Chronic Heart Failure (NYHA Class II-IV) and reduced ejection fraction less than or equal to 40%.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Cardiologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# EPOGEN

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Uncontrolled hypertension.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

# ERTAPENEM

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## Products Affected

- *ertapenem*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Infectious Disease specialist
<b>Coverage Duration</b>	14 days.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ESTROGENS

## Products Affected

- *estradiol oral*
- *estradiol transdermal patch weekly*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# FENTANYL LOZENGE

## Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Acute, intermittent, or postoperative pain.
<b>Required Medical Information</b>	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 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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Pain Specialist, Oncologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# FETZIMA

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## Products Affected

- FETZIMA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# FILGRASTIM

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## Products Affected

- FULPHILA
- NEUPOGEN
- ZARXIO
- ZIEXTENZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to formulary alternative: Nivestym.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist, Infectious Disease specialist, Oncologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# FIRAZYR

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## Products Affected

- *icatibant*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Allergist, Immunologist, Hematologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# FIRMAGON

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## Products Affected

- FIRMAGON KIT W DILUENT SYRINGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Oncologist, Urologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# GENOTROPIN

## Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Endocrinologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# GEODON SOLUTION

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## Products Affected

- GEODON INTRAMUSCULAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# GILENYA

## Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# GLATIRAMER

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## Products Affected

- *glatiramer*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# GLATOPA

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## Products Affected

- *glatopa*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# 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
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
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.
Indications	All FDA-approved Indications.
Off Label Uses	



# GUANFACINE

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# HP ACTHAR

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## Products Affected

- ACTHAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist for infantile spasm and exacerbation of multiple sclerosis
<b>Coverage Duration</b>	Multiple sclerosis: 21 days. For other approved indications: 28 days.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# HRM ANTIPSYCHOTICS

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, ziprasidone, or aripiprazole.
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# 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
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Plaque psoriasis: documentation of psoriasis involving 3% of BSA or greater, or affecting crucial body areas such as hands, feet, face or genitals. 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.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Dermatologist, Gastroenterologist, Ophthalmologist, Rheumatologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# HUMIRA PEDIATRIC CROHNS

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## Products Affected

- HUMIRA(CF) PEDI CROHNS STARTER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# HUMIRA PSORIASIS

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## Products Affected

- HUMIRA PEN PSOR-UVEITS-ADOL  
HS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Plaque psoriasis: documentation of psoriasis involving 3% of BSA or greater, or affecting crucial body areas such as hands, feet, face or genitals. Failure or clinically significant adverse effects to two of the following: acitretin, cyclosporine, methotrexate or phototherapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Dermatologist, Rheumatologist, Ophthalmologist, Gastroenterologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# IMIPRAMINE

## Products Affected

- *imipramine hcl*
- *imipramine pamoate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# IMMUNOGLOBULIN

## Products Affected

- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- GAMMAGARD LIQUID
- GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
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.
Indications	All FDA-approved Indications.
Off Label Uses	



# INCRELEX

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## Products Affected

- INCRELEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Endocrinologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# INDOMETHACIN

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## Products Affected

- *indomethacin oral capsule*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, ibuprofen, meloxicam, nabumetone, naproxen, or sulindac.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# INGREZZA

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## Products Affected

- INGREZZA
- INGREZZA INITIATION PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to the formulary alternative: Austedo. Documentation of baseline Abnormal Involuntary Movement Scale (AIMS) scores. Reauthorization only: Documentation of positive response to medication therapy as evidenced by an improved AIMS score as compared to baseline.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist, Psychiatrist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# INTERFERON BETA-1A

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## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

# INTRALIPID

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## Products Affected

- INTRALIPID INTRAVENOUS EMULSION 30 %

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# INVEGA SUSTENNA

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## Products Affected

- INVEGA SUSTENNA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to the formulary alternative: oral paliperidone.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# INVEGA TRINZA

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## Products Affected

- INVEGA TRINZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to all of the formulary alternatives: oral paliperidone and Invega Sustenna.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ISOTRETINOIN

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## Products Affected

- *claravis*
- *isotretinoin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist
Coverage Duration	20 weeks.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	



# ITRACONAZOLE

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## Products Affected

- *itraconazole oral solution*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# KALYDECO

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## Products Affected

- KALYDECO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Infectious Disease specialist, Pulmonologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# KINERET

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## Products Affected

- KINERET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Pediatrician, Rheumatologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# KORLYM

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## Products Affected

- KORLYM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# LEDIPASVIR-SOFOSBUVIR

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## Products Affected

- *ledipasvir-sofosbuvir*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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. 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: sofosbuvir-velpatasvir (generic Epclusa).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Gastroenterologist, Hepatologist, Infectious Disease specialist
<b>Coverage Duration</b>	12 weeks.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# LEUKINE

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## Products Affected

- LEUKINE INJECTION RECON SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Excessive leukemia myeloid blasts in the bone marrow or peripheral blood equal to or greater than 10%.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist, Oncologist
<b>Coverage Duration</b>	3 months.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to the formulary alternative: Zarxio.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# LEUPROLIDE ACETATE

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## Products Affected

- *leuprolide subcutaneous kit*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Oncologist, Urologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# LEVALBUTEROL

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## 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*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to the formulary alternative: albuterol inhalant solution.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# LIDOCAINE PATCH

## Products Affected

- *lidocaine topical adhesive patch, medicated 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternatives: gabapentin.
Indications	All FDA-approved Indications.
Off Label Uses	

# LINEZOLID

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

# LUPRON DEPOT

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## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Endometriosis: Patient has had surgical ablation to prevent recurrence, or history of failure, contraindication, or intolerance to oral contraceptives.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# LYRICA

## Products Affected

- *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg*
- *pregabalin oral solution*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# MEGESTROL

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Cachexia associated with AIDS: Failure or clinically significant adverse effects to all of the formulary alternatives: dronabinol and oxandrolone.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

# MEPROBAMATE

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## Products Affected

- *meprobamate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to at least two of the formulary alternatives: buspirone, duloxetine, escitalopram, paroxetine, or venlafaxine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# METHOCARBAMOL

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## Products Affected

- *methocarbamol oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# METHOXSALLEN

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## Products Affected

- *methoxsalen*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Dermatologist, Rheumatologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: calcipotriene, clobetasol, cyclosporine, fluocinonide, methotrexate, or tazarotene.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# METHYLDOPA

## Products Affected

- *methyldopa*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# METHYLDOPA/HYDROCHLOROTHIAZIDE

## Products Affected

- *methyldopa-hydrochlorothiazide*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# METYROSE

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## Products Affected

- DEMSER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Essential hypertension.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# MODAFINIL

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## Products Affected

- *modafinil*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Narcolepsy: Failure or clinically significant adverse effects to all of the formulary alternatives: dextroamphetamine and methylphenidate.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# MULTAQ

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## Products Affected

- MULTAQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Cardiologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# MYCAMINE

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## Products Affected

- MYCAMINE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# NAYZILAM

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## Products Affected

- NAYZILAM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# NEUPRO

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## Products Affected

- NEUPRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# NUCALA

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## Products Affected

- NUCALA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Asthma: Failure or clinically significant adverse effects to two of the formulary alternatives: 1) budesonide, Flovent, Arnuity Ellipta or Qvar and 2) fluticasone-salmeterol, Wixela, or Breo Ellipta.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Allergist, Immunologist, Pulmonologist, Rheumatologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# NUEDEXTA

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## Products Affected

- NUEDEXTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# NUPLAZID

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## Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# NUTRILIPID

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## Products Affected

- NUTRILIPID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# OCTREOTIDE

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## Products Affected

- *octreotide acetate injection solution*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# OLANZAPINE ODT

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## Products Affected

- *olanzapine oral tablet, disintegrating*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of difficulty or inability to swallow or failure or clinically significant adverse effects to the formulary alternative: oral olanzapine.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# OLANZAPINE SOLUTION

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## Products Affected

- *olanzapine intramuscular*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# OMNITROPE

## Products Affected

- OMNITROPE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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/m <sup>2</sup> , at or below 8mcg/L if BMI at or above 25 and below 30kg/m <sup>2</sup> , or at or below 4mcg/L if BMI at or above 30kg/m <sup>2</sup> ],[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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Endocrinologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# ORAL ANTIPSYCHOTICS

## Products Affected

- CAPLYTA
- FANAPT
- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG
- *paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 6 mg, 9 mg*
- *quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg*
- SAPHRIS
- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone, ziprasidone or aripiprazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

# ORENCIA

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## 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
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
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.
Indications	All FDA-approved Indications.
Off Label Uses	

# ORKAMBI

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## Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of homozygous F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Infectious Disease specialist, Pulmonologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# OXANDROLONE

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## Products Affected

- *oxandrolone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# OXBRYTA

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## Products Affected

- OXBRYTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of at least 1 episode of vaso-occlusive crisis (VOC) in the past 12 months. Hemoglobin (Hgb) greater than or equal to 5.5 and less than or equal to 10.5 g/dL. Re-authorization: Increase from baseline hemoglobin (Hgb) by greater than or equal to 1g/dL.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hematologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# OXERVATE

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## Products Affected

- OXERVATE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of Stage 2 or 3 neurotrophic keratitis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Ophthalmologist
<b>Coverage Duration</b>	8 weeks.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# PAH

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## Products Affected

- *ambrisentan*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to the formulary alternative: sildenafil or tadalafil.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Cardiologist, Pulmonologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# PARATHYROID HORMONE ANALOGS

## Products Affected

- FORTEO
- TYMLOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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. Failure or clinically significant adverse effects to one of the formulary alternatives: alendronic acid or risedronate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Medical justification required for treatment duration beyond 24 months.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# PDE5 INHIBITORS

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## Products Affected

- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with nitrates or PDE5 inhibitors.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

# PEGASYS

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic Hepatitis C: Treatment length is determined by FDA labeling or AASLD recommendation
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

# PHENOBARBITAL

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## Products Affected

- *phenobarbital*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# PHENTERMINE

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	BMI greater than or equal to 27 kg/m <sup>2</sup> 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 <sup>2</sup> . Reauthorization: Documented weight loss of 5% during the first 3 month period and lack of side effects.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# PIMECROLIMUS

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## Products Affected

- *pimecrolimus*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# POSACONAZOLE

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## Products Affected

- *noxafil oral suspension*
- *posaconazole oral tablet, delayed release (dr/ec)*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to one of the formulary alternatives: fluconazole, itraconazole, or voriconazole.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# PREMARIN TABLETS

## Products Affected

- PREMARIN ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
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.
Indications	All FDA-approved Indications.
Off Label Uses	

# PREMPRO TABLETS

## Products Affected

- PREMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
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.
Indications	All FDA-approved Indications.
Off Label Uses	



# PROCRIT

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Uncontrolled hypertension.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

# PROLIA

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## Products Affected

- PROLIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of 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 (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. Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# PROMACTA

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## Products Affected

- PROMACTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of platelet count. Thrombocytopenia in hepatitis C infection: Documentation of concurrent or planned interferon-based treatment of chronic hepatitis C.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Gastroenterologist, Hematologist, Hepatologist, Infectious Disease specialist, Oncologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Chronic immune (idiopathic) thrombocytopenia: Failure or clinically significant adverse effects to one of the formulary alternatives: dexamethasone, methylprednisolone, prednisolone or prednisone.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# PROMETHAZINE

## Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# PROTRIPTYLINE

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## Products Affected

- *protriptyline*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# QUININE

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## Products Affected

- *quinine sulfate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Prevention or treatment of nocturnal leg cramps.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	10 days.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to one of the formulary alternatives: chloroquine or hydroxychloroquine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# RANOLAZINE

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## Products Affected

- *ranolazine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Concurrent use with strong CYP3A inhibitors or CYP3A inducers.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# RAYALDEE

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## Products Affected

- RAYALDEE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Stage 5 chronic kidney disease or end stage renal disease on dialysis.
<b>Required Medical Information</b>	Documented serum total 25-hydroxyvitamin D levels less than 30 ng/mL
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Nephrologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# REPATHA

## Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Primary hyperlipidemia: Documentation of current LDL levels above 100mg/dL while taking maximally tolerated statin therapy and ezetimibe therapy, unless intolerant or contraindicated to statin or ezetimibe therapy. Secondary prevention of ASCVD: Documentation of at least one high risk feature: recent ACS (within the past 12 months), history of MI, history of ischemic stroke, or symptomatic peripheral arterial disease (history of claudication with ABI greater than 0.85, or previous revascularization or amputation). Heterozygous Familial Hypercholesterolemia (HeFH) or Homozygous Familial Hypercholesterolemia (HoFH): Documentation to confirm diagnosis by genetic testing or by clinical criteria (such as Simon Broome or the Dutch Lipid Clinic Network criteria, or history of untreated LDL-C greater than 180 mg/dL together with xanthoma or cornealis), or evidence of Familial Hypercholesterolemia in first or second-degree relatives.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Cardiologist, Endocrinologist, Lipid specialist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# RESTASIS

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## Products Affected

- RESTASIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Ophthalmologist, Optometrist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# RETACRIT

## Products Affected

- RETACRIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Uncontrolled hypertension.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

# REXULTI

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## Products Affected

- REXULTI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, ziprasidone or aripiprazole. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# RISPERDAL CONSTA

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## Products Affected

- RISPERDAL CONSTA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to the formulary alternative: oral risperidone.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# RUFINAMIDE

## Products Affected

- BANZEL ORAL SUSPENSION
- BANZEL ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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, clobazam or zonisamide. For Rufinamide suspension: Failure or clinically significant adverse effects to one of the formulary alternatives: Rufinamide tablet.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# SAPROPTERIN

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## Products Affected

- KUVAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# SECUADO

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## Products Affected

- SECUADO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone, ziprasidone or aripiprazole.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# SIGNIFOR

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## Products Affected

- SIGNIFOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# SITAGLIPTIN

## Products Affected

- JANUMET
- JANUMET XR ORAL TABLET, ER
- MULTIPHASE 24 HR 100-1,000 MG, 50-1,000 MG, 50-500 MG
- JANUVIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to two of the formulary alternatives: metformin containing products and alogliptin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

# SOFOSBUVIR-VELPATASVIR

## Products Affected

- *sofosbuvir-velpatasvir*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Gastroenterologist, Hepatologist, Infectious Disease specialist
<b>Coverage Duration</b>	12 weeks.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# SOMATULINE DEPOT

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## Products Affected

- SOMATULINE DEPOT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Endocrinologist, Oncologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to the formulary alternative: octreotide.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# SOMAVERT

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## Products Affected

- SOMAVERT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Endocrinologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to the formulary alternative: octreotide.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# SPRITAM

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## Products Affected

- SPRITAM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to the formulary alternative: levetiracetam oral solution.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# STELARA

## Products Affected

- STELARA SUBCUTANEOUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Dermatologist, Gastroenterologist, Rheumatologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# SYLATRON

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## Products Affected

- SYLATRON SUBCUTANEOUS KIT  
200 MCG, 300 MCG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Dermatologist, Oncologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# SYMDEKO

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## Products Affected

- SYMDEKO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Infectious Disease specialist, Pulmonologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# SYMLIN

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## Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Confirmed gastroparesis.
<b>Required Medical Information</b>	Documentation of a history of HbA1C scores of 7% or higher after at least 3 months of optimal therapy with insulin.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# SYMPAZAN

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## Products Affected

- SYMPAZAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of difficulty or inability to swallow. 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, valproic acid or zonisamide.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# SYNAREL

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## Products Affected

- SYNAREL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# TACROLIMUS OINTMENT

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## Products Affected

- *tacrolimus topical*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the topical formulary alternatives: clobetasol, betamethasone, fluocinolone, or fluocinonide.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# TAKHZYRO

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## Products Affected

- TAKHZYRO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing. Failure or clinically significant adverse effects to the formulary alternative: danazol.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Allergist, Immunologist, Hematologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# TAZORAC

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
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.
Indications	All FDA-approved Indications.
Off Label Uses	

# TECFIDERA

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## Products Affected

- TECFIDERA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# TESTOSTERONE

## Products Affected

- *testosterone cypionate intramuscular oil*  
100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)
- *testosterone enanthate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Hypogonadism: Documentation of testosterone levels below the lab reference range.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

# TESTOSTERONE PUMP

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## Products Affected

- *testosterone transdermal gel in metered-dose pump*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: Androderm, testosterone cypionate, testosterone enanthate or testosterone transdermal gel.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# TETRABENAZINE

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## Products Affected

- *tetrabenazine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# TIGECYCLINE

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## Products Affected

- *tigecycline*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Infectious Disease specialist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# TOBI PODHALER

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## Products Affected

- TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Infectious Disease specialist, Pulmonologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# TOBRAMYCIN SOLUTION

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## Products Affected

- *tobramycin in 0.225 % nacl*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Infectious Disease specialist, Pulmonologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# TOFACITINIB

## Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Rheumatoid Arthritis: 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. Ulcerative colitis: Failure or clinically significant adverse effects to the formulary alternative: Humira.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Gastroenterologist, Rheumatologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# TOLCAPONE

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## Products Affected

- *tolcapone*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documentation of concurrent use with levodopa and carbidopa.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# TRIENTINE

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## Products Affected

- *trientine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Biliary cirrhosis, rheumatoid arthritis.
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to the formulary alternative: Depen.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# TRIHXYPHENIDYL

## Products Affected

- *trihexyphenidyl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
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.
Indications	All FDA-approved Indications.
Off Label Uses	

# TRIMIPRAMINE

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## Products Affected

- *trimipramine*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# TRINTELLIX

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## Products Affected

- TRINTELLIX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, or sertraline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# VALCHLOR

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## Products Affected

- VALCHLOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Dermatologist, Oncologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# VANCOMYCIN CAPSULE

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## Products Affected

- *vancomycin oral capsule 125 mg, 250 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	C diff diarrhea: Reauthorization: Documentation of C. Difficile positive stool
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	3 months.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# VEMLIDY

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## Products Affected

- VEMLIDY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hepatologist, Gastroenterologist, Infectious Disease specialist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# VIBERZI

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## Products Affected

- VIBERZI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	History of gallbladder removal.
<b>Required Medical Information</b>	Failure or clinically significant adverse effects to the all of the formulary alternatives: dicyclomine and loperamide.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# VIGABATRIN

## Products Affected

- *vigabatrin oral powder in packet*
- *vigabatrin oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Neurologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	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
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# VIIBRYD

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## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, paroxetine, or sertraline.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# VORICONAZOLE

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## Products Affected

- *voriconazole intravenous*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# XATMEP

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## Products Affected

- XATMEP

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Oncologist, Pediatrician, Rheumatologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# XGEVA

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## Products Affected

- XGEVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Oncologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# XIFAXAN

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## Products Affected

- XIFAXAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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 all of the formulary alternative: loperamide. Traveler's diarrhea: Failure or clinically significant adverse effects to one of the formulary alternatives: ciprofloxacin or levofloxacin.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# XIIDRA

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## Products Affected

- XIIDRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Ophthalmologist, Optometrist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# XOLAIR

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## Products Affected

- XOLAIR SUBCUTANEOUS RECON SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Allergist, Dermatologist, Immunologist, Pulmonologist
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Subject to Part B vs Part D determination.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	



# XYREM

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## Products Affected

- XYREM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	Daytime excessive sleepiness in patients with narcolepsy: Failure or clinically significant adverse effects to the formulary alternative: modafinil.
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ZEPATIER

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## Products Affected

- ZEPATIER

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	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. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. For genotype 1a: Documentation for NS5A polymorphism testing.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Gastroenterologist, Hepatologist, Infectious Disease specialist
<b>Coverage Duration</b>	12 to 16 weeks dependent on genotype and polymorphism, cirrhosis, or previous treatment.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

# ZYPREXA RELPREVV

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## Products Affected

- ZYPREXA RELPREVV  
INTRAMUSCULAR SUSPENSION FOR  
RECONSTITUTION 210 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented history of receiving oral olanzapine without any clinically significant side effects. Failure or clinically significant adverse effects to two of the formulary alternatives: Invega Sustenna, Invega Trinza or Risperdal Consta.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Until the end of calendar year.
<b>Other Criteria</b>	
<b>Indications</b>	All FDA-approved Indications.
<b>Off Label Uses</b>	

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