Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ACTEMRA SC

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

RHEUMATOID ARTHRITIS, GIANT CELL ARTERITIS: Prescribed by or in consultation with a rheumatologist. JUVENILE IDIOPATHIC ARTHRITIS: Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist.

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. GIANT CELL ARTERITIS: Failure of methotrexate or azathioprine, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ACTIQ

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

16 years and older.

Prescriber Restrictions:

Coverage Duration:

Through the end of the Plan contract year.

Other Criteria:

Member is already taking and is tolerant to around-the-clock opioid therapy. Members 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:

ACYCLOVIR

Covered Uses:

All medically accepted 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:

ADCIRCA

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:

ADEMPAS

Covered Uses:

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

Exclusion Criteria:

Members on concomitant phosphodiesterase (PDE) inhibitors (e.g., sildenafil, tadalafil, vardenafil, dipyridamole or theophylline) or nitrates (e.g., Nitrodur, Nitrobid, Nitrostat, Isordil, Ismo).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

AFINITOR

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

BREAST CANCER: hormone-receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative recurrent or metastatic disease.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist. TUBEROUS SCLEROSIS COMPLEX ASSOCIATED PARTIAL ONSET SEIZURES: Prescribed by or in consultation with an oncologist or neurologist.

Coverage Duration:

12 months.

Other Criteria:

RENAL CELL CARCINOMA WITH CLEAR CELL HISTOLOGY: Failure of one prior therapy (e.g., Votrient, Sutent), unless contraindicated or clinically significant adverse effects are experienced. BREAST CANCER: Prescribed in combination with exemestane, fulvestrant or tamoxifen AND history of prior endocrine therapy (e.g., letrozole, anastrozole) unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

AIMOVIG

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Member experiences 4 or more migraine days per month for at least 3 months. CONTINUATION OF THERAPY: Member is responding positively to therapy as evidenced by a reduction in migraine days per month from baseline.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist, headache, or pain specialist.

Coverage Duration:

Initial: 3 months. Reauthorizations: 6 months.

Other Criteria:

Failure of two of the following oral migraine preventative therapies, each from different therapeutic classes, unless contraindicated or clinically significant adverse effects are experienced: antiepileptic drugs (e.g., divalproex sodium, sodium valproate, topiramate), beta-blockers (e.g., metoprolol, propranolol, timolol), antidepressants (e.g., amitriptyline, venlafaxine).

Prior Authorization Group Description:

AJOVY

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Member experiences 4 or more migraine days per month for at least 3 months. CONTINUATION OF THERAPY: Member is responding positively to therapy as evidenced by a reduction in migraine days per month from baseline.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist, headache or pain specialist.

Coverage Duration:

Initial: 3 months. Reauthorizations: 6 months.

Other Criteria:

Failure of two of the following oral migraine preventative therapies, each from different therapeutic classes, unless contraindicated or clinically significant adverse effects are experienced: antiepileptic drugs (e.g., divalproex sodium, sodium valproate, topiramate), beta-blockers (e.g., metoprolol, propranolol, timolol), antidepressants (e.g., amitriptyline, venlafaxine).

Prior Authorization Group Description:

ALECENSA

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 anaplastic lymphoma kinase (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:

ALUNBRIG

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Disease is ALK-positive.

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:

AMITRIPTYLINE

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

AMITRIPTYLINE/CHLORDIAZEPOXIDE

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: duloxetine, escitalopram, or venlafaxine XR.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

AMITRIPTYLINE/PERPHENAZINE

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, unless contraindicated or clinically significant adverse effects are experienced: duloxetine, escitalopram, or venlafaxine XR.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

AMPHOTERICIN B

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Abelcet only: Failure of conventional amphotericin B therapy unless contraindicated or clinically significant adverse effects are experienced. Ambisome when treating patients with Aspergillus species, Candida species and/or Cryptococcus species infections: Failure of conventional amphotericin B therapy unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

AMPYRA

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:

ANTIHISTAMINES

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:

Allergic rhinitis: Failure to two of the following, unless contraindicated or clinically significant adverse effects are experienced: levocetirizine, desloratadine, fluticasone propionate nasal suspension, flunisolide nasal solution or triamcinolone acetonide nasal inhaler.

Prior Authorization Group Description:

ARANESP

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Anemia due to myelodysplastic syndrome. Myelofibrosis-associated anemia.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ARIKAYCE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Positive sputum culture after at least 6 consecutive months of a multidrug background regimen therapy (e.g., clarithromycin or azithromycin, ethambutol, and rifamycin). CONTINUATION OF THERAPY: documentation of at least 3 consecutive negative monthly sputum cultures in the first 6 months of therapy or at least 2 consecutive negative monthly sputum cultures in the last 2 months of therapy. Member has not received Arikayce treatment for more than 12 months after converting to negative sputum status.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an infectious disease specialist or pulmonologist.

Coverage Duration:

Initial: 6 months. Reauthorizations: 12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

AUBAGIO

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:

AUSTEDO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

TARDIVE DYSKINESIA: 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:

HUNTINGTON'S DISEASE: Prescribed by or in consultation with a neurologist. TARDIVE DYSKINESIA: Prescribed by or in consultation with a psychiatrist or neurologist.

Coverage Duration:

12 months.

Other Criteria:

HUNTINGTON'S DISEASE: Failure of tetrabenazine, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

BALVERSA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Presence of susceptible fibroblast growth factor receptor (FGFR) 3 or FGFR2 genetic alterations.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Disease has progressed during or following at least one line of platinum-containing chemotherapy.

Prior Authorization Group Description:

BAXDELA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Current culture and sensitivity report shows isolated pathogen is a gram-positive or gram-negative organism susceptible to delafloxacin.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

14 days.

Other Criteria:

Failure of one fluoroquinolone, unless all are contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

BELEODAQ

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 Group Description:

BELSOMRA

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:

For patients 65 years of age and older: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: Rozerem, Silenor 6 mg/day or less, trazodone or temazepam. For patients under 65 years of age: Failure of zolpidem or zolpidem CR, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

BENLYSTA

Covered Uses:

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

Exclusion Criteria:

Previous anaphylaxis to Benlysta, severe active lupus nephritis or severe active central nervous system lupus.

Required Medical Information:

Documentation of systemic lupus erythematosus positive for anti-nuclear antibody (ANA) and/or anti-double-stranded DNA [anti-dsDNA]).

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Currently receiving standard therapy for systemic lupus erythematosus that includes one or more of the following agents, unless all agents are contraindicated: glucocorticoids (e.g., prednisone), antimalarial (e.g., hydroxychloroquine or chloroquine), non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate).

Prior Authorization Group Description:

BENZTROPINE

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

BLEOMYCIN

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:

BOSULIF

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Documentation that the member has Philadelphia chromosome positive 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:

BOTOX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CHRONIC MIGRAINE HEADACHE: Persistent history of chronic, debilitating migraine headaches with frequent attacks on more than 15 days per month.

Age Restrictions:

Strabismus or blepharospasm associated with dystonia: 12 years of age or older.

Prescriber Restrictions:

Chronic migraine headache: Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

Chronic migraine headache: Failure of prophylactic treatment with ONE of the following, unless contraindicated or clinically significant adverse effects are experienced: divalproex, topiramate, timolol or propranolol AND Failure of abortive therapy with ONE of the following, unless contraindicated or clinically significant adverse effects are experienced: sumatriptan, rizatriptan, zolmitriptan, naratriptan, almotriptan, frovatriptan, Relpax, ergotamine/caffeine or dihydroergotamine.

Prior Authorization Group Description:

BRAFTOVI

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Positive for BRAF V600E or V600K mutation.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

MELANOMA: Prescribed in combination with Mektovi. COLON CANCER, RECTAL CANCER: Prescribed in combination with Mektovi and either Erbitux or Vectibix.

Prior Authorization Group Description:

BRIVIACT

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 generic antiepileptic drugs, unless contraindicated or clinically significant adverse effects are experienced: lamotrigine, topiramate, oxcarbazepine, carbamazepine, phenytoin, valproic acid or divalproex sodium.

Prior Authorization Group Description:

BUTABARBITAL

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:

Insomnia: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: Rozerem, Silenor 6 mg/day or less, trazodone or temazepam. For use as a daytime sedative: patient is continuing on this medication without adverse effects.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

C1 ESTERASE INHIBITOR

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 immunologist, allergist, hematologist or rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

CABLIVI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Prescribed in combination with plasma exchange therapy. Prescribed in combination with immunosuppressive therapy (i.e., glucocorticoids, rituximab). CONTINUATION OF THERAPY: Member has received no more than 58 days of Cablivi therapy after completion of plasma exchange therapy AND member meets one of the following (a or b): a) If request is for a new treatment cycle, member has experienced no more than two recurrences while taking Cablivi and Cablivi is prescribed in combination with plasma exchange and immunosuppressive therapy (i.e., glucocorticoids, rituximab) OR b) If request is for treatment extension, member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters: increase in platelet counts, reduction in neurological symptoms, or improvements in organ-damage markers (lactate dehydrogenase, cardiac troponin I, and serum creatinine).

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a hematologist.

Coverage Duration:

Initial: 60 days. Reauthorization: 58 days post plasma-exchange.

Other Criteria:

Prior Authorization Group Description:

CABOMETYX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Non-small cell lung cancer: Documentation of an RET gene rearrangement.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

CALQUENCE

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:

Previously received at least one prior therapy (e.g., rituximab-containing regimen).

Prior Authorization Group Description:

CAPRELSA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

NON-SMALL CELL LUNG CANCER: Documentation of RET gene rearrangements.

Age Restrictions:

Prescriber Restrictions:

MEDULLARY AND DIFFERENTIATED THYROID CARCINOMA: Prescribed by or in consultation with an oncologist or endocrinologist. NON-SMALL CELL LUNG CANCER: Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

DIFFERENTIATED THYROID CARCINOMA: Failure of lenvatinib or sorafenib, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

CAYSTON

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:

CERDELGA

Covered Uses:

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

Exclusion Criteria:

Extensive metabolizer (EM) or intermediate metabolizer (IM) taking a strong or moderate CYP2D6 inhibitor concomitantly with a strong or moderate CYP3A inhibitor AND IMs or poor metabolizer (PM) taking a strong CYP3A inhibitor.

Required Medical Information:

An FDA-cleared genotyping test has determined that this patient is a CYP2D6 extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM).

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

CEREZYME

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Type 3 Gaucher disease.

Exclusion Criteria:

Required Medical Information:

Documentation of at least one of the following conditions resulting from Gaucher disease: anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

CHLORZOXAZONE

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:

CHORIONIC GONADOTROPIN

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Induction of ovulation and pregnancy in the anovulatory, infertile woman in whom the cause of anovulation is secondary and not due to primary ovarian failure. Treatment of obesity.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

CINQAIR

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 400 cells/mcL within the past 3 months.

Age Restrictions:

18 years of age or older.

Prescriber Restrictions:

Prescribed by or in consultation with an allergist, pulmonologist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

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.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

CLADRIBINE

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 Group Description:

CLOMIPRAMINE

Covered Uses:

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

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 selective serotonin reuptake inhibitor (e.g., fluoxetine, fluvoxamine, sertraline), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

COMETRIQ

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

NON-SMALL CELL LUNG CANCER: Documentation of an RET gene rearrangement.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

DIFFERENTIATED THYROID CARCINOMA: Failure of Lenvima or Nexavar unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

COPIKTRA

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 Group Description:

COTELLIC

Covered Uses:

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

Exclusion Criteria:

Patients with wild-type BRAF melanoma.

Required Medical Information:

Disease is positive for the BRAF V600E or V600K mutation.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with Zelboraf.

Prior Authorization Group Description:

CRYSVITA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

DNA testing results confirm the presence of mutations in the PHEX gene or documentation of elevated serum fibroblast growth factor 23 (FGF23) levels. Current (within the last 30 days) serum phosphorus level is below the reference range for age and gender. CONTINUATION OF THERAPY: Member meets all approval criteria and has had an increase in serum phosphorus level from baseline and/or maintenance within the normal range for age and gender, while on Crysvita therapy.

Age Restrictions:

At least 1 year of age.

Prescriber Restrictions:

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

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

CYCLOBENZAPRINE 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:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

CYTARABINE

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:

For acute non-lymphocytic leukemia: use in combination with other approved anti-cancer drugs.

Prior Authorization Group Description:

DAKLINZA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

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:

12 to 24 weeks based on cirrhosis status, genotype, prior treatment, or ribavirin eligibility.

Other Criteria:

Must be used in combination with Sovaldi. 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 Group Description:

DAURISMO

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Age 75 years or greater, OR medical justification supports inability to use intensive induction chemotherapy. Prescribed in combination with low-dose cytarabine.

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:

DIPYRIDAMOLE

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:

DISOPYRAMIDE

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:

DOPTELET

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

THROMBOCYTOPENIA WITH CHRONIC LIVER DISEASE: 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:

THROMBOCYTOPENIA WITH CHRONIC LIVER DISEASE: Prescribed by or in consultation with a hematologist, hepatologist, or gastroenterologist. CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): Prescribed by or in consultation with a hematologist.

Coverage Duration:

THROMBOCYTOPENIA WITH CHRONIC LIVER DISEASE: 4 weeks. CHRONIC ITP: 12 months.

Other Criteria:

THROMBOCYTOPENIA WITH CHRONIC LIVER DISEASE: For members with platelet count less than 40 x 10^9/L, failure of Mulpleta unless contraindicated or clinically significant adverse effects are experienced. CHRONIC ITP: Failure of a corticosteroid (e.g., prednisone, methylprednisolone, or dexamethasone), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

DOXEPIN

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:

ELIDEL

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 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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

EMEND 40 MG

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Four weeks.

Other Criteria:

Prior Authorization Group Description:

EMFLAZA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by one of the following: Genetic testing (e.g., dystrophin deletion or duplication mutation found) OR if genetic studies are negative (i.e., no mutation identified), positive muscle biopsy (e.g., absence of dystrophin protein).

Age Restrictions:

2 years of age or older.

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

EMGALITY

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

MIGRAINE PROPHYLAXIS: Member experiences 4 or more migraine days per month for at least 3 months. EPISODIC CLUSTER HEADACHE: Member experiences 1 or more cluster headache attacks every other day and no more than 8 cluster headache attacks per day, with a total of at least 5 previous attacks. Member has had at least 2 cluster headache attack periods which lasted for 1 year or less each and were separated by at least 3 months. CONTINUATION OF THERAPY, MIGRAINE PROPHYLAXIS: Member is responding positively to therapy as evidenced by a reduction in migraine days per month from baseline. CONTINUATION OF THERAPY, EPISODIC CLUSTER HEADACHE: Member is responding positively to therapy as evidenced by a reduction in cluster headache attack frequency. Member has not received more than 12 months of consecutive treatment OR it has been at least 3 months since the member last received Emgality.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist, headache or pain specialist.

Coverage Duration:

Initial: 3 months. Reauthorizations: 6 months.

Other Criteria:

MIGRAINE PROPHYLAXIS: Failure of two of the following oral migraine preventative therapies, each from different therapeutic classes, unless contraindicated or clinically significant adverse effects are experienced: antiepileptic drugs (e.g., divalproex sodium, sodium valproate, topiramate), beta-blockers (e.g., metoprolol, propranolol, timolol), antidepressants (e.g., amitriptyline, venlafaxine).

Prior Authorization Group Description:

ENBREL

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist. 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 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. 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:

ENDARI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age 5 or older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ENTRESTO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Left ventricular ejection fraction less than or equal to 35%.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a cardiologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ENTYVIO

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 gastrointestinal (GI) specialist.

Coverage Duration:

12 months.

Other Criteria:

Failure of Humira or Remicade, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

EPCLUSA

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Treatment of HCV genotype 1, 2, 3, 4, 5, or 6 with decompensated cirrhosis and sofosbuvir or NS5A-based treatment failure.

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:

12 to 24 weeks based on cirrhosis status, genotype, prior treatment, or ribavirin eligibility.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

EPIDIOLEX

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age greater than or equal to 2 years.

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

LENNOX-GASTAUT SYNDROME: will be used as adjunctive therapy with other antiepileptic drugs (e.g., topiramate, lamotrigine, felbamate, rufinamide, clobazam, or clonazepam).

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

EPOETIN

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Anemia due to myelodyspastic syndrome. Anemia associated with myelofibrosis. Anemia secondary to combination ribavirin and interferon-alfa therapy in patients infected with hepatitis C virus.

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:

ERGOLOID MESYLATES

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:

Alzheimer's dementia: Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: donepezil, memantine, rivastigmine or galantamine.

Prior Authorization Group Description:

ERLEADA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Concurrent use of a gonadotropin-releasing hormone (GnRH) analog or past bilateral orchiectomy. Disease is not metastatic.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ESBRIET

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:

ESTROGENS(Fyavolv , Mimvey Lo , Femhrt , Premphase , Premarin , Lopreeza , Amabelz , Prempro , Mimvey , Climara , Divigel , Activella , Estrace , estropipate)

Covered Uses:

All medically accepted 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:

Atrophic Vaginitis and Kraurosis Vulvae: Failure to one of the following, unless contraindicated or clinically significant adverse effects are experienced: Estradiol vaginal tablet, Femring or Premarin vaginal cream.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

EXONDYS 51

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Duchenne muscular dystrophy with mutation amenable to exon 51 skipping confirmed by genetic testing.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

6 months.

Other Criteria:

Currently stable on an oral corticosteroid regimen (e.g., prednisone), unless contraindicated or member has experienced clinically significant adverse effects.

Prior Authorization Group Description:

FARYDAK

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 hematologist or oncologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of two prior regimens, including Velcade and an immunomodulatory agent (e.g., dexamethasone), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

FASENRA

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:

12 years of age or older.

Prescriber Restrictions:

Prescribed by or in consultation with an allergist, pulmonologist, or immunologist.

Coverage Duration:

12 months.

Other Criteria:

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.

Prior Authorization Group Description:

FERRIPROX

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 deferoxamine, Exjade or Jadenu, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

FIORINAL WITH CODEINE

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 ibuprofen, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

FIRAZYR

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:

Prescribed by or in consultation with an immunologist, allergist, hematologist or rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

FIRDAPSE

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documentation of a baseline clinical muscle strength assessment (examples may include but are not limited to the Quantitative Myasthenia Gravis (QMG) score, triple-timed up-and-go test (3TUG), Timed 25-foot Walk test (T25FW)). CONTINUATION OF THERAPY: Member is responding positively to therapy as evidenced by clinical muscle strength assessments.

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:

FLECTOR

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Acute Pain: 4 weeks. Cancer-related neuropathic pain: Through the end of the Plan contract year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

FLUOROURACIL

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:

FORTEO

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:

Member meets one of the following (a or b): a) Prescribed by or in consultation with one of the following specialists: a gynecologist, endocrinologist, rheumatologist, geriatrician, orthopaedist, or physiatrist OR b) Failure of a bisphosphonate (e.g., alendronate) unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

GALAFOLD

Covered Uses:

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

Exclusion Criteria:

Amenable GLA variants (mutations) associated with benign phenotypes (i.e., phenotypes known not to cause Fabry disease), including the following GLA mutation: c.937G to T, (p.(D313Y)).

Required Medical Information:

Presence of at least one amenable GLA variant (mutation) as confirmed by one of the following resources: Galafold Prescribing Information brochure (package insert - Section 12, Table 2), Amicus Fabry GLA Gene Variant Search Tool: http://www.fabrygenevariantsearch.com/hcp, or Amicus Medical Information at 1-877-4AMICUS or medinfousa@amicusrx.com.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a clinical geneticist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

GANCICLOVIR

Covered Uses:

All medically accepted 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:

GATTEX

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:

GILENYA

Covered Uses:

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

Exclusion Criteria:

Baseline QTc interval greater than or equal to 500 msec.

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:

GILOTRIF

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

NON-SMALL CELL LUNG CANCER (NSCLC): Histology is squamous cell carcinoma or disease is positive for a sensitizing EGFR mutation (e.g., exon 19 deletion or insertion, exon 21 point mutation [L858R, L861Q], exon 18 point mutation [G719X], exon 20 point mutation [S768I]).

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:

GLATIRAMER

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:

GLYBURIDE

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: glipizide or glipizide/metformin combination product.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

GLYBURIDE/METFORMIN

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: glipizide or glipizide/metformin combination product.

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

GRANIX

Covered Uses:

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

HARVONI

Covered Uses:

All FDA-approved indications not otherwise excluded from Part D. Treatment of HCV genotype 1, 4, 5, or 6 with decompensated cirrhosis and sofosbuvir or NS5A-based treatment failure. Treatment of HCV genotype 4, 5, or 6 with decompensated cirrhosis. Treatment of HCV genotype 5 or 6 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:

8 to 24 weeks based on cirrhosis status, genotype, prior treatment, or ribavirin eligibility.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

HERCEPTIN

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Documentation that the patient has human epidermal growth factor receptor (HER2) positive cancer.

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:

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 Protocol

Medicare Part D – 2019

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 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 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 Protocol

Medicare Part D – 2019

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 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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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:

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 Group Description:

INREBIC

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

MYELOFIBROSIS: Confirmation of a recent (within the last 30 days) thiamine level of 70 nmol/L (3 mcg/dL) or greater. Confirmation of a recent (within the last 30 days) platelet count of 50,000/mcL or greater.

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:

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:

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

JAKAFI

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:

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:

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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:

6 months of age or older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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 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:

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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, glatiramer, Copaxone, Glatopa, Extavia or Rebif.

Prior Authorization Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

LONSURF

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

COLORECTAL CANCER: Documentation that the member does or does not have the RAS (KRAS or NRAS) wild type gene. GASTRIC CANCER, GASTROESOPHAGEAL ADENOCARCINOMA: Documentation that the member does or does not have a HER2/neu-positive tumor.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

COLORECTAL CANCER: If tumor expresses the RAS wild type gene, failure of Erbitux or Vectibix, unless contraindicated or clinically significant adverse effects are experienced. GASTRIC CANCER, GASTROESOPHAGEAL ADENOCARCINOMA: If tumor is HER2/neu-positive (i.e., HER2-overexpressing), failure of Herceptin, 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:

NON-SMALL CELL LUNG CANCER: Disease is ALK or ROS1 positive.

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 Protocol

Medicare Part D – 2019

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 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:

MAVENCLAD

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

CONTINUATION OF THERAPY: Member has not yet received 2 courses (4 cycles) lifetime total.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

12 months.

Other Criteria:

RELAPSING-REMITTING MULTIPLE SCLEROSIS: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, glatiramer, Copaxone, Glatopa, Extavia, or Rebif.

Prior Authorization Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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. NON-SMALL CELL LUNG CANCER, ANAPLASTIC THYROID CANCER: Positive for BRAF V600E mutation.

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.

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:

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 Protocol

Medicare Part D – 2019

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 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., Neupogen, Zarxio, Granix, or Nivestym).

Prior Authorization Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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:

MULTIPLE MYELOMA: 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:

NIVESTYM

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:

NONPREFERRED

Covered Uses:

Refer to Preferred Drug List Criteria Guide on Texas Vendor Drug Program website.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Refer to Preferred Drug List Criteria Guide on Texas Vendor Drug Program website.

Other Criteria:

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

NUBEQA

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Concurrent use of a gonadotropin-releasing hormone (GnRH) analog (e.g., Zoladex, Vantas, leuprolide/Lupron Depot, Eligard, Trelstar, Firmagon) or past bilateral orchiectomy. Disease is not metastatic.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or urologist.

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:

NUZYRA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Request is for continuation of therapy initiated in an acute care hospital from which member was discharged OR Culture and sensitivity (C&S) report for the current infection shows isolated pathogen is an organism susceptible to omadacycline, unless provider submits documentation that obtaining a C&S report is not feasible.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

14 days.

Other Criteria:

For members initiating Nuzyra therapy outside of an acute care hospital, one of the following (a, b, or c): a) If a C&S report is available: Failure of 2 antibiotics to which the isolated pathogen is susceptible (if available) per C&S report, unless all are contraindicated or clinically significant adverse effects are experienced. b) C&S report shows resistance or lack of susceptibility of the isolated pathogen to all antibiotics FDA-approved for member's diagnosis. c) If provider documents that obtaining a C&S report is not feasible: Failure of 2 antibiotics indicated for member's diagnosis (if available), unless all are contraindicated or clinically significant adverse effects are experienced.

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 Protocol

Medicare Part D – 2019

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, glatiramer, Copaxone, Glatopa, Extavia or Rebif.

Prior Authorization Protocol

Medicare Part D – 2019

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 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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

OXERVATE

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 ophthalmologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

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:

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:

Member meets one of the following (a or b): a) therapy was initiated in an inpatient setting during a recent (within 60 days) hospital administration, OR b) 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 Protocol

Medicare Part D – 2019

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:

PIQRAY

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Hormone receptor (HR)-positive (i.e., estrogen or progesterone receptor [ER/PR]-positive), HER2-negative, advanced (locally recurrent) or metastatic, and positive for PIK3CA-mutation.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with fulvestrant after disease progression on an endocrine therapy (e.g., anastrozole, exemestane, fulvestrant, toremifene, letrozole, tamoxifen, or megestrol acetate).

Prior Authorization Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

PRALUENT

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

GENETICALLY MEDIATED PRIMARY HYPERLIPIDEMIA (INCLUDING HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA): Confirmation (e.g., medical records, chart notes, laboratory values) of LDL level suggestive of a diagnosis of familial hypercholesterolemia (e.g., adults: LDL of 190 mg/dL or greater). NON-GENETICALLY MEDIATED PRIMARY HYPERLIPIDEMIA: Request meets both of the following (a and b): a) Confirmation of a LDL of 100 mg/dL or greater AND b) a diagnosis of secondary hyperlipidemia has been ruled out with confirmation of absence of all of the following potential causes of elevated cholesterol (a-e): a) hypothyroidism, b) obstructive liver disease, c) renal disease, d) nephrosis, e) medications which can increase lipid levels including, but not limited to: glucocorticoids, sex hormones, antipsychotics, antiretrovirals, immunosuppressive agents, retinoic acid derivatives. HYPERCHOLESTEROLEMIA WITH HISTORY OF CLINICAL ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD): Confirmation of an LDL of 70 mg/dL or greater AND history of clinical ASCVD 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: Confirmation 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 Protocol

Medicare Part D – 2019

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:

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 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:

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

REPATHA

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

GENETICALLY MEDIATED PRIMARY HYPERLIPIDEMIA (INCLUDING HETEROZYGOUS OR HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA): Confirmation (e.g., medical records, chart notes, laboratory values) of LDL level suggestive of a diagnosis of familial hypercholesterolemia (e.g., adults: LDL 190 mg/dL or greater). NON-GENETICALLY MEDIATED PRIMARY HYPERLIPIDEMIA: Request meets both of the following (a and b): a) Confirmation of a LDL of 100 mg/dL or greater AND b) a diagnosis of secondary hyperlipidemia has been ruled out with confirmation of absence of all of the following potential causes of elevated cholesterol (a-e): a) hypothyroidism, b) obstructive liver disease, c) renal disease, d) nephrosis, e) medications which can increase lipid levels including, but not limited to: glucocorticoids, sex hormones, antipsychotics, antiretrovirals, immunosuppressive agents, retinoic acid derivatives. HYPERCHOLESTEROLEMIA WITH HISTORY OF CLINICAL ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD): Confirmation of an LDL of 70 mg/dL or greater AND history of clinical ASCVD 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: Confirmation 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 anti-inflammatory agent (e.g., corticosteroids, lifitegrast), 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:

REVCOVI

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 immunologist.

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ROZLYTREK

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

ROS1-POSITIVE NON-SMALL CELL LUNG CANCER: Confirmation of a ROS1 mutation. Member has not received prior ROS1 targeted therapy (e.g., Xalkori, Zykadia, Lorbrena). NTRK FUSION-POSITIVE SOLID TUMOR: Confirmation of an NTRK gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1). Member has not received prior NTRK targeted therapy (e.g., Vitrakvi).

Age Restrictions:

NTRK FUSION-POSITIVE SOLID TUMOR: Age greater than or equal to 12 years.

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:

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

RYDAPT

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Acute Myeloid Leukemia: Positive for the FLT3 mutation.

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 gastroenterologist. 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.

Prior Authorization Protocol

Medicare Part D – 2019

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.

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 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:

SPRAVATO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Currently on an oral antidepressant (must not be an agent previously tried and failed). CONTINUATION OF THERAPY: Member is responding positively to therapy and is using Spravato in combination with an oral antidepressant.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Initial: 4 weeks. Reauthorization: 6 months.

Other Criteria:

Failure of two antidepressants (e.g., selective serotonin reuptake inhibitor [SSRI], serotonin-norepinephrine reuptake inhibitor [SNRI], tricyclic antidepressant [TCA], bupropion, mirtazapine) from two different classes, unless contraindicated or clinically significant adverse effects are experienced.

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 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:

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 6 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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

TAGRISSO

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

NON-SMALL CELL LUNG CANCER: Disease is positive for either of the following (a or b): a) sensitizing EGFR mutation (e.g., exon 19 deletion or insertion, exon 21 point mutation (L858R, L861Q), exon 18 point mutation (G719X), exon 20 point mutation (S768I)), OR b) T790M mutation.

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:

TAKHZYRO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Age greater than or equal to 12 years.

Prescriber Restrictions:

Prescribed by or in consultation with an immunologist, allergist, hematologist, or rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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: Disease is positive for a sensitizing EGFR mutation (e.g., exon 19 deletion or insertion, exon 21 point mutation (L858R, L861Q), exon 18 point mutation (G719X), exon 20 point mutation (S768I)).

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

TECENTRIQ

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

EXTENSIVE-STAGE SMALL CELL LUNG CANCER: Prescribed in combination with carboplatin and etoposide. TRIPLE NEGATIVE BREAST CANCER: Hormone-receptor (HR)-negative, estrogen-receptor (ER)-negative, and human epidermal growth factor receptor 2 (HER2)-negative disease. Prescribed in combination with protein-bound paclitaxel (nab-paclitaxel). Tumor expresses PD-L1.

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.

Prior Authorization Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

TEGSEDI

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

Documented transthyretin (TTR) mutation. Documented amyloid deposition on biopsy or medical justification is provided as to why treatment should be initiated in the presence of a negative biopsy or no biopsy. Member has not had a liver transplant. CONTINUATION OF THERAPY: Maintained on therapy with positive response, including but not limited to improvement in any of the following parameters: 1) neuropathy (motor function, sensation, reflexes, walking ability), 2) nutrition (body mass index), 3) cardiac parameters (Holter monitoring, echocardiography, electrocardiogram, plasma BNP or NT-proBNP, serum troponin), 4) renal parameters (creatinine clearance, urine albumin), 5) ophthalmic parameters (eye exam).

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:

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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. For newly diagnosed acute myeloid leukemia (AML), member is age 60 years or older OR medical justification supports inability to use intensive induction therapy.

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 where medical justification does not support inability to use intensive induction therapy, disease has relapsed or is refractory following treatment with standard antineoplastic induction agents (e.g., cytarabine, idarubicin, daunorubicin, cladribine, midostaurin).

Prior Authorization Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

TURALIO

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:

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:

Member meets one of the following (a or b): a) Prescribed by or in consultation with one of the following specialists: a gynecologist, endocrinologist, rheumatologist, geriatrician, orthopaedist, or physiatrist OR b) 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:

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, glatiramer, 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:

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

VALCHLOR

Covered Uses:

All medically accepted 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 Protocol

Medicare Part D – 2019

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:

MANTLE CELL LYMPHOMA: Failure of at least one previous therapy (e.g., a Rituxan based regimen), unless contraindicated or clinically significant adverse effects are experienced. CLL/SLL: Request meets one of the following (a or b): a) Prescribed in combination with Gazyva as first-line therapy OR b) Failure of at least one previous therapy (e.g., Imbruvica, Campath, or high-dose methylprednisolone with Rituxan), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

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:

XPOVIO

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

Member has received at least 4 prior lines of therapy that include all of the following (a, b, and c): a) Two proteasome inhibitors (e.g., bortezomib, Kyprolis, Ninlaro), b) Two immunomodulatory agents (e.g., Revlimid, pomalidomide, Thalomid), c) One anti-CD38 monoclonal antibody (e.g., Darzalex).

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 Protocol

Medicare Part D – 2019

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 Protocol

Medicare Part D – 2019

Prior Authorization Group Description:

ZELBORAF

Covered Uses:

All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria:

Required Medical Information:

MELANOMA, ERDHEIM-CHESTER DISEASE: Positive for the BRAF V600 mutation. NON-SMALL CELL LUNG CANCER, COLORECTAL CANCER: Positive for the BRAF V600E mutation. DIFFERENTIATED THYROID CARCINOMA: Positive for the BRAF mutation.

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.

Prior Authorization Protocol

Medicare Part D – 2019

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:

ZULRESSO

Covered Uses:

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

Exclusion Criteria:

Required Medical Information:

No more than 6 months have passed since member has given birth.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

4 weeks.

Other Criteria:

Failure of one of the following oral antidepressants, unless contraindicated or clinically significant adverse effects are experienced: selective serotonin reuptake inhibitor (SSRI), serotonin-norepinephrine reuptake inhibitor (SNRI), tricyclic antidepressant (TCA), bupropion, mirtazapine.

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 Protocol

Medicare Part D – 2019

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.