Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

GLYBURIDE/METFORMIN

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

GRANIX

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

HARVONI

Prior Authorization Indication:

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

Off Label Uses:

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

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 – 2020

Prior Authorization Group Description:

HERCEPTIN

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Disease is human epidermal growth factor receptor (HER2) positive.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

GASTRIC AND ESOPHAGEAL CANCER: prescribed in combination with systemic chemotherapy (e.g., cisplatin and either capecitabine or 5-fluorouracil). ENDOMETRIAL CARCINOMA: prescribed in combination with carboplatin and paclitaxel.

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

HETLIOZ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

HUMAN GROWTH HORMONE

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

For the following indications, prescribed by or in consultation with: PSORIATIC ARTHRITIS, PLAQUE PSORIASIS - rheumatologist or dermatologist. CROHN'S DISEASE, ULCERATIVE COLITIS - gastroenterologist. RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS - rheumatologist. HIDRADENITIS SUPPURATIVA - rheumatologist, dermatologist or gastroenterologist. UVEITIS - ophthalmologist or 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 – 2020

Prior Authorization Group Description:

HYDROCODONE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

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

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

HYDROXYZINE HCL INJECTION

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

HYDROXYZINE HCL ORAL

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

HYDROXYZINE PAMOATE

Prior Authorization Indication:

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

Off Label Uses:

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

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ACUTE LYMPHOBLASTIC LEUKEMIA (ALL): disease is Philadelphia chromosome positive (Ph+).

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 – 2020

Prior Authorization Group Description:

IDHIFA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

ILARIS

Prior Authorization Indication:

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

Off Label Uses:

Acute gouty arthritis.

Exclusion Criteria:

Required Medical Information:

Confirmation 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 gastroenterologist. ALL OTHER COVERED INDICATIONS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

ILUMYA

Prior Authorization Indication:

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

Off Label Uses:

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 Group Description:

IMATINIB

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

CHRONIC MYELOID LEUKEMIA (CML), ACUTE LYMPHOBLASTIC LEUKEMIA (ALL): disease is Philadelphia chromosome positive. CHRONIC MYELOMONOCYTIC LEUKEMIA: disease is positive for a platelet-derived growth factor receptor (PDGFR) mutation or a 5q3133 mutation. MYELODYSPLASTIC/MYELOPROLIFERATIVE DISEASES: disease is positive for a PDGFR mutation. AGGRESSIVE SYSTEMIC MASTOCYTOSIS: disease is D816V c-Kit mutation negative or c-Kit mutational status is unknown. MELANOMA: disease is KIT-positive.

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 – 2020

Prior Authorization Group Description:

IMBRUVICA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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:

Prior Authorization Group Description:

IMIPRAMINE

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

INDOMETHACIN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

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

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

INFLECTRA

Prior Authorization Indication:

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

Off Label Uses:

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 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. 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 – 2020

Prior Authorization Group Description:

INGREZZA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a psychiatrist or neurologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

INLYTA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 WITH CLEAR CELL HISTOLOGY: Failure of one prior therapy (e.g., Votrient, Sutent), unless contraindicated or clinically significant adverse effects are experienced. DIFFERENTIATED THYROID CARCINOMA: Failure of Lenvima or Nexavar unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

INTERFERON BETA-1A

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

INTERFERON BETA-1B

Prior Authorization Indication:

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

Off Label Uses:

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:

INTUNIV

Prior Authorization Indication:

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

Off Label Uses:

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 both of the following, unless contraindicated or clinically significant adverse effects are experienced: amphetamine-based stimulant and methylphenidate based-stimulant.

Prior Authorization Group Description:

JAKAFI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

JUBLIA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

JUXTAPID

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

JYNARQUE

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

KADCYLA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

KADIAN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Medical justification as to why patient cannot take an equivalent daily dose of an alternative generically available extended- release morphine sulfate product.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

KALYDECO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Presence of one mutation in the CFTR gene that is responsive to ivacaftor. Confirmation that a homozygous F508del mutation in the CFTR gene is not present.

Age Restrictions:

6 months of age or older.

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

KERYDIN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

KETOROLAC TROMETHAMINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

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

Required Medical Information:

Age Restrictions:

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

Prescriber Restrictions:

Coverage Duration:

5 days.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

KEVEYIS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

KEVZARA

Prior Authorization Indication:

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

Off Label Uses:

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 Group Description:

KEYTRUDA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

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

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

KISQALI(Kisqali , Kisqali Femara Co-Pack)

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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:

Prescribed by or in consultation with an oncologist.

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 – 2020

Prior Authorization Group Description:

KORLYM

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an endocrinologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

KUVAN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Recent (within 90 days) phenylalanine (Phe) blood level is greater than 360 micromol/L. CONTINUATION OF THERAPY: Confirmation of a reduction in Phe blood levels since initiation of therapy.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a metabolic or genetic disease specialist.

Coverage Duration:

Initial: 3 months. Reauthorization: 12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

KYNAMRO

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

LATUDA

Prior Authorization Indication:

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

Off Label Uses:

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 Group Description:

LAZANDA

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

LEMTRADA

Prior Authorization Indication:

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

Off Label Uses:

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 Group Description:

LENVIMA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

AML following induction therapy, Mobilization of hematopoietic progenitor cells into peripheral blood for collection by leukapheresis and autologous transplantation, Following autologous peripheral blood progenitor cell or bone marrow transplantation (BMT) in members with NHL, ALL, HL for acceleration of myeloid reconstitution, Following allogeneic BMT for acceleration of myeloid reconstitution, Acute Radiation Syndrome: Failure of Neupogen, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

LIDODERM

Prior Authorization Indication:

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

Off Label Uses:

Diabetic peripheral neuropathy. Cancer-related neuropathic pain.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

LONSURF

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

COLORECTAL CANCER: Confirmation that the patient does or does not have the RAS (KRAS or NRAS) wild type gene. GASTRIC CANCER, GASTROESOPHAGEAL ADENOCARCINOMA: Confirmation that the patient 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

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 Group Description:

LOTRONEX

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Male patients.

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

LUCEMYRA

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

LYNPARZA TABLET

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 confirmation of human epidermal growth factor receptor 2 (HER2)-negative disease.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

MAVYRET

Prior Authorization Indication:

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

Off Label Uses:

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

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

MEGACE ES

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

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

Age Restrictions:

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

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

MEKINIST

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

MEKTOVI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

MEPERIDINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

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

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

MEPROBAMATE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

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

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

METAXALONE

Prior Authorization Indication:

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

Off Label Uses:

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:

METHAMPHETAMINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Treatment of obesity.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

METHOCARBAMOL

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

METHOTREXATE INJ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, RHEUMATOID ARTHRITIS: Prescribed by or in consultation with a rheumatologist. PSORIASIS: Prescribed by or in consultation with a rheumatologist or a dermatologist.

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

METHYLDOPA

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

MIRVASO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

MOZOBIL

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Member is scheduled to receive autologous stem cell transplantation.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with a granulocyte-colony stimulating factor (G-CSF) (i.e., Neupogen, Zarxio, Granix, or Nivestym).

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

MULPLETA

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

NAMENDA

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

NATPARA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Recent (dated within the last 30 days) serum calcium level is less than 7.5 mg/dL. Recent (dated within the last 30 days) lab result shows sufficient 25-hydroxyvitamin D stores (at least 50 nmol/L or 20 ng/mL). CONTINUATION OF THERAPY: Maintained on therapy with positive response as evidenced by a recent (dated within the last 90 days) serum calcium level within 8-9 mg/dL.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an endocrinologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of an active form of vitamin D (e.g., calcitriol) unless contraindicated or clinically significant adverse events are experienced.

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

NERLYNX

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 Confirmation of previous treatment with trastuzumab as adjuvant therapy and disease is hormone receptor positive or early stage (stage 1-3).

Prior Authorization Group Description:

NEULASTA

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

NEUPOGEN

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

NINLARO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with dexamethasone.

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

NORTHERA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

NUBEQA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

NUCALA

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

NUEDEXTA

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

NUPLAZID

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

NUVIGIL

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

NUZYRA

Prior Authorization Indication:

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

Off Label Uses:

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 confirms 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 confirms 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 – 2020

Prior Authorization Group Description:

OCALIVA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a hepatologist or gastroenterologist.

Coverage Duration:

12 months.

Other Criteria:

Prescribed in combination with ursodeoxycholic acid unless contraindicated or clinically significant adverse effects are experienced to ursodeoxycholic acid.

Prior Authorization Group Description:

OCREVUS

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

ODOMZO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

OFEV

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

OLUMIANT

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

OPSUMIT

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

ORALAIR

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Confirmation of a positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the following grass species: Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass.

Age Restrictions:

Age greater than or equal to 10 years and less than or equal to 65 years.

Prescriber Restrictions:

Prescribed by or in consultation with an allergist or immunologist.

Coverage Duration:

12 months.

Other Criteria:

Failure of both of the following, unless contraindicated or clinically significant adverse effects are experienced: oral antihistamines and intranasal corticosteroids.

Prior Authorization Group Description:

ORENITRAM

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

ORILISSA

Prior Authorization Indication:

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

Off Label Uses:

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:

200 mg twice daily: 6 months. 150 mg once daily: 12 months.

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 – 2020

Prior Authorization Group Description:

ORKAMBI

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

ORPHENADRINE

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

OXERVATE

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

PALYNZIQ

Prior Authorization Indication:

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

Off Label Uses:

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, b, or c): 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 – 2020

Prior Authorization Group Description:

PENNSAID

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Failure of ONE oral non-steroidal anti-inflammatory drug (e.g., ibuprofen, naproxen, fenoprofen, ketoprofen, mefenamic acid, meclofenamate, indomethacin, tolmetin, diclofenac, etodolac, diflunisal, meloxicam, piroxicam), unless all are contraindicated or clinically significant adverse effects are experienced. Failure of either diclofenac 1.5% topical solution or diclofenac 1% topical gel, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

PENTAZOCINE/NALOXONE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

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

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

PERSERIS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

PHENOBARBITAL

Prior Authorization Indication:

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

Off Label Uses:

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 Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

PIQRAY

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

PRALUENT

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

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

PREVYMIS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

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

Required Medical Information:

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 – 2020

Prior Authorization Group Description:

PROCARDIA CAPSULES

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

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

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

PROLASTIN C

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

PROLIA

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

PROMACTA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

CHRONIC IMMUNE THROMBOCYTOPENIA, SEVERE APLASTIC ANEMIA: Prescribed by or in consultation with a hematologist. THROMBOCYTOPENIA IN CHRONIC HEPATITIS C: Prescribed by or in consultation with a hematologist, gastroenterologist, or an infectious disease specialist.

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 Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

PROTOPIC

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

PROVIGIL

Prior Authorization Indication:

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

Off Label Uses:

Multiple sclerosis-related fatigue.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

PURIXAN

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

One of the following: Failure of mercaptopurine tablets, unless contraindicated or clinically significant adverse effects are experienced OR member has a swallowing disorder or an inability to swallow tablets or capsules..

Prior Authorization Group Description:

QUALAQUIN

Prior Authorization Indication:

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

Off Label Uses:

Babesiosis. Plasmodium vivax malaria.

Exclusion Criteria:

For the treatment or prevention of nocturnal leg cramps.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

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

Other Criteria:

Plasmodium vivax malaria: Infection is chloroquine-resistant.

Prior Authorization Group Description:

RADICAVA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a neurologist.

Coverage Duration:

6 months.

Other Criteria:

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

Prior Authorization Group Description:

RAYALDEE

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

RELISTOR

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

REMICADE

Prior Authorization Indication:

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

Off Label Uses:

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 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. 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 – 2020

Prior Authorization Group Description:

REPATHA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

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 greater than 190 mg/dL). Hypercholesterolemia: Confirmation of an LDL of 70 mg/dL or greater AND history of clinical atherosclerotic cardiovascular disease defined as one of the following: Acute coronary syndromes, Myocardial Infarction, Stable or unstable angina, Coronary or other arterial revascularization (e.g., percutaneous coronary intervention or coronary artery bypass graft surgery), Stroke, Peripheral artery disease presumed to be of atherosclerotic origin, Transient ischemic attack (TIA), Clinically significant coronary heart disease (CHD) diagnosed by invasive or noninvasive testing (such as coronary angiography, stress test using treadmill, stress echocardiography, or nuclear imaging), Carotid artery occlusion greater than 50% without symptoms, Renal artery stenosis or renal artery stent procedure. CONTINUATION OF THERAPY: 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 – 2020

Prior Authorization Group Description:

REVATIO

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

REVCOVI

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

REVLIMID

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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:

REXULTI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

RITUXIMAB

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

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

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

RUBRACA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Mutations in the BRCA genes OR member has a complete or partial response to two or more platinum-based chemotherapy regimens.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

RYDAPT

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

SAVELLA

Prior Authorization Indication:

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

Off Label Uses:

Depression.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

SEROQUEL XR

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

SILIQ

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

SIMPONI(auto-injector, prefilled syringe)

Prior Authorization Indication:

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

Off Label Uses:

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 Group Description:

SIMPONI ARIA

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

SOMA

Prior Authorization Indication:

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

Off Label Uses:

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:

SOMAVERT

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an endocrinologist.

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

SOVALDI

Prior Authorization Indication:

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

Off Label Uses:

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

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 Group Description:

SPRAVATO

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

SPRITAM

Prior Authorization Indication:

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

Off Label Uses:

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

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

CHRONIC MYELOGENOUS LEUKEMIA, ACUTE LYMPHOBLASTIC LEUKEMIA: Confirmation 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 Group Description:

STELARA IV

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

4 weeks.

Other Criteria:

CROHN'S DISEASE: Failure of Humira or Remicade and one of the following, unless contraindicated or clinically significant adverse effects are experienced: 6-mercaptopurine, azathioprine or methotrexate.

Prior Authorization Group Description:

STELARA SC

Prior Authorization Indication:

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

Off Label Uses:

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: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

12 months.

Other Criteria:

PLAQUE PSORIASIS: Failure of ONE of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine, or acitretin. PSORIATIC ARTHRITIS: Failure of one TNF inhibitor (e.g., Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Remicade, Inflectra), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

STIVARGA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

STRENSIQ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

SUBSYS

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

SURMONTIL

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

SYMDEKO

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

SYMLINPEN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Previous use of mealtime insulin therapy or an insulin pump.

Prior Authorization Group Description:

SYMPAZAN

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

TAGRISSO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

TAKHZYRO

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

TALZENNA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Confirmation of human epidermal growth factor receptor 2 (HER2)-negative disease and mutation in the BRCA genes.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

TARCEVA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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)). RENAL CELL CARCINOMA: Confirmation of non-clear cell histology.

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

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

CHRONIC MYELOGENOUS LEUKEMIA, ACUTE LYMPHOBLASTIC LEUKEMIA: Confirmation 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 Group Description:

TAVALISSE

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

TECENTRIQ

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

TECFIDERA

Prior Authorization Indication:

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

Off Label Uses:

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:

TEGSEDI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Confirmation of transthyretin (TTR) mutation. Confirmation of 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 Group Description:

TENEX

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

TETRABENAZINE

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

TIBSOVO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Presence of an isocitrate dehydrogenase-1 (IDH1) 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, cladribine, midostaurin).

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

TREMFYA

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

TRIHEXYPHENIDYL

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

TYMLOS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

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

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

TYSABRI

Prior Authorization Indication:

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

Off Label Uses:

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 gastroenterologist.

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. CROHN'S DISEASE: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: Humira or Remicade.

Prior Authorization Group Description:

ULTRAVATE LOTION

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

UPTRAVI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

VALCHLOR

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

VANCOCIN

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

VENCLEXTA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 Group Description:

VERSACLOZ

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

VERZENIO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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:

Prescribed as a single agent or in combination with an aromatase inhibitor (e.g., letrozole, anastrozole or exemestane) 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 – 2020

Prior Authorization Group Description:

VIMOVO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

VINBLASTINE

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Confirmation 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 Group Description:

VINCRISTINE

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

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

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

VITRAKVI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Known acquired tropomyosin receptor kinase resistance mutation.

Required Medical Information:

Confirmation of positive neurotrophic receptor tyrosine kinase gene fusion mutation. Disease is metastatic or surgical resection is likely to result in severe morbidity.

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 – 2020

Prior Authorization Group Description:

VIZIMPRO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Confirmation of EGFR exon 19 deletion or exon 21 (L858R) substitution mutations.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

VOSEVI

Prior Authorization Indication:

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

Off Label Uses:

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:

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

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

VOTRIENT

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 Group Description:

VRAYLAR

Prior Authorization Indication:

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

Off Label Uses:

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

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

NON-SMALL CELL LUNG CANCER: Disease is ALK, ROS1, or MET positive. INFLAMMATORY MYOFIBROBLASTIC TUMOR, ANAPLASTIC LARGE CELL LYMPHOMA: 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 – 2020

Prior Authorization Group Description:

XATMEP

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Less than 18 years of age.

Prescriber Restrictions:

ACUTE LYMPHOCYTIC LEUKEMIA: Prescribed by or in consultation with an oncologist or hematologist.
POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

12 months.

Other Criteria:

Medical justification as to why member cannot use methotrexate tablets.

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

XELJANZ

Prior Authorization Indication:

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

Off Label Uses:

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 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. PSORIATIC ARTHRITIS: Failure of one TNF inhibitor (e.g., Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Remicade, Inflectra), unless predominantly axial disease, contraindicated, or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

XEOMIN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

XERMELO

Prior Authorization Indication:

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

Off Label Uses:

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

Prior Authorization Group Description:

XOLAIR

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

XOSPATA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Confirmation 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 – 2020

Prior Authorization Group Description:

XPOVIO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 Group Description:

XTANDI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Non-metastatic prostate cancer: Concurrent use of a gonadotropin-releasing hormone (GnRH) analog or past bilateral orchiectomy.

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

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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, MALIGNANT PLEURAL MESOTHELIOMA: Failure of a platinum-containing regimen (e.g., cisplatin, carboplatin), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

YONSA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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:

Medical justification supports inability to use Zytiga. 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 – 2020

Prior Authorization Group Description:

ZALTRAP

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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 Group Description:

ZARXIO

Prior Authorization Indication:

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

Off Label Uses:

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 – 2020

Prior Authorization Group Description:

ZEJULA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

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

Prior Authorization Group Description:

ZELBORAF

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

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:

ERDHEIM-CHESTER DISEASE, HAIRY CELL LEUKEMIA: Prescribed by or in consultation with an oncologist or hematologist. ALL OTHER ONCOLOGY INDICATION: Prescribed by or in consultation with an oncologist.

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. COLORECTAL CANCER: Failure of irinotecan or platinum-based therapy (e.g., oxaliplatin), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2020

Prior Authorization Group Description:

ZEPATIER

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

If cirrhosis is present, confirmation of Child-Pugh A status. For genotype 1a, confirmation 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

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Confirmation 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 Group Description:

ZYDELIG

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with a hematologist or oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

ZYKADIA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

NON-SMALL CELL LUNG CANCER: Disease is ALK or ROS1 positive. If disease is ROS1 positive, Zykadia is prescribed as first-line therapy. INFLAMMATORY MYOFIBROBLASTIC TUMOR: Disease is ALK-positive.

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist.

Coverage Duration:

12 months.

Other Criteria:

Prior Authorization Group Description:

ZYTIGA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

12 months.

Other Criteria:

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

ABSTRAL 1
ACTEMRA SC 2
ACTIQ 3
ACYCLOVIR 4
ADCIRCA 5
ADEMPAS 6
AFINITOR 7
AIMOVIG 8
AJOVY 9
ALECENSA 10
ALUNBRIG 11
AMANTADINE 12
AMITRIPTYLINE 13
AMITRIPTYLINE/CHLORDIAZEPOXIDE 14
AMITRIPTYLINE/PERPHENAZINE 15
AMPHOTERICIN B 16
AMPYRA 17
ANTIHISTAMINES 18
ANTIHISTAMINE COMBINATIONS 19
ARANESP 20
AUBAGIO 21
AVASTIN 22
BALVERSA 23
BAXDELA 24
BELEODAQ 25
BELSOMRA 26
BENLYSTA 27
BENZTROPINE 28
BLEOMYCIN 29
BOSULIF 30
BOTOX 31
BRAFTOVI 32
BRIVIACT 33
BUTABARBITAL 34
C1 ESTERASE INHIBITOR 35
CABOMETYX 36
CALQUENCE 37
CAPRELSA 38
CARISOPRODOL/ASPIRIN 39
CARISOPRODOL/ASPIRIN/CODEINE 40
CAYSTON 41
CERDELGA 42
CEREZYME 43
CHLORZOXAZONE 44
CHORIONIC GONADOTROPIN 45
CINQAIR 46
CLADRIBINE 47
CLOMIPRAMINE 48
COMETRIQ 49
COPIKTRA 50
COTELLIC 51
CRINONE 52
CROFELEMER 53
CRYSVITA 54
CYCLOBENZAPRINE HCL 55
CYTARABINE 56
DAKLINZA 57
DAURISMO 58
DICLOFENAC GEL 59
DIPYRIDAMOLE 60
DISOPYRAMIDE 61
DOPTELET 62
DOXEPIN 63
DOXEPIN CREAM 64
ELIDEL 65
EMEND 40 MG 66
EMFLAZA 67
EMGALITY 68
ENBREL 69
ENDARI 70
ENTYVIO 71
EPCLUSA 72
EPIDIOLEX 73
EPOETIN 74
ERGOLOID MESYLATES 75
ERLEADA 76
ESBRIET 77
ESTROGENS(Premphase , Premarin , Lopreeza , Alora , Mimvey Lo , Femhrt , Vivelle-Dot , Menostar , Activella , Estrace , Evamist , estropipate, Climara Pro , Combipatch , Angeliq , Amabelz , Prempro , Mimvey , Elestrin , Climara , Divigel , Duavee) 78
EVZIO 79
EXONDYS 51 80
EYLEA 81
FARYDAK 82
FASENRA 83
FENTORA 84
FERRIPROX 85
FIORICET WITH CODEINE 86
FIORINAL WITH CODEINE 87
FIRAZYR 88
FIRDAPSE 89
FLECTOR 90
FLUOROURACIL 91

FORTEO 92
GALAFOLD 93
GANCICLOVIR 94
GATTEX 95
GILENYA 96
GILOTRIF 97
GLATIRAMER 98
GLIMEPIRIDE 99
GLYBURIDE 100
GLYBURIDE/METFORMIN 101
GRANIX 102
HARVONI 103
HERCEPTIN 104
HETLIOZ 105
HUMAN GROWTH HORMONE 106
HUMIRA 107
HYDROCODONE 108
HYDROXYZINE HCL INJECTION 109
HYDROXYZINE HCL ORAL 110
HYDROXYZINE PAMOATE 111
ICLUSIG 112
IDHIFA 113
ILARIS 114
ILUMYA 115
IMATINIB 116
IMBRUVICA 117
IMIPRAMINE 118
INDOMETHACIN 119
INFLECTRA 120
INGREZZA 121
INLYTA 122
INTERFERON BETA-1A 123
INTERFERON BETA-1B 124
INTUNIV 125
JAKAFI 126
JUBLIA 127
JUXTAPID 128
JYNARQUE 129
KADCYLA 130
KADIAN 131
KALYDECO 132
KERYDIN 133
KETOROLAC TROMETHAMINE 134
KEVEYIS 135
KEVZARA 136
KEYTRUDA 137
KISQALI(Kisqali , Kisqali Femara Co-Pack) 138
KORLYM 139
KUVAN 140
KYNAMRO 141
LATUDA 142
LAZANDA 143
LEMTRADA 144
LENVIMA 145
LEUKINE 146
LIDODERM 147
LONSURF 148
LORBRENA 149
LOTRONEX 150
LUCEMYRA 151
LYNPARZA TABLET 152
MAVYRET 153
MEGACE 154
MEGACE ES 155
MEKINIST 156
MEKTOVI 157
MEPERIDINE 158
MEPROBAMATE 159
METAXALONE 160
METHAMPHETAMINE 161
METHOCARBAMOL 162
METHOTREXATE INJ 163
METHYLDOPA 164
MIRVASO 165
MOZOBIL 166
MULPLETA 167
NAMENDA 168
NATPARA 169
NERLYNX 170
NEULASTA 171
NEUPOGEN 172
NINLARO 173
NORTHERA 174
NUBEQA 175
NUCALA 176
NUEDEXTA 177
NUPLAZID 178
NUVIGIL 179
NUZYRA 180
OCALIVA 181
OCREVUS 182
ODOMZO 183
OFEV 184
OLUMIANT 185

OPSUMIT 186
ORALAIR 187
ORENITRAM 188
ORILISSA 189
ORKAMBI 190
ORPHENADRINE 191
OXERVATE 192
PALYNZIQ 193
PENNSAID 194
PENTAZOCINE/NALOXONE 195
PERSERIS 196
PHENOBARBITAL 197
PIQRAY 198
PRALUENT 199
PREVYMIS 200
PROCARDIA CAPSULES 201
PROLASTIN C 202
PROLIA 203
PROMACTA 204
PROTOPIC 205
PROVIGIL 206
PURIXAN 207
QUALAQUIN 208
RADICAVA 209
RAYALDEE 210
RELISTOR 211
REMICADE 212
REPATHA 213
REVATIO 214
REVCOVI 215
REVLIMID 216
REXULTI 217
RITUXIMAB 218
RUBRACA 219
RYDAPT 220
SAVELLA 221
SEROQUEL XR 222
SILIQ 223
SIMPONI(auto-injector, prefilled syringe) 224
SIMPONI ARIA 225
SOMA 226
SOMAVERT 227
SOVALDI 228
SPRAVATO 229
SPRITAM 230
SPRYCEL 231
STELARA IV 232
STELARA SC 233
STIVARGA 234
STRENSIQ 235
SUBSYS 236
SURMONTIL 237
SYMDEKO 238
SYMLINPEN 239
SYMPAZAN 240
TAGRISSO 241
TAKHZYRO 242
TALZENNA 243
TARCEVA 244
TASIGNA 245
TAVALISSE 246
TECENTRIQ 247
TECFIDERA 248
TEGSEDI 249
TENEX 250
TETRABENAZINE 251
TIBSOVO 252
TREMFYA 253
TRIHEXYPHENIDYL 254
TYMLOS 255
TYSABRI 256
ULTRAVATE LOTION 257
UPTRAVI 258
VALCHLOR 259
VANCOCIN 260
VENCLEXTA 261
VERSACLOZ 262
VERZENIO 263
VIMOVO 264
VINBLASTINE 265
VINCRISTINE 266
VITRAKVI 267
VIZIMPRO 268
VOSEVI 269
VOTRIENT 270
VRAYLAR 271
XALKORI 272
XATMEP 273
XELJANZ 274
XEOMIN 275
XERMELO 276
XOLAIR 277
XOSPATA 278
XPOVIO 279

XTANDI 280
YERVOY 281
YONSA 282
ZALTRAP 283
ZARXIO 284
ZEJULA 285
ZELBORAF 286
ZEPATIER 287
ZINPLAVA 288
ZYDELIG 289
ZYKADIA 290
ZYTIGA 291