Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

HETLIOZ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

HUMAN GROWTH HORMONE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

CHILDREN AND ADOLESCENTS WITH GROWTH HORMONE DEFICIENCY, SHOX DEFICIENCY IN CHILDREN: Baseline height must be greater than 2 standard deviations below the mean for gender and age. Growth rate is such that the member is unlikely to attain an adult height in the normal range - 59 inches for girls and 63 inches for boys. TURNER SYNDROME: Confirmed by karyotype. PRADER-WILLI or NOONAN SYNDROME: Baseline height must be less than the 5th percentile for gender and age OR 2 or more standard deviations below the mean measured paternal height. Growth rate is such that the member is unlikely to attain an adult height in the normal range - 59 inches for girls and 63 inches for boys.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Adult Growth Hormone Deficiency: 12 months. HIV Wasting or Cachexia, Children: 6 months.

Other Criteria:

HIV Wasting or Cachexia: Member is being treated with concomitant antiretroviral therapy.

Prior Authorization Group Description:

HUMIRA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist. CROHN'S DISEASE, ULCERATIVE COLITIS: Prescribed by or in consultation with a gastrointestinal (GI) specialist. RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist. HIDRADENITIS SUPPURATIVA: Prescribed by or in consultation with a rheumatologist, dermatologist or GI specialist.

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PLAQUE PSORIASIS: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine or acitretin.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

HYDROCODONE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

3 months initial for non-malignant pain then 12 months. 12 months for cancer pain.

Other Criteria:

Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: MS Contin, Kadian, Duragesic, Opana ER, Avinza or Oxycontin.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

HYDROXYZINE HCL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Pruritus: Failure of one of the following topical agents, unless contraindicated or clinically significant adverse effects are experienced: betamethasone, hydrocortisone, triamcinolone, fluticasone, clobetasol, fluocinonide or fluocinolone. Anxiety: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: venlafaxine, buspirone, duloxetine or escitalopram. All other FDA approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Group Description:

HYDROXYZINE HCL INJECTION

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

HYDROXYZINE PAMOATE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Pruritus: Failure of one of the following topical agents, unless contraindicated or clinically significant adverse effects are experienced: betamethasone, hydrocortisone, triamcinolone, fluticasone, clobetasol, fluocinonide or fluocinolone. Anxiety: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: venlafaxine, buspirone, duloxetine or escitalopram. All other FDA approved indications: Patient is continuing on this medication without adverse effects.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ICLUSIG

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Acute Lymphoblastic Leukemia (ALL): Documentation of Philadelphia chromosome positive (Ph+) disease.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

IDHIFA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Presence of an isocitrate dehydrogenase-2 (IDH2) mutation.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

For age less than 60 years, disease has relapsed or is refractory following treatment with a first line chemotherapy regimen (e.g., cytarabine, idarubicin, daunorubicin, Vyxeos, cladribine, Rydapt, Mylotarg).

Prior Authorization Group Description:

ILARIS

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Acute gouty arthritis.

Exclusion Criteria:

Required Medical Information:

Documentation of current weight.

Age Restrictions:

Cryopyrin-Associated Periodic Syndromes: 4 years and older. All other covered indications: 2 years and older.

Prescriber Restrictions:

SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS: Prescribed by or in consultation with a dermatologist, rheumatologist, or gastrointestinal (GI) specialist. ALL OTHER COVERED INDICATIONS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

ILUMYA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of one of the following unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine or acitretin. Failure of one of the following unless contraindicated or clinically significant adverse effects are experienced: Cosentyx, Humira, Inflectra, Remicade, Stelara, Taltz, and Tremfya.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

IMATINIB

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

IMBRUVICA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

CHRONIC GRAFT-VERSUS-HOST DISEASE: Prescribed by or in consultation with an oncologist, hematologist, or bone marrow transplant specialist. ALL OTHER INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

MANTLE CELL LYMPHOMA: Member has received at least one prior therapy (e.g., Rituxan, vincristine, cytarabine, cisplatin, doxorubicin, Treanda). MARGINAL ZONE LYMPHOMA: Member has received at least one prior anti-CD20-based therapy.

Prior Authorization Group Description:

IMIPRAMINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Depression: Failure of one of the following generic antidepressants, unless contraindicated or clinically significant adverse effects are experienced: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine or venlafaxine XR.

Prior Authorization Group Description:

INDOMETHACIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of naproxen and sulindac, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

INFLECTRA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Psoriatic Arthritis/Plaque Psoriasis: Prescribed by or in consultation with a rheumatologist or dermatologist.
Crohn's Disease/Ulcerative Colitis: Prescribed by or in consultation with a gastrointestinal (GI) specialist.
Rheumatoid Arthritis/Ankylosing Spondylitis: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Rheumatoid Arthritis: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.
Plaque Psoriasis: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description:

INGREZZA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Development of tardive dyskinesia is secondary to a centrally acting dopamine receptor blocking agent (neuroleptic) (e.g., first- or second-generation antipsychotics such as chlorpromazine or aripiprazole, antiemetics such as promethazine or metoclopramide, the tri-cyclic antidepressant amoxapine).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a psychiatrist or neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

INLYTA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

FOLLICULAR CARCINOMA, HURTHLE CELL CARCINOMA, PAPILLARY CARCINOMA: Disease is iodine refractory and either unresectable or metastatic.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

INTERFERON BETA-1A

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

INTERFERON BETA-1B

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

INTERMEZZO 1.75 MG

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

INTERMEZZO 3.5 MG

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

INTUNIV

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Attention Deficit Hyperactivity Disorder: Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: dexmethylphenidate, methylphenidate or mixed amphetamine salts.

Prior Authorization Group Description:

JAKAFI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

POLYCYTHEMIA VERA: Failure of hydroxyurea, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

JUBLIA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of terbinafine tablets, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

JUXTAPID

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of Repatha 420 mg, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

JYNARQUE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a nephrologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

KADCYLA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Kadcyla will be used as a single-agent therapy.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

KADIAN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Medical justification as to why patient cannot take an equivalent daily dose of a generically available strength of Kadian.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

KALYDECO

Covered Uses:

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

Exclusion Criteria:

Patients with cystic fibrosis who are homozygous for the F508del mutation.

Required Medical Information:

Presence of one mutation in the CFTR gene that is responsive to ivacaftor as detected by an FDA-cleared cystic fibrosis mutation test.

Age Restrictions:

1 year of age or older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

KERYDIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of terbinafine tablets, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

KETOROLAC TROMETHAMINE

Covered Uses:

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

Exclusion Criteria:

Patients with active peptic ulcer disease. Advanced renal impairment or at risk for renal failure due to volume depletion. Suspected or confirmed cerebrovascular bleeding, hemorrhagic diathesis, incomplete hemostasis and those at high risk for bleeding. Patient currently receiving aspirin or NSAIDs (Non-steroidal anti-inflammatory drugs). Patient currently receiving Probenecid or pentoxifylline.

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

5 days.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

KEVEYIS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

KEVZARA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

KEYTRUDA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

CLASSICAL HODGKIN LYMPHOMA, PRIMARY MEDIASTINAL LARGE B-CELL LYMPHOMA: Prescribed by or in consultation with an oncologist or hematologist. ALL OTHER INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

KISQALI(Kisqali , Kisqali Femara Co-Pack)

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Breast cancer is hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, and advanced or metastatic.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

For Kisqali: Prescribed in combination with an aromatase inhibitor (e.g., letrozole, anastrozole, or exemestane), fulvestrant, or tamoxifen. If prescribed in combination with tamoxifen: Medical justification supports need to use tamoxifen over an aromatase inhibitor or fulvestrant. For men receiving an aromatase inhibitor: Prescribed in combination with an agent that suppresses testicular steroidogenesis (e.g., gonadotropin-releasing hormone agonists).

Prior Authorization Group Description:

KORLYM

Covered Uses:

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

Exclusion Criteria:

Pregnancy.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

KUVAN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Documentation of a reduction in blood phenylalanine levels since initiation of therapy.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial: 3 months. Reauthorization: 12 months.

Other Criteria:

Prior Authorization Group Description:

KYNAMRO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of Repatha 420 mg, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

LATUDA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of two of the following atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

LAZANDA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 18 or greater

Prescriber Restrictions:

Coverage Duration:

Through the end of the Plan contract year.

Other Criteria:

Patient is already taking and is tolerant to around-the-clock opioid therapy. Patients are considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Group Description:

LEMTRADA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of TWO of the following, unless contraindicated or clinically significant adverse effects are experienced: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, Copaxone, Glatopa, Extavia or Rebif.

Prior Authorization Group Description:

LENVIMA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

RENAL CELL CARCINOMA: Prescribed in combination with Afinitor AND if histology is clear cell or unknown, failure of a regimen consisting of or including one of the following drugs unless contraindicated or clinically significant adverse effects are experienced: Avastin, Cabometyx, Inlyta, Nexavar, Opdivo, Proleukin, Sutent, Tarceva, Torisel, Votrient, or Yervoy. MEDULLARY THYROID CARCINOMA: Failure of Cometriq or Caprelsa unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

LEUKINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Use Following Induction Chemotherapy in Acute Myelogenous Leukemia, Use in Mobilization and Following Transplantation of Autologous Peripheral Blood Progentior Cells, Use in Myeloid Reconstitution After Autologous or Allogeneic Bone Marrow Transplantation, Acute Radiation Syndrome: Failure of Neupogen, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

LIDODERM

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Diabetic peripheral neuropathy. Cancer-related neuropathic pain.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

LONSURF

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Documentation that the patient does or does not have the RAS (KRAS or NRAS) wild type gene.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: 5-fluorouracil, capecitabine, oxaliplatin, irinotecan, Avastin, Cyramza, Stivarga or Zaltrap. If tumor expresses the RAS wild type gene, failure of Erbitux or Vectibix, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

LORBRENA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Disease is ALK or ROS1 positive and either recurrent, advanced or metastatic.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

For ALK-positive disease: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: Alecensa, Alunbrig, Zykadia. For ROS1-positive disease: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: Xalkori, Zykadia.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

LOTRONEX

Covered Uses:

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

Exclusion Criteria:

Male patients.

Required Medical Information:

Female patient with irritable bowel symptoms persisting for at least 6 months.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

LUCEMYRA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Diagnosis of opioid dependence (may be limited to physiologic dependence/tolerance) or opioid use disorder. Member is currently or will be undergoing abrupt opioid discontinuation within the next seven days and one of the following: member has taken one or more opioids for at least the last three weeks OR an opioid antagonist (e.g., naltrexone) has been or will be administered after a period of opioid use. Medical justification supports why an opioid taper (e.g., with buprenorphine, methadone or other opioid) cannot be used. Lucemyra has not been prescribed for a prior opioid withdrawal event within the last 30 days or medical justification supports retreatment.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a physician specializing in one of the following areas: emergency medicine/inpatient care, pain management, addiction psychiatry.

Coverage Duration:

14 days per course of treatment.

Other Criteria:

Prior Authorization Group Description:

LUNESTA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: Rozerem, Silenor 6 mg/day or less, trazodone or temazepam.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

LYNPARZA CAPSULE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Mutations in the BRCA genes as detected by an FDA approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

LYNPARZA TABLET

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Ovarian, fallopian tube or primary peritoneal cancer: Mutations in the BRCA genes OR member has a complete or partial response to two or more platinum-based chemotherapy regimens. Breast Cancer: Mutations in the BRCA genes and documentation of human epidermal growth factor receptor 2 (HER2)-negative disease.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

MAVYRET

Covered Uses:

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

Exclusion Criteria:

Treatment-experienced patients with both NS3/4A protease inhibitor and NS5A inhibitor.

Required Medical Information:

If cirrhosis is present, confirmation of Child-Pugh A status. Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

8 to 16 weeks based on genotype, cirrhosis status, prior treatment regimen.

Other Criteria:

If member has been previously treated with an HCV regimen containing NS5A inhibitor or an NS3/4A protease inhibitor, but not both, member has genotype 1.

Prior Authorization Group Description:

MEGACE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

BREAST CANCER AND ENDOMETRIAL CANCER: Megestrol acetate is being used for palliative treatment.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

ANOREXIA AND CACHEXIA ASSOCIATED WITH AIDS: Failure of dronabinol and oxandrolone, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

MEGACE ES

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

BREAST CANCER AND ENDOMETRIAL CANCER: Megestrol acetate is being used for palliative treatment.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

ANOREXIA AND CACHEXIA ASSOCIATED WITH AIDS: Failure of dronabinol and oxandrolone, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

MEKINIST

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Uveal melanoma.

Exclusion Criteria:

Required Medical Information:

MELANOMA: Positive for BRAF V600E or V600K mutation as detected by an FDA-approved test. NON-SMALL CELL LUNG CANCER, ANAPLASTIC THYROID CANCER: Positive for BRAF V600E mutation as detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

NON-SMALL CELL LUNG CANCER, ANAPLASTIC THYROID CANCER: Prescribed in combination with Tafinlar.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

MEKTOVI

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Positive for BRAF V600E or V600K mutation as detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with Braftovi.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

MEPERIDINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Pain: Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: codeine, hydromorphone, morphine, oxymorphone, hydrocodone/acetaminophen or oxycodone.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

MEPROBAMATE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: venlafaxine, buspirone, duloxetine or escitalopram.

Prior Authorization Group Description:

METAXALONE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

METHAMPHETAMINE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Treatment of obesity.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

METHOCARBAMOL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

METHOTREXATE INJ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of generic methotrexate injection, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

METHYLDOPA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: amlodipine/benazepril, benazepril, benazepril/hydrochlorothiazide, captopril, captopril/hydrochlorothiazide, fosinopril, fosinopril/hydrochlorothiazide, lisinopril, lisinopril/hydrochlorothiazide, quinapril, quinapril/hydrochlorothiazide, losartan, losartan/hydrochlorothiazide, valsartan, valsartan/hydrochlorothiazide, irbesartan, irbesartan/hydrochlorothiazide, candesartan, candesartan/hydrochlorothiazide, carvedilol, labetalol, acebutolol, atenolol, bisoprolol, bisoprolol/hydrochlorothiazide, timolol, nadolol, propranolol, metoprolol, metoprolol/hydrochlorothiazide, pindolol, nifedipine SR, amlodipine, nicardipine.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

MIRCERA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of Procrit (epoetin alfa), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

MIRVASO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Erythema of rosacea with papules or pustules: Failure of topical metronidazole, oral doxycycline or Finacea, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

MOZOBIL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Must be administered in combination with a granulocyte-colony stimulating factor (G-CSF) (i.e., filgrastim, filgrastim-sndz, or tbo-filgrastim).

Prior Authorization Group Description:

MULPLETA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Recent (within the past 14 days) platelet count is less than 50 x 10^9/L. Member is scheduled to undergo a medical or dental procedure within the next 30 days.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a hematologist, hepatologist, or gastroenterologist.

Coverage Duration:

4 weeks.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

NAMENDA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Vascular dementia.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 59 years and younger. Prior authorization is not required for patients 60 years and older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

NATPARA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

NERLYNX

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Human epidermal growth factor receptor 2 (HER2)-positive breast cancer.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with capecitabine for recurrent brain metastases OR Documentation of previous treatment with trastuzumab as adjuvant therapy and disease is hormone receptor positive or early stage (stage 1-3).

Prior Authorization Group Description:

NEULASTA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Mobilization of peripheral-blood progenitor cells prior to autologous transplantation. Supportive care post autologous hematopoietic cell transplantation.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

NEUPOGEN

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Myelodysplastic syndrome. Neutropenia in patients with HIV/AIDS.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

NINLARO

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with dexamethasone.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

NITROFURANTOIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Urinary tract infectious disease, Acute treatment: Failure of ONE of the following, unless contraindicated or clinically significant adverse effects are experienced: sulfamethoxazole/trimethoprim or ciprofloxacin. Urinary tract infectious disease, Prophylaxis: Patient is continuing on this medication without adverse effects.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

NORTHERA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

NUCALA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Blood eosinophil count of greater than or equal to 150 cells/mcL within the past 3 months.

Age Restrictions:

ASTHMA: 12 years of age or older.

Prescriber Restrictions:

ASTHMA: Prescribed by or in consultation with an allergist, pulmonologist, or immunologist. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS: Prescribed by or in consultation with a pulmonologist, immunologist, rheumatologist, or nephrologist.

Coverage Duration:

12 months.

Other Criteria:

ASTHMA: Prescribed in combination with ONE inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide), unless contraindicated or clinically significant adverse effects are experienced AND Prescribed in combination with ONE long-acting beta-agonist (e.g., salmeterol, formoterol, vilanterol), unless contraindicated or clinically significant adverse effects are experienced. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS: Failure of ONE glucocorticoid, unless contraindicated or clinically significant adverse events are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

NUEDEXTA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

NUPLAZID

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

NUVIGIL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

OCALIVA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Must be used in combination with ursodeoxycholic acid unless patient is intolerant to ursodeoxycholic acid.

Prior Authorization Group Description:

OCREVUS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Relapsing Forms Of Multiple Sclerosis: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, Copaxone, Glatopa, Extavia or Rebif.

Prior Authorization Group Description:

ODOMZO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

OFEV

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

OLUMIANT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of one of the following agents, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine, or auranofin. Failure of at least one TNF inhibitor unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

OPSUMIT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

ORALAIR

Covered Uses:

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

Exclusion Criteria:

Severe, unstable or uncontrolled asthma. History of any severe allergic reaction to sublingual allergen immunotherapy.

Required Medical Information:

Positive skin test or in vitro testing for pollen-specific IgE antibodies for Sweet Vernal, Orchard, Perennial Rye, Timothy and Kentucky Blue Grass.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an allergist or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Failure to 2 of the following, unless contraindicated or clinically significant adverse effects are experienced: antihistamines, leukotriene modifiers or nasal steroids.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ORENITRAM

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

ORILISSA

Covered Uses:

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

Exclusion Criteria:

For 200 mg twice daily requests, members with osteoporosis.

Required Medical Information:

Continuation of therapy: improvement in dysmenorrhea, dyspareunia, pelvic pain/induration/tenderness, or size of endometrial lesions. Total duration of therapy has not exceeded 6 months for 200 mg twice daily or 24 months for 150 mg once daily dosing.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gynecologist.

Coverage Duration:

Up to 6 months for 200 mg twice daily or up to 12 months for 150 mg once daily.

Other Criteria:

Failure of ONE non-steroidal anti-inflammatory drug (e.g., ibuprofen, naproxen, fenoprofen, ketoprofen, mefenamic acid, meclofenamate, indomethacin, tolmetin, diclofenac, etodolac, diflunisal, meloxicam, piroxicam) or ONE progestin-containing agent (e.g., norethindrone, ethinyl estradiol with (desogestrel, ethynodiol diacetate, drospirenone, etonogestrel, levonorgestrel, norelgestromin, norethindrone, norgestimate, or norgestrel), estradiol valerate/dienogest, mestranol/norethindrone, depot injectable medroxyprogesterone acetate), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ORKAMBI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Presence of homozygous F508del mutation in an FDA-cleared cystic fibrosis mutation test.

Age Restrictions:

2 years of age or older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

ORPHENADRINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

OSMOLEX ER

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Medical justification supports inability to use immediate-release amantadine.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of immediate-release amantadine unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

PALYNZIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Recent (within 90 days) phenylalanine (Phe) blood level is greater than 600 micromol/L. CONTINUATION OF THERAPY: Positive response as evidenced by one of the following: a) Blood Phe level has decreased by at least 20% from pre-treatment baseline, b) Blood Phe level is less than or equal to 600 micromol/L, c) Member has been using 20 mg per day for at least 6 months, but a dose titration to 40 mg per day is being requested after failure to meet therapeutic targets (a or b above).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an endocrinologist, metabolic disease specialist, or genetic disease specialist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

PENTAZOCINE/NALOXONE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: codeine, hydromorphone, morphine, oxymorphone, hydrocodone/acetaminophen or oxycodone.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

PERSERIS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of TWO of the following atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: aripiprazole, ziprasidone, quetiapine, olanzapine, risperidone, asenapine, iloperidone, paliperidone.

Prior Authorization Group Description:

PHENOBARBITAL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Partial seizures: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: carbamazepine, phenytoin, topiramate, tiagabine, levetiracetam, gabapentin, lamotrigine, oxcarbazepine, primidone or divalproex. Generalized seizures: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: carbamazepine, phenytoin, topiramate, levetiracetam, primidone or lamotrigine.

Prior Authorization Group Description:

PRALUENT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Heterozygous Familial Hypercholesterolemia : Documentation (e.g., medical records, chart notes, laboratory values) of LDL level suggestive of a diagnosis of heterozygous familial hypercholesterolemia (e.g., Adults: LDL greater than 190 mg/dL). Hypercholesterolemia: Documentation of an LDL of 70 mg/dL or greater AND documented history of clinical atherosclerotic cardiovascular disease defined as one of the following: Acute coronary syndromes, Myocardial Infarction, Stable or unstable angina, Coronary or other arterial revascularization (e.g., percutaneous coronary intervention or coronary artery bypass graft surgery), Stroke, Peripheral artery disease presumed to be of atherosclerotic origin, Transient ischemic attack (TIA), Clinically significant coronary heart disease (CHD) diagnosed by invasive or noninvasive testing (such as coronary angiography, stress test using treadmill, stress echocardiography, or nuclear imaging), Carotid artery occlusion greater than 50% without symptoms, Renal artery stenosis or renal artery stent procedure. CONTINUATION OF THERAPY: Documentation of LDL reduction while on Praluent therapy AND, if tolerated, confirmation of continued statin therapy at the maximally tolerated dose.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.

Coverage Duration:

6 months.

Other Criteria:

Failure of two of the following at maximally tolerated doses, unless contraindicated or clinically significant adverse effects are experienced: atorvastatin, rosuvastatin, simvastatin, ezetimibe/simvastatin, pitavastatin, pravastatin, fluvastatin, or lovastatin.

Prior Authorization Group Description:

PREVYMIS

Covered Uses:

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

Exclusion Criteria:

Member is receiving pimozide or ergot alkaloids. Member is receiving cyclosporine co-administered with pitavastatin or simvastatin.

Required Medical Information:

Intravenous (IV) Prevymis: Medical justification why the member cannot use oral therapy.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncology, hematology, infectious disease, or transplant specialist.

Coverage Duration:

Through day 100 post-transplantation.

Other Criteria:

Failure of generic valacyclovir or generic ganciclovir, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

PROCARDIA CAPSULES

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

CHRONIC STABLE ANGINA: Failure of ONE of the following, unless contraindicated or clinically significant adverse effects are experienced: nifedipine SR, amlodipine or nicardipine. VASOSPASTIC ANGINA: Failure of ONE of the following, unless contraindicated or clinically significant adverse effects are experienced: nifedipine SR or amlodipine.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

PROLASTIN C

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a pulmonologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

PROLIA

Covered Uses:

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

Exclusion Criteria:

Hypocalcemia (unless corrected prior to initiating therapy).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

For men with non-metastatic prostate cancer: Receiving or has received androgen deprivation therapy [i.e., leuprolide (Lupron), bicalutamide (Casodex) or Nilandron]. For women with breast cancer: Receiving or has received adjuvant aromatase inhibitor therapy [i.e., anastrozole (Arimidex), exemestane (Aromasin) or letrozole (Femara)].

Prior Authorization Group Description:

PROMACTA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Thrombocytopenia in Chronic Hepatitis C: Documentation of current or planned interferon-based treatment of chronic hepatitis C.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Chronic Immune (Idiopathic) Thrombocytopenia: Failure of a corticosteroid (e.g., prednisone, methylprednisolone, or dexamethasone), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

PROTOPIC

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Tacrolimus 0.1%: 16 years and older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of two medium to high potency topical corticosteroids (e.g., amcinonide, fluticasone propionate, triamcinolone acetonide, betamethasone valerate, fluocinolone acetonide, hydrocortisone butyrate, mometasone furoate, desoximetasone, fluocinonide or betamethasone dipropionate), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

PROVIGIL

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Multiple sclerosis-related fatigue.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

PURIXAN

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Lymphoblastic lymphoma.

Exclusion Criteria:

Required Medical Information:

Member has a documented swallowing disorder or an inability to swallow tablets or capsules.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of mercaptopurine tablets, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

QUALAQUIN

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Babesiosis. Plasmodium vivax malaria.

Exclusion Criteria:

For the treatment or prevention of nocturnal leg cramps.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Malaria: 7 days. Babesiosis: 7-10 days.

Other Criteria:

Plasmodium vivax malaria: Infection is chloroquine-resistant.

Prior Authorization Group Description:

RADICAVA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Forced vital capacity greater than or equal to 80%, disease duration of less than or equal to 2 years, functionally retains most activities of daily living (defined as a baseline revised ALS Functional Rating Scale (ALSFRS-R) score with greater than or equal to 2 points in each of the 12 items, meets diagnostic criteria of definite or probable amyotrophic lateral sclerosis (ALS) based on El Escorial revised criteria. CONTINUATION OF THERAPY: Member continues to retain most activities of daily living, forced vital capacity greater than or equal to 80%, and ALSFRS-R score with greater than or equal to 2 points in each of the 12 items.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

6 months.

Other Criteria:

Prescribed in combination with riluzole unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

RANEXA

Covered Uses:

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

Exclusion Criteria:

Patients on strong CYP3A inhibitors (e.g., ketoconazole, HIV protease inhibitors, clarithromycin) or CYP3A inducers (e.g., rifampin, phenobarbital).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

RAYALDEE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Patient has stage 3 or 4 chronic kidney disease (CKD) and serum total 25-hydroxyvitamin D level less than 30 ng/mL.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

RELISTOR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of Amitiza and Movantik, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

REMICADE

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Wegener's Granulomatosis.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Psoriatic Arthritis/Plaque Psoriasis: Prescribed by or in consultation with a rheumatologist or dermatologist.
Crohn's Disease/Ulcerative Colitis: Prescribed by or in consultation with a gastrointestinal (GI) specialist.
Rheumatoid Arthritis/Ankylosing Spondylitis: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Rheumatoid Arthritis: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.
Plaque Psoriasis: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description:

REPATHA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Heterozygous or Homozygous Familial Hypercholesterolemia : Documentation (e.g., medical records, chart notes, laboratory values) of LDL level suggestive of a diagnosis of familial hypercholesterolemia (e.g., Adults: LDL greater than 190 mg/dL). Hypercholesterolemia: Documentation of an LDL of 70 mg/dL or greater AND documented history of clinical atherosclerotic cardiovascular disease defined as one of the following: Acute coronary syndromes, Myocardial Infarction, Stable or unstable angina, Coronary or other arterial revascularization (e.g., percutaneous coronary intervention or coronary artery bypass graft surgery), Stroke, Peripheral artery disease presumed to be of atherosclerotic origin, Transient ischemic attack (TIA), Clinically significant coronary heart disease (CHD) diagnosed by invasive or noninvasive testing (such as coronary angiography, stress test using treadmill, stress echocardiography, or nuclear imaging), Carotid artery occlusion greater than 50% without symptoms, Renal artery stenosis or renal artery stent procedure. CONTINUATION OF THERAPY: Documentation of LDL reduction while on Repatha therapy AND, if tolerated, confirmation of continued statin therapy at the maximally tolerated dose.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.

Coverage Duration:

6 months.

Other Criteria:

Failure of two of the following at maximally tolerated doses, unless contraindicated or clinically significant adverse effects are experienced: atorvastatin, rosuvastatin, simvastatin, ezetimibe/simvastatin, pitavastatin, pravastatin, fluvastatin, or lovastatin.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

RESTASIS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of one ophthalmic corticosteroid unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

REVATIO

Covered Uses:

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

Exclusion Criteria:

Members on concomitant nitrates (e.g., Nitrodur, Nitrobid, Nitrostat, Isordil, Ismo). Members on concomitant guanylate cyclase stimulator, such as riociguat (Adempas).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

REVLIMID

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Members who are pregnant.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

REXULTI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of aripiprazole and one of the following generic atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: risperidone, olanzapine, quetiapine, ziprasidone.

Prior Authorization Group Description:

RITUXIMAB

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

All oncology indications: Prescribed by or in consultation with an oncologist or hematologist. Rheumatoid arthritis, granulomatosis with polyangiitis, microscopic polyangiitis: Prescribed by or in consultation with a rheumatologist. Pemphigus vulgaris: Prescribed by or in consultation with a dermatologist.

Coverage Duration:

12 months.

Other Criteria:

Rheumatoid Arthritis: Prescribed in combination with methotrexate, unless contraindicated or clinically significant adverse effects were experienced with prior methotrexate therapy AND failure of Enbrel or Humira, unless contraindicated or clinically significant adverse effects are experienced. Granulomatosis with polyangiitis, Microscopic polyangiitis: Prescribed in combination with a glucocorticoid (e.g. prednisone, prednisolone, dexamethasone).

Prior Authorization Group Description:

RUBRACA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

NON-MAINTENANCE TREATMENT: Mutations in the BRCA genes as detected by an FDA approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

MAINTENANCE TREATMENT: Completed two or more platinum-based chemotherapy regimens and is in a complete or partial response.

Prior Authorization Group Description:

RYDAPT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Acute Myeloid Leukemia: Positive for the FLT3 mutation as detected by an FDA-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay).

Age Restrictions:

Prescriber Restrictions:

Acute Myeloid Leukemia: Prescribed by or in consultation with an oncologist or hematologist. Advanced Systemic Mastocytosis: Prescribed by or in consultation with an oncologist, allergist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Acute Myeloid Leukemia: for induction therapy, prescribed in combination with cytarabine and daunorubicin OR for consolidation therapy, prescribed in combination with cytarabine.

Prior Authorization Group Description:

SAVELLA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Depression.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Fibromyalgia: Failure of duloxetine or Lyrica, unless contraindicated or clinically significant adverse effects are experienced. Depression: Failure of ONE of the following generic antidepressants, unless contraindicated or clinically significant adverse effects are experienced: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine, or venlafaxine XR.

Prior Authorization Group Description:

SEROQUEL XR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Schizophrenia: Failure of two of the following generic atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: risperidone, olanzapine, quetiapine immediate release, ziprasidone, aripiprazole.

Prior Authorization Group Description:

SILIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description:

SIMPONI(auto-injector, prefilled syringe)

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist or dermatologist. ULCERATIVE COLITIS: Prescribed by or in consultation with a gastrointestinal (GI) specialist. RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PSORIATIC ARTHRITIS: Failure of methotrexate, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

SIMPONI ARIA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist or dermatologist. RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PSORIATIC ARTHRITIS: Failure of methotrexate, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

SOMA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

SOMAVERT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Inadequate response to surgery or radiation therapy, unless surgery or radiation therapy is not appropriate for the patient.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

SONATA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: Rozerem, Silenor 6 mg/day or less, trazodone or temazepam.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

SOVALDI

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. For the treatment of hepatitis C virus genotypes 5 and 6. Treatment of HCV genotype 2 or 3 in liver transplant recipients.

Exclusion Criteria:

Required Medical Information:

Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

Criteria will be applied consistent with current AASLD-IDSA guidance.

Other Criteria:

Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: Mavyret, Harvoni, Epclusa, Vosevi, and Zepatier for applicable genotypes.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

SPRITAM

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Medical justification must be provided why patient cannot take generic levetiracetam tablets or liquid.

Prior Authorization Group Description:

SPRYCEL

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

CHRONIC MYELOGENOUS LEUKEMIA, ACUTE LYMPHOBLASTIC LEUKEMIA: Documentation that the member has Philadelphia chromosome positive disease.

Age Restrictions:

Prescriber Restrictions:

CHRONIC MYELOGENOUS LEUKEMIA, ACUTE LYMPHOBLASTIC LEUKEMIA: Prescribed by or in consultation with an oncologist or hematologist. ALL OTHER COVERED ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

GASTROINTESTINAL STROMAL TUMOR: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: imatinib, Sutent or Stivarga.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

STIVARGA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

STRENSIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

SUBSYS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 18 or greater.

Prescriber Restrictions:

Coverage Duration:

Through the end of the Plan contract year.

Other Criteria:

Patient is already taking and is tolerant to around-the-clock opioid therapy. Patients are considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

SURMONTIL

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Irritable bowel syndrome.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Depression: Failure of one of the following generic antidepressants, unless contraindicated or clinically significant adverse effects are experienced: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine, or venlafaxine XR.

Prior Authorization Group Description:

SYMDEKO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Presence of homozygous F508del mutation or at least one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor.

Age Restrictions:

Age greater than or equal to 12 years.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

SYMLINPEN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Previous use of mealtime insulin therapy or an insulin pump.

Prior Authorization Group Description:

SYMPAZAN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Medical justification supports inability to use clobazam tablets and oral suspension (e.g., contraindications to excipients).

Prior Authorization Group Description:

TAGRISSO

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Disease is positive for any of the following, as detected by an FDA-approved test: exon 19 deletions, exon 21 L858R mutations, or T790M mutation with progression on or after an EGFR TKI therapy (e.g., Tarceva, Iressa, or Gilotrif).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

TALZENNA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Documentation of human epidermal growth factor receptor 2 (HER2)-negative disease and mutation in the BRCA genes as detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

TARCEVA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

NON-SMALL CELL LUNG CANCER: Documentation of EGFR exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

PANCREATIC CANCER: Prescribed in combination with gemcitabine.

Prior Authorization Group Description:

TASIGNA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Members with hypokalemia, hypomagnesemia, or long QT syndrome.

Required Medical Information:

CHRONIC MYELOGENOUS LEUKEMIA, ACUTE LYMPHOBLASTIC LEUKEMIA: Documentation that the member has Philadelphia chromosome positive disease.

Age Restrictions:

Prescriber Restrictions:

CHRONIC MYELOGENOUS LEUKEMIA, ACUTE LYMPHOBLASTIC LEUKEMIA: Prescribed by or in consultation with an oncologist or hematologist. GASTROINTESTINAL STROMAL TUMOR: Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

GASTROINTESTINAL STROMAL TUMOR: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: imatinib, Sutent or Stivarga.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

TAVALISSE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of a corticosteroid (e.g., prednisone, methylprednisolone, or dexamethasone), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

TECENTRIQ

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

NON-SMALL CELL LUNG CANCER: If a known epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic tumor aberration exists, then for ALK+ disease: prior trial of Xalkori, Alecensa, or Zykadia OR for EGFR+ disease: prior trial of Tarceva, Gilotrif or Iressa. SMALL CELL LUNG CANCER: Prescribed in combination with carboplatin and etoposide.

Prior Authorization Group Description:

TECFIDERA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

TENEX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: amlodipine/benazepril, benazepril, benazepril/hydrochlorothiazide, captopril, captopril/hydrochlorothiazide, fosinopril, fosinopril/hydrochlorothiazide, lisinopril, lisinopril/hydrochlorothiazide, quinapril, quinapril/hydrochlorothiazide, losartan, losartan/hydrochlorothiazide, valsartan, valsartan/hydrochlorothiazide, irbesartan, irbesartan/hydrochlorothiazide, candesartan, candesartan/hydrochlorothiazide, carvedilol, labetalol, acebutolol, atenolol, bisoprolol, bisoprolol/hydrochlorothiazide, timolol, nadolol, propranolol, metoprolol, metoprolol/hydrochlorothiazide, pindolol, nifedipine SR, amlodipine, nicardipine.

Prior Authorization Group Description:

TETRABENAZINE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

TIBSOVO

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Presence of an isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test (e.g., Abbott RealTime IDH1 Assay).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

For age less than 60 years, disease has relapsed or is refractory following treatment with a first-line chemotherapy regimen (e.g., cytarabine, idarubicin, daunorubicin, cladribine, midostaurin).

Prior Authorization Group Description:

TREMFYA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a rheumatologist or dermatologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of ONE of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine, or acitretin.

Prior Authorization Group Description:

TRIHEXYPHENIDYL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Parkinsons disease/Parkinsonism: Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: amantadine, levodopa/carbidopa, entacapone, pramipexole, ropinirole, selegiline.

Prior Authorization Group Description:

TYMLOS

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Total duration of therapy on parathyroid hormone (PTH) analogs (e.g., Tymlos, Forteo) has not exceeded 2 years.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of a bisphosphonate (e.g., alendronate) unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

TYSABRI

Covered Uses:

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

Exclusion Criteria:

Patients who have or have had progressive multifocal leukoencephalopathy.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS: Prescribed by or in consultation with a neurologist. CROHN'S DISEASE: Prescribed by or in consultation with a GI specialist.

Coverage Duration:

12 months.

Other Criteria:

RELAPSING FORMS OF MULTIPLE SCLEROSIS: Failure or clinically significant adverse effects to one of the following: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, Copaxone, Glatopa, Extavia or Rebif. CROHN'S DISEASE: Failure or clinically significant adverse effects to Humira or Remicade.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ULTRAVATE LOTION

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of generic halobetasol propionate and generic clobetasol propionate, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

UPTRAVI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

VALCHLOR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of one of the following skin-directed therapies unless contraindicated or clinically significant adverse effects are experienced: topical corticosteroid (e.g., betamethasone, clobetasol), topical retinoid (e.g., Targretin, Avage, Fabior, Tazorac), topical imiquimod (Aldara).

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

VANCOCIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

C. Diff diarrhea: 14 days. Staph enterocolitis: 10 days. Recurrent C. Diff: 12 weeks.

Other Criteria:

Prior Authorization Group Description:

VENCLEXTA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

AML: Age 60 years or greater, OR medical justification supports inability to use intensive induction chemotherapy. Prescribed in combination with azacitidine, decitabine, or low-dose cytarabine.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

CLL/SLL, MANTLE CELL LYMPHOMA: Failure of at least one previous therapy (e.g., for CLL/SLL Imbruvica, Campath, or high-dose methylprednisolone with Rituxan, for mantle cell lymphoma a Rituxan based regimen), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

VERSACLOZ

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Psychotic disorder associated with Parkinson's disease.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of clozapine (Clozaril) or FazaClo, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

VERZENIO

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

For men receiving an aromatase inhibitor: Prescribed in combination with an agent that suppresses testicular steroidogenesis (e.g., gonadotropin-releasing hormone agonists).

Prior Authorization Group Description:

VIBERZI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of loperamide unless contraindicated or clinically significant adverse effects are experienced AND For members 64 years and younger, failure of diphenoxylate-atropine (Lomotil) or dicyclomine, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

VIMOVO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: pantoprazole, lansoprazole or omeprazole AND For osteoarthritis or rheumatoid arthritis: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: ibuprofen, diclofenac sodium or potassium, etodolac, fenoprofen, ketoprofen, meloxicam, naproxen, oxaprozin, piroxicam, salsalate, sulindac, tolmetin OR For ankylosing spondylitis: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: diclofenac sodium, naproxen or sulindac OR For juvenile idiopathic arthritis: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: etodolac, ibuprofen, meloxicam, naproxen, oxaprozin, tolmetin.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

VINBLASTINE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Documentation that vinblastine is being used as palliative therapy.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

VINCRISTINE

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Patients with the demyelinating form of Charcot-Marie-Tooth syndrome.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

VITRAKVI

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Known acquired tropomyosin receptor kinase resistance mutation.

Required Medical Information:

Documentation of positive neurotrophic receptor tyrosine kinase gene fusion mutation.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Disease has progressed following standard first-line treatment unless contraindicated, clinically significant adverse effects are experienced, or there are not such alternative treatments available.

Prior Authorization Group Description:

VIZIMPRO

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Documentation of EGFR exon 19 deletion or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

VOSEVI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

If cirrhosis is present, confirmation of Child-Pugh A status. Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

12 weeks.

Other Criteria:

If HCV genotype 1, 2, 3, 4, 5 or 6, member has previously been treated with an HCV regimen containing one of the following NS5A inhibitors: daclatasvir, elbasvir, ledipasvir, ombitasvir, or velpatasvir. Alternatively, if HCV genotype is 1a or 3, member has previously been treated with an HCV regimen containing sofosbuvir.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

VOTRIENT

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

VRAYLAR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of TWO of the following atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: aripiprazole, ziprasidone, quetiapine, olanzapine, risperidone.

Prior Authorization Group Description:

XALKORI

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

NON-SMALL CELL LUNG CANCER: Documentation of ALK, ROS1, or MET positive disease.
INFLAMMATORY MYOFIBROBLASTIC TUMOR, ANAPLASTIC LARGE CELL LYMPHOMA: Documentation of ALK-positive disease.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

XATMEP

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Less than 18 years of age.

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist (for acute lymphoblastic leukemia) or rheumatologist (for polyarticular juvenile idiopathic arthritis).

Coverage Duration:

12 months.

Other Criteria:

Medical justification as to why member cannot use methotrexate tablets.

Prior Authorization Group Description:

XELJANZ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

RHEUMATOID ARTHRITIS: Prescribed by or in consultation with a rheumatologist. PSORIATIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist or dermatologist. ULCERATIVE COLITIS (IMMEDIATE-RELEASE ONLY): Prescribed by or in consultation with a gastrointestinal (GI) specialist.

Coverage Duration:

12 months.

Other Criteria:

RHEUMATOID ARTHRITIS: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PSORIATIC ARTHRITIS: Failure of methotrexate, unless predominantly axial disease, contraindicated, or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

XEOMIN

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

XERMELO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Prescribed in combination with a somatostatin analog (e.g., octreotide, lanreotide) unless contraindicated or clinically significant adverse effects are experienced.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure to a trial of a somatostatin analog (e.g., octreotide, lanreotide) unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

XOLAIR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

ASTHMA: Positive skin test or in vitro reactivity to a perennial aeroallergen AND immunoglobulin E (IgE) level greater than or equal to 30 IU/mL.

Age Restrictions:

ASTHMA: 6 years of age or older. CHRONIC IDIOPATHIC URTICARIA: 12 years of age or older.

Prescriber Restrictions:

ASTHMA: Prescribed by or in consultation with a pulmonologist, immunologist, or allergist. CHRONIC IDIOPATHIC URTICARIA: Prescribed by or in consultation with an allergist, dermatologist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

ASTHMA: Failure of one inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide), unless contraindicated or clinically significant adverse effects are experienced. CHRONIC IDIOPATHIC URTICARIA: Failure of one H1 Antihistamine (e.g., levocetirizine or desloratadine), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

XOSPATA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Documentation of the presence of a FLT3 mutation.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

XTANDI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

YERVOY

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Small cell lung cancer.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

SMALL CELL LUNG CANCER: Failure of a platinum-containing regimen (e.g., cisplatin, carboplatin containing regimen). SMALL CELL LUNG CANCER, RENAL CELL CARCINOMA: Prescribed in combination with Opdivo.

Prior Authorization Group Description:

YONSA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with methylprednisolone. Member has previously had bilateral orchiectomy, failed androgen deprivation therapy (ADT) or will use ADT concurrently with Yonsa.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ZALTRAP

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with irinotecan or FOLFIRI (5-fluorouracil, leucovorin, and irinotecan). Previous treatment with one of the following: oxaliplatin-containing regimen (e.g., FOLFIRI, FOLFOX [leucovorin, 5-fluorouracil, oxaliplatin], CapeOX [capecitabine, oxaliplatin]) OR 5-fluorouracil and leucovorin containing regimen OR capecitabine containing regimen.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ZARXIO

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Myelodysplastic syndrome. Neutropenia in patients with HIV/AIDS. Hematopoietic syndrome of acute radiation syndrome.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ZEJULA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Completed two or more platinum-based chemotherapy regimens and is in a complete or partial response.

Prior Authorization Group Description:

ZELBORAF

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Patients with wild-type BRAF disease.

Required Medical Information:

MELANOMA, NON-SMALL CELL LUNG CANCER, ERDHEIM-CHESTER DISEASE: Positive for the BRAF V600E mutation detected by an FDA-approved test.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

NON-SMALL CELL LUNG CANCER: Failure of Tafinlar or Mekinist, unless contraindicated or clinically significant adverse effects are experienced. THYROID CARCINOMA: Failure of Lenvima or Nexavar, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

ZEPATIER

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

If cirrhosis is present, confirmation of Child-Pugh A status. For genotype 1a, documentation of presence or absence of NS5A resistance-associated polymorphisms. Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist, hepatologist or infectious disease physician.

Coverage Duration:

12 to 16 wks based on genotype,presence of NS5A resistance-associated polymorphisms,prior treatment.

Other Criteria:

Prior Authorization Group Description:

ZINPLAVA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation of positive Clostridium difficile test.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

4 weeks.

Other Criteria:

Will receive or is currently receiving antibacterial drug treatment for Clostridium difficile infection (e.g., metronidazole, vancomycin, fidaxomicin) concomitantly with Zinplava. Has received appropriate treatment for past CDI recurrences, including a pulsed vancomycin regimen.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ZOLPIDEM

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: Rozerem, Silenor 6 mg/day or less, trazodone or temazepam.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ZYDELIG

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a hematologist or oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

ZYKADIA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

NON-SMALL Cell LUNG CANCER: Documentation of ALK or ROS1 positive disease. INFLAMMATORY MYOFIBROBLASTIC TUMOR: Documentation of ALK-positive disease.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ZYTIGA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with prednisone. Member has previously had bilateral orchiectomy, failed androgen deprivation therapy (ADT) or will use ADT concurrently with Zytiga.

ABSTRAL 1
ACTEMRA SC 2
ACTIQ 3
ACYCLOVIR 4
ADCIRCA 5
ADEMPAS 6
AFINITOR 7
AIMOVIG 8
ALECENSA 9
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AMITRIPTYLINE 11
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