2015 Medicare Part D
Prior Authorization Requirements

Effective: November 01, 2015
ACTEMRA

Drugs
ACTEMRA INTRAVENOUS SOLUTION 200 MG/10 ML (20 MG/ML)

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH ENBREL AND HUMIRA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
ACTEMRA SUBCUTANEOUS

Drugs
ACTEMRA SUBCUTANEOUS

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR FAILURE WITH ENBREL AND HUMIRA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
ACTIMMUNE

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
ADASUVE

Drugs
ADASUVE

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION THAT THE PATIENT HAS DIFFICULTY SWALLOWING OR HAS COMPLIANCE CONCERNS WITH ORAL NON-INHALATION DOSAGE FORMS, AND (3) DOCUMENTATION THAT ADASUVE WILL BE ADMINISTERED IN AN ENROLLED HEALTHCARE SETTING IN COMPLIANCE WITH THE FDA-APPROVED ADASUAVE REMS PROGRAM.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF VASOREACTIVE PULMONARY ARTERIAL HYPERTENSION (PAH) WITH TRIAL AND FAILURE OF CALCIUM CHANNEL BLOCKER THERAPY, OR DIAGNOSIS OF NON-VASOREACTIVE PAH, AND (2) TRIAL AND FAILURE OF SILDENAFIL ORAL.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY PULMONOLOGY OR CARDIOLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
AMPYRA

Drugs
AMPYRA

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, (2) DOCUMENTATION THAT THE PATIENT IS CURRENTLY ABLE TO WALK 25 FEET, AND (3) PHYSICIAN ATTESTATION THAT PATIENT HAS DIFFICULTY WALKING. RENEWAL CRITERIA: DOCUMENTATION OF A POSITIVE RESPONSE.

Age Restriction

Prescriber Restriction

Coverage Duration
TWO MONTHS, THEN BALANCE OF CONTRACT YEAR IF POSITIVE RESPONSE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
ANDROGEN THERAPY

Drugs
ANDRODERM, ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP, ANDROGEL TRANSDERMAL GEL IN PACKET 1% (50 MG/5 GRAM), androxy, DEPO-TESTOSTERONE INTRAMUSCULAR OIL 200 MG/ML, testosterone cypionate, testosterone enanthate, testosterone transdermal gel, testosterone transdermal gel in metered-dose pump 1.25 gram/actuation (1%), testosterone transdermal gel in packet

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTED TESTOSTERONE DEFICIENCY IN MALES OF LESS THAN 300 NG/DL.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
ANORO ELLIPTA

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF TRIAL AND FAILURE OF SPIRIVA MONOTHERAPY.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
ANTICONVULSANTS - SELECT AGENTS

Drugs
APTIOM, FYCOMPA ORAL TABLET

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY NEUROLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
ANTIDEPRESSANTS - NON-PREFERRED AGENTS

Drugs
BRINTELLIX, FETZIMA, VIIBRYD

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO TWO PREFERRED ALTERNATIVE ANTIDEPRESSANTS, SUCH AS: CITALOPRAM, ESCITALOPRAM, FLUOXETINE, PAROXETINE, SERTRALINE, VENLAFAXINE, OR DULOXETINE.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
ANTIGLAUCOMA AGENTS - PRESERVATIVE FREE

Drugs
COSOPT (PF), ZIOPTAN (PF)

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION THAT THE PATIENT HAS A SENSITIVITY TO PRESERVATIVES IN OTHER FORMULARY PRODUCTS SUCH AS LATANOPROST, BIMATOPROST, TRAVOPROST, OR OTHER EYE DROPS FOR GLAUCOMA.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
ANTINEOPLASTIC INJECTABLES

Drugs
ABRAXANE, ADCETRIS, ALIMTA INTRAVENOUS RECON SOLN 500 MG, amifostine crystalline, ARRANON, ARZERRA INTRAVENOUS SOLUTION 100 MG/5 ML, AVASTIN, azacitidine, BELEODAQ, BICNU, BLINCYTO, BUSULFEX, carboplatin intravenous solution, cisplatin, CLOLAR, COSMEGEN, CYRAMZA, dacarbazine intravenous recon soln 200 mg, dactinomycin, daunorubicin intravenous solution, DAUNOXOME, decitabine, DOCETAXEL INTRAVENOUS SOLUTION 10 MG/ML, docetaxel intravenous solution 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml), ELSPAR, epirubicin intravenous solution 50 mg/25 ml, ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML, ERWINAZE, FASLODEX, fludarabine intravenous recon soln, FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML), GAZYVA, gemcitabine intravenous recon soln 1 gram, HALAVEN, HERCEPTIN, idarubicin, ifosfamide intravenous recon soln 1 gram, irinotecan intravenous solution 100 mg/5 ml, ISTODAX, IXEMPRA INTRAVENOUS RECON SOLN 45 MG, JEVTANA, KADCYLA INTRAVENOUS RECON SOLN 100 MG, KEYTRUDA, KYPROLIS, LUPRON DEPOT, LUPRON DEPOT (3 MONTH), LUPRON DEPOT (4 MONTH), LUPRON DEPOT (6 MONTH), melphalan hcl, mitomycin intravenous recon soln 20 mg, mitoxantrone, MUSTARGEN, ONCASPAR, ONTAK, OPDIVO INTRAVENOUS SOLUTION 40 MG/4 ML, oxaliplatin intravenous solution 100 mg/20 ml, paclitaxel, pentostatin, PERJETA, PHOTOFRIN, PROLEUKIN, SLYVANT, TEMODAR INTRAVENOUS, teniposide, thiopeta, TORISEL, TREANDA INTRAVENOUS RECON SOLN 100 MG, TREANDA INTRAVENOUS SOLUTION, TRISENOX, UNITUXIN, UVADEX, VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML), VELCADE, vincaspar pfs intravenous solution 1 mg/ml, vincristine intravenous solution 1 mg/ml, vinorelbine intravenous solution 50 mg/5 ml, VORAXAZE, YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML), ZANOSAR

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL: FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, OR (2) DOCUMENTATION THAT A PATIENT IS CURRENTLY RECEIVING OR HAS PREVIOUSLY RECEIVED AND BENEFITED FROM THE USE OF THIS MEDICATION FOR THE TREATMENT OF CANCER. RENEWAL: DOCUMENTATION OF A BENEFICIAL RESPONSE.

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
ANTINEOPLASTIC INJECTABLES WITH BVD

Drugs
adriamycin intravenous recon soln 10 mg, bleomycin injection recon soln 30 unit, cladribine, cytarabine, cytarabine (pf) injection recon soln 500 mg, cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml), doxorubicin, peg-liposomal, fluorouracil intravenous solution 2.5 gram/50 ml, vinblastine intravenous solution

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL: FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, OR (2) DOCUMENTATION THAT A PATIENT IS CURRENTLY RECEIVING OR HAS PREVIOUSLY RECEIVED AND BENEFITED FROM THE USE OF THIS MEDICATION FOR THE TREATMENT OF CANCER. RENEWAL: DOCUMENTATION OF A BENEFICIAL RESPONSE.

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.
ANTIPARKINSON AGENTS

Drugs
NEUPRO

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF SIGNIFICANT SIDE EFFECTS, LOSS OF EFFICACY, OR COMPLIANCE CONCERNS WITH REGULAR RELEASE PRAMIPEXOLE OR ROPINIROLE.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
ATYPICAL ANTIPSYCHOTIC AGENTS

Drugs
FANAPT, INVEGA, LATUDA, paliperidone, REXULTI, SAPHRIS (BLACK CHERRY)

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO TWO OF THE FOLLOWING ALTERNATIVES: RISPERIDONE, ZIPRASIDONE, OLANZAPINE, QUETIAPINE REGULAR RELEASE, SEROQUEL XR OR ARIPIPRAZOLE (ABILIFY).

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
BETASERON SUBCUTANEOUS KIT

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO EXTAVIA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY NEUROLOGY

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
CALCITRIOL TOPICAL

Drugs
calcitriol topical

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE WITH OR CONTRAINDICATIONS TO POTENT TOPICAL STEROIDS OR A GENERIC TOPICAL CALCIPOTRIENE PRODUCT.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
CIMZIA, CIMZIA POWDER FOR RECONST

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR RHEUMATOLOGY: DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH ENBREL AND HUMIRA, OR FOR GASTROENTEROLOGY: DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO A CONVENTIONAL THERAPY AGENT (SUCH AS MESALAMINE, A STEROID, AZATHIOPRINE OR METHOTREXATE) AND HUMIRA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY AND GASTROENTEROLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
clomipramine

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: DIAGNOSIS OF OBSESSIVE-COMPULSIVE DISORDER, OR DOCUMENTATION THAT THE PATIENT IS MONITORED FOR ADVERSE DRUG EVENTS.

Age Restriction
RESTRICTIONS APPLY TO PATIENTS GREATER THAN 64 YEARS OF AGE.

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
CLONIDINE EXTENDED RELEASE

Drugs
clonidine hcl oral tablet extended release 12 hr

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTED FAILURE WITH STANDARD GENERIC ADHD MEDICATIONS SUCH AS METHYLPHENIDATE OR DEXTROAMPHETAMINE-AMPHETAMINE COMBINATION.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
**Drugs**

**COMETRIQ**

**Covered Uses**
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria**

**Required Medical Information**
INITIAL CRITERIA FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION THAT DISEASE PROGRESSION HAS NOT OCCURRED.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

**Other Criteria**
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
COPAXONE SUBCUTANEOUS SYRINGE

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY NEUROLOGY

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
COSENTYX (2 SYRINGES)

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
MAY NOT USE COSENTYX CONCURRENTLY WITH OTHER BIOLOGIC THERAPIES.

Required Medical Information
PLAQUE PSORIASIS INITIAL CRITERIA: (1) DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS (AT LEAST 10% BODY SURFACE AREA, OR PALMAR/PLANTAR PRESENTATIONS), AND (2) MEDICAL CHART DOCUMENTATION OF BASELINE DISEASE ACTIVITY AND TREATMENT GOALS, AND (3) MEDICAL CHART DOCUMENTATION OF CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH ENBREL AND HUMIRA. RENEWAL CRITERIA: MEDICAL CHART DOCUMENTATION THAT TREATMENT GOALS HAVE BEEN MET FOR THERAPY.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY DERMATOLOGY

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
CYCLOSET

Drugs
CYCLOSET

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF TYPE 2 DIABETES MELLITUS AND (2) INADEQUATE GLYCEMIC CONTROL AFTER USE OF TWO OTHER ORAL DIABETES MEDICATIONS.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs

CYSTARAN

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA: DIAGNOSIS OF CYSTINOSIS. RENEWAL CRITERIA: DOCUMENTATION OF CLINICAL TREATMENT EFFECT (SUCH AS DOCUMENTATION OF SLIT LAMP EXAM RESULTS)

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY PROVIDERS SPECIALIZING IN GENETICS AND METABOLISM.

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF SEVERE COPD CONFIRMED WITH AN FEV-1 LESS THAN 50 PERCENT OF PREDICTED, AND (2) ASSOCIATED CHRONIC BRONCHITIS AS DEFINED BY THE PRESENCE OF COUGH AND SPUTUM PRODUCTION FOR AT LEAST 3 MONTHS IN EACH OF TWO CONSECUTIVE YEARS, AND (3) DOCUMENTATION OF INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATIONS TO TWO OF THE FOLLOWING: LONG-ACTING BETA-AGONIST (SUCH AS FORMOTEROL OR SALMETEROL), ANTICHOLINERGIC (SUCH AS IPRATROPIUM) OR ORAL INHALED STEROID (SUCH AS BECLOMETHASONE, BUDESONIDE, FLUTICASONE OR MOMETASONE).

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
DESVENLAFAXINE

Drugs
desvenlafaxine, DESVENLAFAXINE FUMARATE, PRISTIQ

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE TO VENLAFAXINE ER AND DULOXETINE.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
DIFICID

Drugs
DIFICID

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF CLOSTRIDIUM DIFFICILE INFECTION, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO METRONIDAZOLE AND VANCOMYCIN.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
DIGOXIN

Drugs
digitek oral tablet 250 mcg, digoxin oral tablet 250 mcg

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) THE PATIENT IS CURRENTLY STABLE ON DIGOXIN 0.25 MG AND IS MONITORED FOR ADVERSE DRUG EVENTS, OR (2) FOR PATIENTS WITH ATRIAL FIBRILLATION AND CONTRAINDICATIONS OR INADEQUATE RESPONSE TO COMBINATION THERAPY WITH A LOWER DOSE OF DIGOXIN AND EITHER A BETA BLOCKER OR A NON DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKER (SUCH AS DILTIAZEM OR VERAPAMIL), OR (3) FOR PATIENTS WITH HEART FAILURE AND CONTRAINDICATIONS OR INADEQUATE RESPONSE TO COMBINATION THERAPY WITH A LOWER DOSE OF DIGOXIN AND A BETA BLOCKER.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
DIHYDROERGOTAMINE

Drugs
dihydroergotamine

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH A TRIPTAN MEDICATION SUCH AS SUMATRIPTAN, NARATRIPTAN OR RIZATRIPTAN.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs

DIPENTUM

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF INADEQUATE RESPONSE TO SULFASALAZINE AND AN ORAL MESLAMINE PRODUCT (SUCH AS ASACOL OR LIALDA).

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
DULERA

Drugs
DULERA

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE WITH ADVAIR.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
EMSAM

Drugs
EMSAM

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO ONE PREFERRED DRUG FROM EACH OF THE FOLLOWING TWO ANTIDEPRESSANT SUB-CLASSES: (A) SSRI'S SUCH AS CITALOPRAM, ESCITALOPRAM, FLUOXETINE, PAROXETINE, SERTRALINE, AND (B) SNRI'S SUCH AS VENLAFAXINE OR DULOXETINE.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
**ENBREL**

**Drugs**

**ENBREL**

**Covered Uses**

ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria**

**Required Medical Information**

RHEUMATOLOGY: (1) DIAGNOSIS OF AN FDA-APPROVED RHEUMATOLOGY DISORDER, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH METHOTREXATE. DERMATOLOGY: (1) DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS (AT LEAST 5% BODY SURFACE AREA, OR AFFECTING CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE, OR GENITALS), AND (2) DOCUMENTATION OF INADEQUATE RESPONSE WITH EITHER UVB PHOTOTHERAPY, OR SYSTEMIC THERAPY (SUCH AS METHOTREXATE OR ACITRETIN), UNLESS SYSTEMIC THERAPY ALTERNATIVES ARE CONTRAINDICATED.

**Age Restriction**

**Prescriber Restriction**

RESERVED FOR PRESCRIBING BY DERMATOLOGY AND RHEUMATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

**Coverage Duration**

CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

**Other Criteria**

RHEUMATOLOGY: DOSE IS LIMITED TO FDA-APPROVED DOSE OF 50MG PER WEEK.

DERMATOLOGY: INITIAL DOSE IS LIMITED TO FDA-APPROVED DOSE OF 50MG TWO TIMES PER WEEK FOR THREE MONTHS, FOLLOWED BY 50MG PER WEEK WITH DOCUMENTATION OF POSITIVE RESPONSE.
ENZYME REPLACEMENT

Drugs
ADAGEN, ALDURAZYME, CERDELGA, CHOLBAM, ELAPRASE, ELELYSO, ELITEK INTRAVENOUS RECON SOLN 1.5 MG, FABRAZYME INTRAVENOUS RECON SOLN 35 MG, ILARIS (PF), LUMIZYME, MYOZYME, NAGLAZYME, ORFADIN, VPRIV

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY PROVIDERS SPECIALIZING IN GENETICS AND METABOLISM

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
ERYTHROPOIESIS STIMULATING AGENTS

Drugs
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML, ARANESP (IN POLYSORBATE) INJECTION SYRINGE, PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINICATION TO THERAPY.

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR CANCER DIAGNOSIS: DOCUMENTED CHEMOTHERAPY-ASSOCIATED ANEMIA (HEMOGLOBIN LESS THAN 10G/DL OR HEMATOCRIT LESS THAN 30%).

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.
FDA-APPROVED INDICATIONS

Drugs
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 300 MG,
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING, amikacin
injection solution 500 mg/2 ml, ammonium chloride, APOKYN, ARALAST NP INTRAVENOUS RECON
SOLN 500 MG, ARISTADA, ATGAM, BENLYSTA INTRAVENOUS RECON SOLN 120 MG,
BERINERT INTRAVENOUS KIT, BETHKIS, CANCIDAS, CAPASTAT, CAYSTON, chloramphenicol
sod succinate, CHORIONIC GONADOTROPIN, HUMAN, CINRYZE, CORDRAN TAPE LARGE
ROLL, cycloserine, DEMSER, dextrazoxane hcl intravenous recon soln 250 mg, ERAXIS(WATER
DILUENT) INTRAVENOUS RECON SOLN 100 MG. FIRAZYR, fomepizole, FUSILEV, GLASSIA,
HETLIOZ, INVEGA SUSTENNA, INVEGA TRINZA, KALBITOR, KEPIVANCE, levoleucovorin
calcium, LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG, memantine, mesna,
MOVANTIK, MOZOBIL, NAMENDA, NAMENDA TITRATION PAK, NAMENDA XR, NUEDEXTA,
oxandrolone oral tablet 10 mg, 2.5 mg, PROLASTIN-C, PULMOZYME, quinine sulfate, RELISTOR
SUBCUTANEOUS SOLUTION, RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML, rifampin
intravenous, RUCONEST, SIRTURO, SOLIRIS, SOMATULINE DEPOT, SOMAVERT, SYNAGIS
INTRAMUSCULAR SOLUTION 50 MG/0.5 ML, SYNAREL, TOBI, TOBI PODHALER
INHALATION CAPSULE, W/INHALATION DEVICE, tobramycin in 0.225 % nacl, tobramycin in 0.9 %
nacl intravenous piggyback 80 mg/100 ml, tobramycin sulfate injection solution, tranexamic acid intravenous,
XYREM, ZEMAIRA, ZORBTIVE, ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR
RECONSTITUTION 300 MG

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION,
WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
FDA-APPROVED INDICATIONS WITH BVD

Drugs
ABELCET, AMBISOME, *amphotericin b*, BIVIGAM, CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM, CUBICIN, FLEBOGAMMA DIF, *foscarnet*, GAMASTAN S/D, GAMMAGARD LIQUID, GAMMAKED INJECTION SOLUTION 10 GRAM/100 ML (10 %), GAMMAPLEX, GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %), HIZENTRA SUBCUTANEOUS SOLUTION 4 GRAM/20 ML (20 %), HYQVIA, OCTAGAM, PRIVIGEN, ZORTRESS

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.
FONDAPARINUX

Drugs
fondaparinux

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND DOCUMENTATION OF FAILURE OR MEDICAL CONTRAINDICATIONS WITH ENOXAPARIN, OR (2) DIAGNOSIS OF HEPARIN-INDUCED THROMBOCYTOPENIA, OR (3) DIAGNOSIS OF MALIGNANCY WITH HYPERCOAGULABLE STATE.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.
FORTEO

 Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

 Exclusion Criteria

 Required Medical Information
(1) FRAGILITY FRACTURE OF THE SPINE OR HIP WITHIN THE LAST FIVE YEARS, OR (2) SEVERE OSTEOPOROSIS WITH A T-SCORE OF SPINE, HIP OR FEMORAL NECK OF MINUS 3.5 OR LOWER, OR (3) OSTEOPOROSIS WITH A T-SCORE OF MINUS 2.5 OR LOWER AND (A) INTOLERANCE OR CONTRAINDICATION TO BISPHOSPHONATE THERAPY, OR (B) PROGRESSIVE BONE LOSS DEFINED AS BONE LOSS OF THREE PERCENT OR HIGHER DESPITE THERAPY WITH BISPHOSPHONATES, ADEQUATE CALCIUM INTAKE AND VITAMIN D INTAKE WITH VITAMIN D SERUM LEVELS OF 30 NG/ML OR HIGHER.

 Age Restriction

 Prescriber Restriction

 Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

 Other Criteria
FULYZAQ

Drugs
FULYZAQ

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND CONTRAINDICATIONS OR INADEQUATE RESPONSE TO LOPERAMIDE AND DIPHENOXYLATE/ATROPINE. RENEWAL CRITERIA: DOCUMENTATION OF BENEFICIAL RESPONSE.

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
Drugs
GATTEX ONE-VIAL

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA: (1) TREATMENT OF ADULT PATIENTS WITH SHORT BOWEL SYNDROME, AND (2) WHO HAVE BEEN DEPENDENT ON PARENTERAL (OR A COMBINATION OF PARENTERAL AND ENTERAL) NUTRITION FOR ALL NUTRITIONAL REQUIREMENTS FOR AT LEAST ONE YEAR, AND (3) IN WHOM A TAPER FROM PARENTERAL REQUIREMENTS HAS NOT BEEN POSSIBLE OR PLANNED. RENEWAL CRITERIA: DOCUMENTED REDUCTION IN PARENTERAL NUTRITION REQUIREMENTS OF AT LEAST 20% FROM BASELINE.

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
DOSE IS LIMITED TO THE FDA-APPROVED DOSE OF 0.05 MG/KG PER DAY.
GILOTRIF

Drugs
GILOTRIF

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

Required Medical Information
INITIAL CRITERIA FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION THAT THERE HAS BEEN NO DISEASE PROGRESSION.

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
**Drugs**

HARVONI

**Covered Uses**

ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria**

**Required Medical Information**

(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF HEPATITIS C GENOTYPE AND BASELINE VIRAL LOAD, PROVIDER ATTESTATION OF READINESS TO TREAT, PATIENT ATTESTATION OF READINESS FOR TREATMENT, AND SUBMISSION OF VIROLOGIC RESPONSE UPON COMPLETION OF TREATMENT.

**Age Restriction**

**Prescriber Restriction**

RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, OR HEPATOLOGY, OR INFECTIOUS DISEASE SPECIALISTS.

**Coverage Duration**

12-24 WKS PER DIAGNOSIS, FDA LABELING OR CLINICAL GUIDELINES. 8 WK APPROVALS PER PROVIDER REQUEST.

**Other Criteria**

DOSE IS LIMITED TO THE FDA-APPROVED REGIMEN OF ONE TABLET DAILY.
HIGH-STRENGTH OPIOID AGENTS

Drugs
oxycodone oral tablet, oral only, ext. rel. 12 hr 80 mg, OXYCONTIN ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 60 MG, 80 MG

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN ADEQUATE CARE PLAN WHICH INCLUDES ONGOING MONITORING FOR APPROPRIATE USE, SAFETY, AND EFFECTIVENESS.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA AGENTS

Drugs
JUXTAPID, KYNAMRO

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL: (1) DIAGNOSIS OF HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA. RENEWAL: DOCUMENTATION OF BENEFICIAL RESPONSE.

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
Drugs
HUMIRA, HUMIRA PEDIATRIC CROHN'S START, HUMIRA PEN CROHN'S-UC-HS START

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
RHEUMATOLOGY: (1) DIAGNOSIS OF ANKYLOSING SPONDYLITIS OR (2) DIAGNOSIS OF RHEUMATOID ARTHRITIS, JUVENILE IDIOPATHIC ARTHRITIS OR PSORIATIC ARTHRITIS AND DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH METHOTREXATE. DERMATOLOGY: (1) DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS (AT LEAST 5% BODY SURFACE AREA, OR AFFECTING CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE, OR GENITALS), AND (2) DOCUMENTATION OF INADEQUATE RESPONSE WITH EITHER UVB PHOTOTHERAPY, OR SYSTEMIC THERAPY (SUCH AS METHOTREXATE OR ACITRETIN) UNLESS SYSTEMIC THERAPY ALTERNATIVES ARE CONTRAINDICATED. GASTROENTEROLOGY: (1) DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CROHN'S DISEASE AND DOCUMENTATION OF MEDICAL CONTRAINDICATION OR INADEQUATE RESPONSE TO A CONVENTIONAL THERAPY AGENT (SUCH AS MESALAMINE, A STEROID, AZATHIOPRINE OR METHOTREXATE), OR (2) DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE ULCERATIVE COLITIS AND (3) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO A CONVENTIONAL THERAPY AGENT (SUCH AS 6-MERCAPTOPURINE, AZATHIOPRINE OR CYCLOSPORINE).

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY DERMATOLOGY, GASTROENTEROLOGY AND RHEUMATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
RHEUMATOLOGY: INITIAL DOSE IS LIMITED TO FDA-APPROVED DOSE OF 40MG EVERY OTHER WEEK. DERMATOLOGY: INITIAL DOSE IS LIMITED TO FDA-APPROVED DOSE OF 80MG ONCE, THEN 40MG EVERY TWO WEEKS STARTING ONE WEEK AFTER THE INITIAL DOSE FOR A TOTAL OF THREE MONTHS, FOLLOWED BY 40MG EVERY OTHER WEEK WITH DOCUMENTATION OF POSITIVE RESPONSE. GASTROENTEROLOGY: INITIAL DOSE IS LIMITED TO FDA-APPROVED DOSE OF 160MG ONCE, THEN 80MG AT WEEK TWO, FOLLOWED BY 40MG EVERY OTHER WEEK.
IDIOPATHIC PULMONARY FIBROSIS AGENTS

Drugs
ESBRIET, OFEV

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY PULMONOLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs

INCIVEK

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF HEPATITIS C WITH DOCUMENTATION OF HCV GENOTYPE 1 AND VIRAL LOAD, AND (2) PRESCRIBED IN COMBINATION WITH PEGYLATED INTERFERON AND RIBAVIRIN.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, OR HEPATOLOGY, OR INFECTIOUS DISEASE SPECIALISTS.

Coverage Duration
12 WEEKS, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
CRESEMBA ORAL, linezolid, NOXAFIL ORAL, SIVEXTRO, voriconazole, ZYVOX ORAL

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY AN INFECTIOUS DISEASE SPECIALIST.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
INFERGEN SUBCUTANEOUS SOLUTION 15 MCG/0.5 ML

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION FOR THIS MEDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTED FAILURE WITH PEG-INTRON OR PEGASYS OR INTRON-A.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
ITRACONAZOLE

Drugs
itraconazole, SPORANOX ORAL SOLUTION

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR COMPLEX FUNGAL NAIL INFECTIONS (ONYCHOMYCOsis): DOCUMENTED FAILURE ON ORAL TERBINAFINE.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
JAKAFI

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA FOR NEW START PATIENTS: (1) DIAGNOSIS OF INTERMEDIATE- OR HIGH-RISK MYELOFIBROSIS DEFINED BY THE INTERNATIONAL WORKING GROUP CONSENSUS CRITERIA AND, (2) WITH CONSTITUTIONAL SYMPTOMS, AND (2) PALPABLE SPLENOEALY OF AT LEAST 5 CM BELOW THE COSTAL MARGIN. RENEWAL CRITERIA: DOCUMENTATION OF REDUCTION IN SPLEEN VOLUME AND/OR SIZE OR SYMPTOM IMPROVEMENT.

Age Restriction

Prescriber Restriction

Coverage Duration
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
KALYDECO, ORKAMBI

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) CARE MANAGED BY A CYSTIC FIBROSIS TREATMENT CENTER.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
KINERET

Drugs
KINERET

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR RHEUMATOLOGY: DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO ENBREL AND HUMIRA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY AND GENETICS SPECIALISTS WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
*alosetron, LOTRONEX*

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND DOCUMENTATION OF SYMPTOMS CAUSING SIGNIFICANT DISABILITY (E.G. HOSPITALIZATIONS, OR MISSING WORK OR RESTRICTION OF DAILY ACTIVITIES).

Age Restriction

Prescriber Restriction
RESTRICTED ONLY TO PROVIDERS WHO ARE ENROLLED IN THE PRESCRIBING PROGRAM FOR LOTRONEX (PPL).

Coverage Duration
4 WEEKS, THEN BALANCE OF CONTRACT YEAR ONLY IF SIGNIFICANT IMPROVEMENT IN DISABILITY.

Other Criteria
MARQIBO

Drugs
MARQIBO

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION THAT DISEASE PROGRESSION HAS NOT OCCURRED.

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
MECASERMIN

Drugs
INCRELEX

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY ENDOCRINOLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
MEDICALLY ACCEPTED INDICATIONS

Drugs
cyclobenzaprine oral tablet

Covered Uses
ALL FDA-APPROVED INDICATIONS AND MEDICALLY ACCEPTED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION OR CMS-APPROVED COMPENDIA ACCEPTED INDICATION FOR THE REQUESTED MEDICATION.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
MEDROXYPROGESTERONE 400 MG/ML IM INJECTION

Drugs
DEPO-PROVERA INTRAMUCULAR SOLUTION

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF CANCER FOR A NEW START PATIENT, OR (2) DOCUMENTATION THAT A PATIENT IS CURRENTLY RECEIVING OR HAS PREVIOUSLY RECEIVED AND BENEFITED FROM DEPO-PROVERA 400MG/ML INTRAMUCULAR INJECTION FOR THE TREATMENT OF CANCER.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
MENEST

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: (1) PRESCRIBED AS PALLIATIVE THERAPY FOR SELECTED
PATIENTS WITH METASTATIC BREAST CANCER OR ADVANCED PROSTATE CANCER OR (2)
PRESCRIBED FOR ANY OTHER FDA APPROVED INDICATION AND PREVIOUS USE OF TWO OF
THE FOLLOWING: PREMARIN TABLETS, ESTRADIOL TABLETS OR ESTROPIRATE TABLETS.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION,
WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
ARCALYST, CARBAGLU, KUVAN, RAVICTI, SUCRAID

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

Required Medical Information
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) APPROPRIATE DIETARY RESTRICTIONS IN PLACE.
RENEWAL CRITERIA: DOCUMENTATION OF BENEFICIAL RESPONSE.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY PROVIDERS SPECIALIZING IN GENETICS AND METABOLISM

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
MIACALCIN INJECTION

Drugs
MIACALCIN INJECTION

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND DOCUMENTATION OF TRIAL AND FAILURE OR MEDICAL CONTRAINDICATIONS TO BISPHOSPHONATES.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
MULTAQ

Drugs
MULTAQ

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTED FAILURE WITH OR MEDICAL CONTRAINDICATIONS TO FIRST-LINE MEDICATIONS SUCH AS AMIODARONE, FLECAINIDE, PROPafenONE OR SOTALOL.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY CARDIOLOGY

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
MULTIPLE SCLEROSIS - NON-PREFERRED INJECTABLES

Drugs
AVONEX (WITH ALBUMIN), AVONEX INTRAMUSCULAR SYRINGE KIT, EXTAVIA SUBCUTANEOUS KIT, PLEGRIDY SUBCUTANEOUS PEN INJECTOR, PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE OR MEDICAL CONTRAINDICATION TO GLATIRAMER 20 MG AND REBIF.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY NEUROLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
AUBAGIO, GILENYA

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE OR MEDICAL CONTRAINDICATION TO TECFIDERA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY NEUROLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
MULTIPLE SCLEROSIS - PREFERRED AGENTS

Drugs
COPAXONE SUBCUTANEOUS SYRINGE, glatopa, REBIF (WITH ALBUMIN), REBIF REBIDOSE, REBIF TITRATION PACK, TECFIDERA

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY NEUROLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
NARCOTIC AGENTS

Drugs
fentanyl citrate buccal lozenge on a handle 200 mcg, 400 mcg, LAZANDA NASAL SPRAY, NON-AEROSOL 100 MCG/SPRAY, 400 MCG/SPRAY

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION THAT THE PATIENT HAS DIFFICULTY SWALLOWING OR HAS COMPLIANCE CONCERNS WITH ORAL NARCOTIC TABLETS, CAPSULES, OR LIQUID.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
NEUMEGA

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DOCUMENTATION TO SUPPORT USE FOR THE PREVENTION OF SEVERE THROMBOCYTOPENIA (REDUCED PLATELET COUNT) FOLLOWING MYELOSUPPRESSIVE CHEMOTHERAPY IN ADULT PATIENTS WITH NONMYELOID MALIGNANCIES WHO ARE AT HIGH RISK FOR THROMBOCYTOPENIA.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, (2) DOCUMENTATION OF NO IMPROVEMENT WITH SUPPORTIVE MEASURES (HYDRATION, PHYSICAL POSITIONING, OR WRAPS), AND (3) DOCUMENTATION OF TRIAL AND FAILURE WITH FLUDROCORTISONE AND MIDODRINE. RENEWAL CRITERIA: MEDICAL RECORD DOCUMENTATION OF CONTINUED EFFECTIVENESS.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH A CARDIOLOGIST OR NEUROLOGIST

Coverage Duration
ONE MONTH, WITH APPROVAL EVERY THREE MONTHS IF RENEWAL CRITERIA ARE MET.

Other Criteria
NUVIGIL

Drugs
modafinil, NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG, 50 MG

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF NARCOLEPSY OR IDIOPATHIC HYPERSOMNOLENCE, OR (2) DIAGNOSIS OF RESIDUAL SLEEPINESS FROM SLEEP APNEA, OR (3) DIAGNOSIS OF SHIFT WORK DISORDER, OR (4) DIAGNOSIS OF MULTIPLE SCLEROSIS-RELATED FATIGUE AND DOCUMENTATION OF FAILURE WITH AMANTADINE OR METHYLPHENIDATE.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
OLYSIO

Drugs
OLYSIO

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF HEPATITIS C GENOTYPE 1 AND BASELINE VIRAL LOAD, PROVIDER ATTESTATION OF READINESS TO TREAT, AND SUBMISSION OF VIROLOGIC RESPONSE UPON COMPLETION OF TREATMENT. IF GENOTYPE 1A: DOCUMENTATION PATIENT IS NEGATIVE FOR NS3 Q80K POLYMORPHISM. IF REQUESTING COMBINATION USE OF OLYSIO AND SOVALDI, MUST PROVIDE DOCUMENTATION THAT PATIENT IS NON-RESPONDER TO OR INTOLERANT OF PEGYLATED INTERFERON.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, HEPATOLOGY, OR INFECTIOUS DISEASE SPECIALISTS.

Coverage Duration
COVERAGE IS LIMITED TO 12 WEEKS.

Other Criteria
DOSE IS LIMITED TO THE FDA-APPROVED DOSE OF 150MG DAILY. MUST BE USED IN A COMBINATION ANTIVIRAL TREATMENT REGIMEN SUPPORTED BY FDA APPROVED LABELING OR RELEVANT CLINICAL GUIDELINES, SUCH AS (1) TRIPLE THERAPY WITH OLSYIO, PEGYLATED INTERFERON AND RIBAVIRIN OR (2) DUAL THERAPY WITH OLYSIO AND SOVALDI.
ORAL DISSOLVE TABLETS PROTECTED CLASS

Drugs
ABILIFY DISCMELT, aripiprazole oral tablet, disintegrating, clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg, clozapine oral tablet, disintegrating, FAZACLO ORAL TABLET, DISINTEGRATING 150 MG, 200 MG, LAMICTAL ODT, lamotrigine oral tablet, disintegrating, olanzapine oral tablet, disintegrating, risperidone oral tablet, disintegrating

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION THAT THE PATIENT HAS DIFFICULTY SWALLOWING OR HAS COMPLIANCE CONCERNS WITH REGULAR TABLET DOSAGE FORMS.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
OXTELLAR XR, TROKENDI XR

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE TO THE EQUIVALENT IMMEDIATE-RELEASE ORAL DOSAGE FORM, OR COMPLIANCE CONCERNS WITH THE EQUIVALENT IMMEDIATE-RELEASE DOSAGE FORM.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
ORAL LIQUID PROTECTED CLASS

Drugs
VERSACLOZ

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION THAT THE PATIENT HAS DIFFICULTY SWALLOWING OR HAS COMPLIANCE CONCERNS WITH REGULAR TABLET OR CAPSULE DOSAGE FORMS.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
ORAL ONCOLOGY AGENTS

Drugs
BOSULIF, ERIVEDGE, FARYDAK, IBRANCE, ICLUSIG, IMBRUVICA, INLYTA, IRESSA, LENVIMA, LONSURF, LYNPARZA, MEKINIST, ODOMZO, POMALYST, STIVARGA, TAFINLAR, XALKORI, ZELBORAF, ZYDELIG, ZYKADIA

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINICATION TO THERAPY.

Required Medical Information
INITIAL CRITERIA FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION THAT DISEASE PROGRESSION HAS NOT OCCURRED.

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
ORENCIA

Drugs
ORENCIA, ORENCIA (WITH MALTOSE)

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED RHEUMATOLOGY DISORDER AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO ENBREL AND HUMIRA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
ORENITRAM

Drugs
ORENITRAM

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, (2) A PREVIOUS TRIAL OF TREPROSTINIL, AND (3) DEMONSTRATED MEDICAL NECESSITY.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY PULMONOLOGY OR CARDIOLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
OTEZLA, OTEZLA STARTER

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO ENBREL AND HUMIRA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
DOSE IS LIMITED TO THE FDA-APPROVED DOSE OF 30 MG TWICE DAILY.
**PANTOPRAZOLE IV**

**Drugs**

*pantoprazole intravenous*

**Covered Uses**

ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria**

**Required Medical Information**

(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF: (A) FAILURE WITH ORAL FORMULARY PROTON PUMP INHIBITORS OMEPRAZOLE AND LANSOPRAZOLE, OR (B) MEDICAL CONTRAINDICATIONS TO ORAL PROTON PUMP INHIBITORS.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

**Other Criteria**
PARICALCITOL

Drugs
paricalcitol oral

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE WITH CALCITRIOL.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.
Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR TREATMENT OF HEPATITIS C, DOCUMENTATION OF HCV GENOTYPE, VIRAL LOAD AND LIVER FUNCTION TESTS, AND DOCUMENTATION OF INTOLERANCE TO OR ADVERSE EFFECTS FROM PRIOR USE OF PEGINTRON.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, OR HEPATOLOGY, OR INFECTIOUS DISEASE SPECIALISTS.

Coverage Duration
HEP C GENOTYPE 1: UP TO 48 WEEKS. HEP B AND HEP C GENOTYPES 2 OR 3: UP TO 24 WEEKS.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
PEGINTRON

Drugs
PEGINTRON, PEGINTRON REDIPEN

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR TREATMENT OF HEPATITIS C, DOCUMENTATION OF HCV GENOTYPE, VIRAL LOAD AND LIVER FUNCTION TESTS.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, OR HEPATOLOGY, OR INFECTIOUS DISEASE SPECIALISTS.

Coverage Duration
DURATION PER DIAGNOSIS. 12-48 WEEKS PER FDA APPROVED LABELING OR CLINICAL GUIDELINES.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
PROCYSBI

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) A TRIAL OF IMMEDIATE-RELEASE CYSTEAMINE WITH DOCUMENTED EXPLANATION OF WHY TWICE DAILY DOSING IS MEDICALLY NECESSARY. RENEWAL CRITERIA: DOCUMENTATION OF CLINICAL TREATMENT EFFECT (SUCH AS MEASURED BY SERUM OR WBC CYSTINE LEVELS)

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY PROVIDERS SPECIALIZING IN GENETICS AND METABOLISM.

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
PROMACTA

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction
RESTRICTED FOR PRESCRIBING BY PROVIDERS WHO ARE ENROLLED IN THE PROMACTA CARES PROGRAM.

Coverage Duration
TWO MONTHS, THEN BALANCE OF CONTRACT YEAR IF POSITIVE RESPONSE.

Other Criteria
Drugs
epoprostanol (glycine), REMODULIN, REVATIO INTRAVENOUS, sildenafil, TYVASO, TYVASO REFILL KIT, TYVASO STARTER KIT, VELETRI, VENTAVIS

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

Required Medical Information
DIAGNOSIS OF VASOREACTIVE PULMONARY ARTERIAL HYPERTENSION (PAH) WITH TRIAL AND FAILURE OF CALCIUM CHANNEL BLOCKER THERAPY, OR DIAGNOSIS OF NON-VASOREACTIVE PAH.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY PULMONOLOGY OR CARDIOLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.
Drugs
ADEMPAS, LETAIRIS, OPSUMIT, sildenafil, TRACLEER

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

Required Medical Information
DIAGNOSIS OF VASOREACTIVE PULMONARY ARTERIAL HYPERTENSION (PAH) WITH TRIAL AND FAILURE OF CALCIUM CHANNEL BLOCKER THERAPY, OR DIAGNOSIS OF NON-VASOREACTIVE PAH.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
QUETIAPINE ER

Drugs
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION THAT THE PATIENT HAS SIGNIFICANT COMPLIANCE CONCERNS WITH QUETIAPINE REGULAR RELEASE.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
REMICADE

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR RHEUMATOLOGY: (1) DIAGNOSIS OF ANKYLOSING SPONDYLITIS, RHEUMATOID ARTHRITIS, OR PSORIATIC ARTHRITIS AND DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR FAILURE WITH ENBREL AND HUMIRA, OR FOR DERMATOLOGY: (2) DIAGNOSIS OF SEVERE PSORIASIS AND DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR FAILURE WITH ENBREL AND HUMIRA, OR FOR GASTROENTEROLOGY: (3) DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE ULCERATIVE COLITIS AND DOCUMENTATION OF AN INADEQUATE RESPONSE TO CONVENTIONAL THERAPY (SUCH AS AZATHIOPRINE OR MERCAPTOPURINE), OR DIAGNOSIS OF MODERATELY TO SEVERELY ACTIVE CROHN'S DISEASE, AND DOCUMENTATION OF AN INADEQUATE RESPONSE TO CONVENTIONAL THERAPY (SUCH AS AZATHIOPRINE, METHOTREXATE OR MERCAPTOPURINE) AND DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR FAILURE WITH HUMIRA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY DERMATOLOGY, GASTROENTEROLOGY AND RHEUMATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.
RIFAPENTINE

Drugs
PRIFTIN

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY INFECTIOUS DISEASE SPECIALISTS, OR FOR SITES PROVIDING DIRECTLY OBSERVED THERAPY OR EQUIVALENT.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
RITUXAN

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
RHEUMATOLOGY: (1) DIAGNOSIS OF AN FDA-APPROVED RHEUMATOLOGY DISORDER, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR FAILURE WITH ENBREL AND HUMIRA. HEMATOLOGY: (1) DIAGNOSIS OF IDIOPATHIC THROMBOCYTOPENIC PURPURA OR AUTOIMMUNE HEMOLYTIC ANEMIA AND (2) PATIENTS WITH INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATIONS TO CORTICOSTEROIDS.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY ONCOLOGY, HEMATOLOGY AND RHEUMATOLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.
Drugs

RYTARY

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

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF INADEQUATE RESPONSE TO CARBIDOPA/LEVODOPA (IMMEDIATE OR EXTENDED RELEASE).

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
SABRIL

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTED FAILURE ON TWO OTHER FORMULARY SEIZURE MEDICATIONS SUCH AS CARBAMAZEPINE, DIVALPROEX, LEVETIRACETAM, GABAPENTIN, TOPIRAMATE, AND OTHERS.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY NEUROLOGIST

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DOCUMENTATION THAT OTHER THERAPIES HAVE PROVEN INEFFECTIVE FOR HIV-INFECTED PATIENTS DIAGNOSED WITH SIGNIFICANT WASTING.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
SIGNIFOR

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL: DOCUMENTATION OF BENEFICIAL RESPONSE.

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
Drugs
SIMPONI SUBCUTANEOUS SYRINGE

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR RHEUMATOLOGY: DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE WITH ENBREL AND HUMIRA, OR FOR GASTROENTEROLOGY: DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO HUMIRA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY AND GASTROENTEROLOGY WITHIN THE SCOPE OF THE APPLICABLE PRESCRIBER SPECIALTY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
SOMATROPIN

Drugs
NORDITROPIN FLEXPRO, OMNITROPE

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
CRITERIA FOR CHILDREN: TREATMENT IS PRESCRIBED BY A PEDIATRIC ENDOCRINOLOGIST AND EITHER 1 OR 2 OR 3 OR 4: (1) SHORT STATURE INITIAL: A) CURRENT HEIGHT IS 2.5 OR MORE STANDARD DEVIATIONS BELOW NORMAL, OR B) TARGET ADULT HEIGHT OF 2 OR MORE STANDARD DEVIATIONS BELOW MIDPARENTAL HEIGHT, OR C) HEIGHT VELOCITY OF MINUS 2 OR MORE STANDARD DEVIATIONS FOR AGE AND TANNER STAGE, AND D) GROWTH HORMONE (GH) PROVOCATIVE TESTING (GH PEAK LESS THAN 10 MG/ML), OR E) SERUM IGF LEVELS (IGF-1 OR IGFBP-3) LESS THAN 1 STANDARD DEVIATION BELOW NORMAL, OR F) IGF GENERATION TEST (STIMULATE LEVEL 3 TIMES BASELINE OR GREATER THAN 250MG/ML). (1) SHORT STATURE RENEWAL: A) INCREASE IN HEIGHT VELOCITY OF MORE THAN 50% ABOVE BASELINE, AND B) PATIENT HEIGHT IS 5 FEET 8 INCHES OR LESS FOR BOYS OR 5 FEET 3 INCHES OR LESS FOR GIRLS, AND C) PATIENT HAS NOT ACHIEVED MATURE BONE AGE (17 OR GREATER FOR BOYS OR 15 OR GREATER FOR GIRLS), (2) PANHYPOPITUITARISM, (3) PRADER-WILLI, (4) TURNER’S SYNDROME AND BONE AGE IS 15 YEARS OR LESS AND GROWTH IS GREATER THAN 2 CM PER YEAR. CRITERIA FOR ADULTS: TREATMENT IS PRESCRIBED BY AN ENDOCRINOLOGIST AND THE PATIENT HAS GROWTH HORMONE DEFICIENCY (GHD) WITH 1 OR 2 AND 3 AND 4 AND 5 LISTED BELOW: (1) HISTORY OF HYPOTHALAMIC OR PITUITARY DISEASE OR HISTORY OF CRANIAL IRRADIATION, OR (2) LOW IGF-1 LEVELS BASED ON AGE ADJUSTED VALUES AND SERUM GROWTH HORMONE CONCENTRATION OF LESS THAN 5NG/ML (PEAK LEVELS) FOLLOWING STIMULATION TESTING. ITT (INSULIN TOLERANCE TEST) IS THE DIAGNOSTIC TEST OF CHOICE UNLESS CONTRAINDICATED, AND (3) COMPLETE PITUITARY HORMONE FUNCTION HAS BEEN TESTED AND REPLACED WHEN APPROPRIATE, AND (4) THREE OF THE FOLLOWING: A) ALTERED BODY COMPOSITION WITH INCREASED BODY FAT MASS AND DECREASED LEAN BODY MASS, OR B) DECREASED MUSCLE STRENGTH AND EXERCISE CAPACITY, OR C) REDUCED BONE DENSITY OR PRESENCE OF A FRAGILITY FRACTURE, OR D) POOR SLEEP, OR E) IMPAIRED SENSE OF WELL BEING, AND (5) SECONDARY MEDICAL ILLNESSES THAT AFFECT GH HAVE BEEN RULED OUT.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY ENDOCRINOLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
SOVALDI

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF HEPATITIS C GENOTYPE AND BASELINE VIRAL LOAD, PROVIDER ATTESTATION OF READINESS TO TREAT, AND SUBMISSION OF VIROLOGIC RESPONSE UPON COMPLETION OF TREATMENT. IF REQUESTING COMBINATION USE OF SOVALDI AND OLYSIO, MUST PROVIDE DOCUMENTATION THAT PATIENT IS NON-RESPONDER TO OR INTOLERANT OF PEGYLATED INTERFERON.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, HEPATOLOGY, OR INFECTIOUS DISEASE SPECIALISTS.

Coverage Duration
DURATION PER GENOTYPE AND DIAGNOSIS. 12-48 WEEKS PER FDA APPROVED LABELING OR CLINICAL GUIDELINES.

Other Criteria
DOSE IS LIMITED TO THE FDA-APPROVED DOSE OF 400 MG DAILY. MUST BE USED IN A COMBINATION ANTIVIRAL TREATMENT REGIMEN SUPPORTED BY FDA APPROVED LABELING OR RELEVANT CLINICAL GUIDELINES, SUCH AS (1) TRIPLE THERAPY WITH SOVALDI, PEGYLATED INTERFERON AND RIBAVIRIN OR (2) DUAL THERAPY WITH SOVALDI AND OLYSIO.
Drugs
VYTORIN 10-80

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE TO REACH GOALS DESPITE MAXIMUM TOLERATED DOSE OF ATORVASTATIN.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
STELARA SUBCUTANEOUS SYRINGE

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS (AT LEAST 10% BODY SURFACE AREA, OR WITH PALMAR/PLANTAR PRESENTATIONS), AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR FAILURE WITH ENBREL AND HUMIRA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY DERMATOLOGY

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
SUBLINGUAL IMMUNOTHERAPY

Drugs
GRASTEK, RAGWITEK

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF TRIAL AND FAILURE OF SUBCUTANEOUS IMMUNOTHERAPY.

Age Restriction
LIMITED TO THOSE AGES SPECIFIED WITHIN THE FDA-APPROVED LABEL.

Prescriber Restriction
RESERVED FOR PRESCRIBING BY OR IN CONSULTATION WITH AN ALLERGIST OR IMMUNOLOGIST.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
SYNRIBO

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION THAT DISEASE PROGRESSION HAS NOT OCCURRED

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
THALASSEMIA AGENTS

Drugs
EXJADE, FERRIPROX, JADENU

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY HEMATOLOGY AND ONCOLOGY.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
TRETINOIN MICROSPHERES

Drugs
tretinoin microspheres topical gel

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE WITH TRETINOIN (RETIN-A).

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
TRICYCLIC ANTIDEPRESSANTS IN ELDERLY

Drugs
amitriptyline, doxepin oral, imipramine hcl, SURMONTIL, trimipramine

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND DOCUMENTATION THAT THE PATIENT IS MONITORED FOR ADVERSE DRUG EVENTS.

Age Restriction
RESTRICTIONS APPLY TO PATIENTS GREATER THAN 64 YEARS OF AGE.

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
TRULICITY

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF AN INADEQUATE RESPONSE WITH EXENATIDE (BYETTA OR BYDUREON) AND LIRAGLUTIDE (VICTOZA), OR MEDICAL CONTRAINDICATIONS TO THEIR USE.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
TYSABRI

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) FOR NEUROLOGY: DOCUMENTED FAILURE WITH GLATIRAMER AND REBIF, OR FOR GASTROENTEROLOGY: DOCUMENTATION OF AN INADEQUATE RESPONSE TO CONVENTIONAL THERAPY, SUCH AS MERCAPTOPURINE, AZATHIOPRINE OR METHOTREXATE, OR WITH MEDICAL NECESSITY FOR EARLIER USE OF TYSABRI.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY NEUROLOGY AND GASTROENTEROLOGY

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
VALCHLOR

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA FOR NEW START PATIENTS: (1) FOR THE TOPICAL TREATMENT OF STAGE 1A OR 1B MYCOSIS FUNGOIDES-TYPE CUTANEOUS T-CELL LYMPHOMA IN PATIENTS WHO HAVE RECEIVED PRIOR SKIN-DIRECTED THERAPY. RENEWAL CRITERIA: DOCUMENTATION OF BENEFICIAL RESPONSE

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
APPROVALS ARE LIMITED TO A QUANTITY OF TWO 60 GRAM TUBES PER MONTH.
Drugs

VICTRELIS

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL: (1) DIAGNOSIS OF HEPATITIS C WITH DOCUMENTATION OF HCV GENOTYPE 1 AND VIRAL LOAD, AND (2) PRESCRIBED IN COMBINATION WITH PEGYLATED INTERFERON AND RIBAVIRIN. RENEWAL: HCV RNA TESTING AT WEEK 8 FOR DETERMINATION OF RESPONSE GUIDED THERAPY PER FDA-APPROVED DURATION.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, OR HEPATOLOGY, OR INFECTIOUS DISEASE SPECIALISTS.

Coverage Duration
24 WEEKS, THEN UP TO AN ADDITIONAL 20 WEEKS IF RENEWAL CRITERIA ARE MET FOR FDA-APPROVED DURATION.

Other Criteria
VIEKIRA

Drugs
VIEKIRA PAK

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information: (1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, (2) DOCUMENTATION OF HEPATITIS C GENOTYPE AND BASELINE VIRAL LOAD, PROVIDER ATTESTATION OF READINESS TO TREAT, PATIENT ATTESTATION OF READINESS FOR TREATMENT, AND SUBMISSION OF VIROLOGIC RESPONSE UPON COMPLETION OF TREATMENT, AND (3) DOCUMENTED CLINICAL INAPPROPRIATENESS OF OR INABILITY TO TOLERATE HARVONI.

Age Restriction

Prescriber Restrictions: RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY, OR HEPATOLOGY, OR INFECTIOUS DISEASE SPECIALISTS.

Coverage Duration: DURATION PER GENOTYPE AND DIAGNOSIS. 12-24 WEEKS PER FDA APPROVED LABELING OR CLINICAL GUIDELINES.

Other Criteria: LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
VIRAZOLE

Drugs
VIRAZOLE

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, OR (2) FOR TREATMENT OF RESPIRATORY SYNCYTIAL VIRUS INFECTION FOLLOWING STEM CELL TRANSPLANT.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
THIS DRUG MAY BE COVERED UNDER MEDICARE PART B OR PART D DEPENDING ON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE OF THE DRUG AND SETTING WHERE THE DRUG IS DISPENSED TO MAKE THE PART B OR PART D COVERAGE DETERMINATION.
Drugs
ZONTIVITY

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

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO CONCOMITANT ASPIRIN AND CLOPIDOGREL.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs

XELJANZ

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF MEDICAL CONTRAINDICATIONS OR INADEQUATE RESPONSE TO ENBREL AND HUMIRA.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY RHEUMATOLOGY

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
XENAZINE

Drugs
tetrabenazine, XENAZINE

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY NEUROLOGY.

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF POSITIVE RESPONSE.

Other Criteria
XGEVA

Drugs
XGEVA

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) FOR PREVENTION OF SKELETAL-RELATED EVENTS IN PATIENTS WITH BONE METASTASES FROM SOLID TUMORS WITH INADEQUATE RESPONSE OR MEDICAL CONTRAINDICATION TO Zoledronic Acid OR (2) FOR TREATMENT OF ADULTS AND SKELETALLY MATURE ADOLESCENTS WITH GIANT CELL TUMOR OF BONE THAT IS UNRESECTABLE OR WHERE SURGICAL RESECTION IS LIKELY TO RESULT IN SEVERE MORBIDITY.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
XIFAXAN

Covered Uses
ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF HEPATIC ENCEPHALOPATHY AND DOCUMENTATION THAT SIDE EFFECTS HAVE LIMITED THE DOSE OF LACTULOSE, OR (2) DIAGNOSIS OF TRAVELER’S DIARRHEA AND DOCUMENTATION OF TRIAL AND FAILURE OF OR CONTRAINDICATIONS TO CIPROFLOXACIN, OR (3) DIAGNOSIS OF SMALL BOWEL BACTERIAL OVERGROWTH AND DOCUMENTATION OF A TRIAL OF ONE COURSE OF ANTIBIOTIC APPROPRIATE FOR THIS DIAGNOSIS (SUCH AS CIPROFLOXACIN) WITH INADEQUATE RESULTS, OR (4) DIAGNOSIS OF MODERATE TO SEVERE IRRITABLE BOWEL DISEASE, INCLUDING BLOATING, WITHOUT CONSTIPATION AND PRESCRIBING BY GASTROENTEROLOGY WITH AN INADEQUATE RESPONSE TO FIRST LINE THERAPY INCLUDING AN ANTISPASMODIC AGENT SUCH AS DICYCLOMINE AND AN ANTIDIARRHEAL AGENT SUCH AS LOPERAMIDE OR DIPHENOXYLATE/ATROPINE.

Age Restriction

Prescriber Restriction
RESERVED FOR PRESCRIBING BY GASTROENTEROLOGY FOR TREATMENT OF IRRITABLE BOWEL DISEASE

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
SM BOWEL BACTERIAL OVERGROWTH: 10 DAYS A MONTH FOR CONTRACT YR. IRRITABLE BOWEL DISEASE: DOSE IS LIMITED TO 550 MG THREE TIMES DAILY FOR 14 DAYS. RETREATMENT IS LIMITED TO PATIENTS WITH A POSITIVE RESPONSE AND LIMITED TO A MAXIMUM OF ONE 14 DAY TREATMENT IN A TWELVE MONTH PERIOD.
Drugs
XOLAIR

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELED LIMITATION OF USE OR CONTRAINDICATION TO THERAPY.

Required Medical Information
DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (1) FOR ASTHMA: DOCUMENTATION OF FAILURE WITH THE FOLLOWING STANDARD THERAPIES: (A) REGULAR USE OF INHALED STEROIDS (SUCH AS FLOVENT), (B) REGULAR USE OF A LONG-ACTING BETA-AGONIST (SUCH AS SEREVENT), (C) REGULAR USE OR A TRIAL OF A LEUKOTRIENE ANTAGONIST (SUCH AS MONTELUKAST), AND (D) REGULAR OR PERIODIC USE OF ORAL STEROIDS (SUCH AS PREDNISONE), OR (2) FOR CHRONIC URTICARIA: SYMPTOMS FOR LONGER THAN 6 MONTHS, AND DOCUMENTATION OF FAILURE WITH ALL STANDARD THERAPIES: (A) H1 ANTIHISTAMINE (SUCH AS DIPHENHYDRAMINE), (B) H2 ANTIHISTAMINE (SUCH AS RANITIDINE), (C) LEUKOTRIENE ANTAGONIST (SUCH AS MONTELUKAST), AND (D) MULTIPLE COURSES OF OR DEPENDENT ON AN ORAL STEROID (SUCH AS PREDNISONE).

Age Restriction

Prescriber Restriction
FOR CHRONIC URTICARIA: RESERVED FOR PRESCRIBING BY AN ALLERGIST OR DERMATOLOGIST.

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
XTANDI

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria
PATIENT MUST NOT HAVE AN FDA-LABELLED LIMITATION OF USE OR CONTRAINDICTION TO THERAPY.

Required Medical Information
INITIAL CRITERIA FOR NEW START PATIENTS: (1) DIAGNOSIS OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER, AND (2) PRIOR CHEMOTHERAPY WITH DOCETAXEL, OR NOT A CANDIDATE FOR CHEMOTHERAPY, AND (3) PRIOR TREATMENT WITH ABIRATERONE (ZYTIGA) WITH NEW DISEASE PROGRESSION OR IN CASES WHERE ABIRATERONE REGIMENS ARE CONTRAINDICATED OR NOT TOLERATED. RENEWAL CRITERIA: DOCUMENTATION OF NO DISEASE PROGRESSION AND NO NEW CHEMOTHERAPY REGIMENS. FAILURE IS DEFINED AS SYMPTOMS OF PROGRESSIVE DISEASE OR A SUSTAINED INCREASE IN PSA OF 25-50% OVER AT LEAST TWO MONTHS.

Age Restriction

Prescriber Restriction

Coverage Duration
SIX MONTHS, WITH APPROVAL EVERY SIX MONTHS IF RENEWAL CRITERIA ARE MET.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
ZALTRAP

Drugs
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION THAT DISEASE PROGRESSION HAS NOT OCCURRED.

Age Restriction

Prescriber Restriction

Coverage Duration
THREE MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
Drugs
ZYFLO, ZYFLO CR

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
(1) DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D, AND (2) DOCUMENTATION OF FAILURE WITH MONTELUKAST.

Age Restriction

Prescriber Restriction

Coverage Duration
CONTRACT YEAR, BALANCE OF CONTRACT YEAR, OR FDA-APPROVED DURATION, WHICHEVER IS APPLICABLE FOR USE.

Other Criteria
Drugs
ZYTIGA

Covered Uses
ALL FDA-APPROVED INDICATIONS, NOT OTHERWISE EXCLUDED FROM PART D.

Exclusion Criteria

Required Medical Information
INITIAL CRITERIA FOR NEW START PATIENTS: DIAGNOSIS OF AN FDA-APPROVED INDICATION, NOT OTHERWISE EXCLUDED FROM PART D. RENEWAL CRITERIA: DOCUMENTATION THAT (1) DISEASE PROGRESSION HAS NOT OCCURRED AND (2) NO OTHER CHEMOTHERAPY REGIMENS HAVE BEEN INITIATED AND (3) THE PATIENT HAS NOT EXPERIENCED UNACCEPTABLE TOXICITY. FAILURE IS DEFINED AS SYMPTOMS OF PROGRESSIVE DISEASE OR A SUSTAINED INCREASE IN PSA OF 25-50% OVER AT LEAST TWO MONTHS.

Age Restriction

Prescriber Restriction

Coverage Duration
SIX MONTHS, THEN BALANCE OF CONTRACT YEAR IF RENEWAL CRITERIA ARE MET.

Other Criteria
LIMITED TO A DOSE WITHIN THE FDA LABELED DOSING GUIDELINES.
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