You can contact Humana for the most recent list of drugs by calling 1-800-457-4708. You can call us seven days a week, from 8 a.m. – 8 p.m. However, please note that our automated phone system may answer your call during weekends and holidays from Feb. 15 – Sept. 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day. You can also visit Humana.com.

This document applies to the following Humana plans:

Plan	Market	Formulary ID	Version
H1716020	Kansas and Missouri	15082	17
H2649024	Kansas City	15082	17
H6609112	Colorado	15082	17
H6609126	Arkansas and Oklahoma	15082	17

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ABRAXANE	All FDA approved indications not otherwise excluded from Part D.		Breast Cancer. The member has a diagnosis of metastatic (Stage IV) or recurrent breast cancer. The member received prior therapy that included an anthracycline (unless contraindicated). The member has documented hypersensitivity reaction to conventional Taxol (paclitaxel) or Taxotere (docetaxol)or the member has a documented contraindication to standard hypersensitivity premedications. Non-small Cell Lung Cancer (NSCLC). The member has a diagnosis of locally advanced or metastatic NSCLC.The member has documented hypersensitivity reaction to conventional Taxol (paclitaxel) or Taxotere (docetaxol)or the member has a documented contraindication to standard hypersensitivity premedications. Ovarian Cancer. The member has a diagnosis of epithelial ovarian cancer, fallopian tube cancer or primary peritoneal cancer. The member meets one of the following criteria: Progressive, stable or persistent disease on primary chemotherapy. Recurrent disease.The member has documented hypersensitivity reaction to conventional Taxol (paclitaxel) or Taxotere (docetaxol)or the member has a documented contraindication to standard hypersensitivity premedications. Pancreatic Cancer:The member has a diagnosis of metastatic pancreatic cancer AND The member will be using Abraxane (nab-paclitaxel) in combination with gemcitabine.		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Melanoma:The member has a diagnosis of melanoma AND The member meets one of the following criteria:Incompletely resected or unresectable disease.Recurrent or metastatic disease.AND The member has documented hypersensitivity reaction to conventional Taxol (paclitaxel) or Taxotere (docetaxol) or the member has a documented contraindication to standard hypersensitivity premedications.				
ACTIMMUNE	All FDA approved indications not otherwise excluded from Part D.		Chronic Granulomatous Disease (CGD): The member has chronic granulomatous disease (CGD). The member is using Actimmune to reduce the frequency and severity of infections. Severe Malignant Osteopetrosis: The member has severe malignant osteopetrosis confirmed by biopsy. The member is using Actimmune to delay time to disease progression.		Licensed Practitioner	Plan Year	
ACYCLOVIR	All FDA approved indications not otherwise excluded from Part D.		Diagnosis of genital herpes and previous treatment, contraindication, or intolerance to oral acyclovir and one of the following: valacyclovir or famciclovir. OR member has diagnosis of non-life-threatening mucocutaneous HSV infection and is immunocompromised AND member has had previous treatment with generic acyclovir ointment (applies to brand requests only)		Licensed Practitioner	Plan year duration	
ADCIRCA	All FDA approved indications not	Adcirca (tadalafil) therapy is not considered medically	Pulmonary Arterial Hypertension (PAH). The member must have a diagnosis of pulmonary arterial hypertension (WHO Group I).The member must have had prior therapy, intolerance		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.	necessary for members with the following concomitant conditions: Concurrent use of nitrates (e.g., nitroglycerin).Concurrent use of another PDE5 inhibitor, sildenafil (Revatio).	or contraindication to sildenafil (generic Revatio) for the treatment of PAH (WHO Group I).				
ADEMPAS	All FDA approved indications not otherwise excluded from Part D.	Use with nitrates or nitric oxide donors in any form. Use with PDE5 inhibitors.	Chronic Thromboembolic Pulmonary Hypertension (CTEPH).The member must have a diagnosis of Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4)AND The member must have CTEPH classified as inoperable or persistent/recurrent after surgical treatment (i.e. pulmonary endarterectomy).Pulmonary Arterial Hypertension (PAH).The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1)WHO/NYHA Functional Class II or III AND The member must have prior therapy with, intolerance to, or contraindication to ONE phosphodiesterase type 5 (PDE5) inhibitor approved for use in PAH [e.g. Revatio (sildenafil) or Adcirca (tadalafil).		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AFINITOR	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced significant disease progression while on everolimus.	Afinitor (everolimus) will require prior authorization and may be considered medically necessary when the following criteria are met: Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced renal cell carcinoma (stage IV)AND the member has failed to meet therapeutic goals with Inlyta (axitinib) which requires a trial with a first-line agent. The member has a diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis AND The member requires therapeutic intervention but is not a candidate for curative surgical resection.Neuroendocrine Tumors of Pancreatic Origin (PNET).The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) AND The member has disease that is unresectable, locally advanced or metastatic. Angiomyolipoma and Tuberous Sclerosis Complex (TSC).The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex AND Immediate surgery is not required. Metastatic Breast Cancer. The member has a diagnosis of hormone receptor-positive and human epidermal growth factor receptor 2-negative metastatic disease AND The member has experienced disease progression while on Letrozole or Anastrozole therapy AND The member will use Afinitor (everolimus) in combination with Exemestane.		Licensed Practitioner	6 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AFINITOR DISPERZ	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced significant disease progression while on everolimus.	Afinitor (everolimus) will require prior authorization and may be considered medically necessary when the following criteria are met: Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced renal cell carcinoma (stage IV)AND the member has failed to meet therapeutic goals with Inlyta (axitinib) which requires a trial with a first-line agent. The member has a diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis AND The member requires therapeutic intervention but is not a candidate for curative surgical resection.Neuroendocrine Tumors of Pancreatic Origin (PNET).The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) AND The member has disease that is unresectable, locally advanced or metastatic. Angiomyolipoma and Tuberous Sclerosis Complex (TSC).The member has a diagnosis of renal angiomyolipoma and tuberous sclerosis complex AND Immediate surgery is not required. Metastatic Breast Cancer. The member has a diagnosis of hormone receptor-positive and human epidermal growth factor receptor 2-negative metastatic disease AND The member has experienced disease progression while on Letrozole or Anastrozole therapy AND The member will use Afinitor (everolimus) in combination with Exemestane.		Licensed Practitioner	6 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
ALIMTA	All medically accepted indications not otherwise excluded from Part D.	Squamous cell non-small cell lung cancer. Creatinine clearance (CrCl) less than 45 ml/minute.	Malignant Pleural Mesothelioma. Diagnosis of malignant pleural mesothelioma AND must be using Alimta (pemetrexed) as Induction therapy in combination with cisplatin for medically operable clinical stage I-III OR must be using Alimta (pemetrexed) as a single agent or in combination with cisplatin or carboplatin for one of the following: Adjuvant treatment for clinical stage I-III disease. Treatment of unresectable or medically inoperable clinical stage I-III disease. Treatment of clinical stage IV disease or tumors of sarcomatoid histology OR is using Alimta (pemetrexed) as second-line as a single agent if not administered first-line. Non-Small Cell Lung Cancer (Nonsquamous). Diagnosis of nonsquamous non-small cell lung cancer that is locally advanced or metatstatic, AND one of the following applies: Alimta (pemetrexed) is being used in combination with cisplatin or carboplatin therapy for the initial treatment in members with a performance status (PS) 0-2 or elderly patients. Alimta (pemetrexed) is being used in cisplatin or carboplatin-based regimens in combination with Avastin (bevacizumab) in members with PS 0-1 and no history of hemoptysis. As a single agent in PS 2 or elderly patients. Alimta (pemetrexed) is being used as a single agent for the maintenance treatment of members whose disease has not progressed after four cycles of platinum-based first-line		Licensed Practitioner	Plan Year Duration	Bladder Cancer. Diagnosis of metastatic bladder cancer AND Alimta (pemetrexed) is being used as second-line or subsequent therapy as a single agent for metastatic disease. Cervical Cancer. Diagnosis of cervical cancer AND Alimta (pemetrexed) is being used as a second-line or subsequent therapy as a single agent for local/regional recurrence or distant metastases. Ovarian Cancer. Diagnosis of Ovarian Cancer, or Epithelial Ovarian Cancer/Fallopian Tube Cancer/Primary Peritoneal Cancer AND Alimta (pemetrexed) is being used as a single agent for

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			chemotherapy OR As a single agent for the treatment of members with locally advanced or metastatic disease after prior chemotherapy OR As a single agent for recurrence or metastasis in members who achieved tumor response or stable disease following first-line chemotherapy with Alimta (pemetrexed).				persistent disease or recurrence therapy. Thymic Malignancy. Diagnosis of thymic malignancy AND Alimta (pemetrexed) is being used as second-line therapy as a single agent.
AMITRIPTYLINE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
AMPYRA	All FDA approved indications not otherwise excluded from Part D.	History of seizure disorder.Moderate to severe renal impairment (CrCl less 50ml/min).	Ampyra dalfampridine may be considered medically necessary when the following criteria are met.Multiple Sclerosis.Member must have a diagnosis of one of the four types of multiple sclerosis: Relapse Remitting or Primary Progressive or Secondary Progressive or Progressive Relapsing.Patient must be ambulatory.Initial timed 25-foot walk T25W test between eight and 45 seconds or another objective measure of gait that		Licensed Practitioner	6 month duration and then reauthorization at six months for plan year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			provides evidence of significant walking impairment related to multiple sclerosis.Reauthorization Criteria. Documentation of improvement in walking using the T25W test or another objective measure of gait.			duration.	
APTIOM	All FDA approved indications not otherwise excluded from Part D.	Use of oxcarbazepine	Adjunctive treatment for adults with partial-onset seizures: Inadequately controlled partial-onset seizures AND Concomitant use of at least one antiepileptic medication.		Licensed Practitioner	Plan year duration	
ARALAST NP	All FDA approved indications not otherwise excluded from Part D.	IgA deficient members or presence of antibodies against IgA.	Congenital Alpha1-antitrypsin Deficiency: The member has a diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed. The member has an alpha1-antitrypsin phenotype of PiZZ, PiZ(null), or Pi (null, null) or phenotypes associated with serum alpha 1-antitrypsin concentrations of less than 50mg/dL if/when measured by laboratories using nephelometry instead of radial immunodiffusion. Otherwise, a deficiency is shown at 80mg/dL. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema).		Licensed Practitioner	Plan Year Duration	
ARCALYST	All FDA		Rilonacept may be considered medically necessary when the		Licensed	Plan year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D.		following criteria are met- Diagnosis of Familial Cold Autoinflammatory Syndrome or Muckle-Wells Syndrome.		Practitioner		
ARZERRA	All FDA approved indications not otherwise excluded from Part D.		Arzerra/ofatumumab will require prior authorization. For new starts only.This agent may be considered medically necessary when the following criteria are met:The patient has a diagnosis of relapsed or refractory Chronic Lymphocytic Leukemia (CLL) and the Patient has failed (relapsed or refractory) purine-analog based therapy (fludarabine, cladribine, or pentostatin) AND Campath/alemtuzumab therapy.Chronic Lymphocytic Leukemia (CLL) Previously Untreated: The member has a diagnosis of chronic lymphocytic leukemia AND The member has not previously received treatment for CLL AND The member is not appropriate for fludarabine-based therapy.		Licensed Practitioner	Plan year duration	
AVASTIN	All FDA approved indications not otherwise excluded from Part D.	Used in lung cancer members that have small cell or squamous cell disease, recent hemoptysis, untreated CNS	Metastatic colorectal cancer: Diagnosis of metastatic colorectal cancer AND one of the following apply: Member is using bevacizumab in combination with 5-fluorouracil based chemotherapy for first or second-line therapy. Member is using bevacizumab in combination with fluoropyrimidine-irinotecan or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line therapy in patients who have progressed on first-		Licensed Practitioner	six month duration.	Recurrent Primary CNS Tumor (including Glioblastoma multiforme).The member has a diagnosis of progressive or recurrent glioblastoma or anaplastic

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		metastasis, history of bleeding, continuing anticoagulation, or as a single agent (unless maintenance as described in Coverage Determinations). Metastatic Breast Cancer – not indicated for members with breast cancer that has progressed following anthracycline AND taxane chemotherapy administered for metastatic or recurrent disease. Should not be	line bevacizumab-containing regimens. Non-small cell lung cancer (non-squamous cell histology). Member has NSCLC with non-squamous cell histology AND Member is using bevacizumab in combination with cisplatin or carboplatin based regimens for unresectable, locally advanced, recurrent, or metastatic NSCLC OR Member is using bevacizumab as single-agent continuation maintenance therapy if bevacizumab was used as first line treatment for recurrence or metastasis and the member has a performance status of 0-1. Metastatic breast cancer (Effectiveness based on improvement in progression-free survival. No data available demonstrating improvement in disease-related symptoms or survival with bevacizumab). Member is female and has metastatic HER-2 negative breast cancer . Member is using bevacizumab in combination with paclitaxel for first-line therapy AND Member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2. Recurrent Ovarian Cancer: Bevacizumab is being used to treat recurrent ovarian cancer. Stage IV/Metastatic (Unresectable) Renal Cell Carcinoma. Member has renal cell cancer. Member is using bevacizumab to treat stage IV unresectable kidney cancer in combination with interferon alpha. OR Member is using bevacizumab as subsequent therapy for relapsed or medically unresectable stage IV disease with predominant clear cell				glioma AND Bevacizumab is being used as a single agent or in combination with irinotecan, carmustine or temozolomide.The member does not have a CNS hemorrhage.Soft Tissue Sarcoma. The member has a diagnosis of angiosarcoma and bevacizumab is being used as a single agent OR The member has a diagnosis of solitary fibrous tumor and hemangiopericytoma and bevacizumab is being used in combination with temozolomide. Age Related Macular Degeneration.Bevacizumab is being used to treat age related macular degeneration. Diabetic

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		initiated in members with recent hemoptysis or untreated brain metastases due to increased risk of hemorrhage. Should not be used in members who experience a severe arterial thromboembolic event. Should not be used in members with gastrointestinal perforation. Bevacizumab should not be used in members with fistula formation involving internal organs. Bevacizumab should not be used	histology following progression with cytokine therapy.				Macular Edema: Bevacizumab is being used to treat diabetic macular edema.Macular Retinal Edema. Bevacizumab is being used to treat central or branch retinal vein occlusion with macular retinal edema.Cervical Cancer: The member has persistent, recurrent, or metastatic cervical cancer AND Bevacizumab will be used in combination with paclitaxel and cisplatin or paclitaxel and topotecan. Endometrial Cancer: The member has progressive endometrial cancer AND Bevacizumab will be used as a single-agent.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		in members experiencing a hypertensive crisis or hypertensive encephalopathy. Bevacizumab should not be used for at least 28 days following major surgery or until surgical incision is fully healed. Bevacizumab may not be used in conjunction with Vectibix based on the negative outcomes in the PACCE trial. Bevacizumab may not be used in conjunction with Erbitux until further					

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		safety and efficacy data supporting the concomitant use of these two agents is available (BOND II and CAIRO II have not demonstrated a definitive benefit, CALGB 80405 is an ongoing trial). Bevacizumab may not be used in the adjuvant or neoadjuvant setting.Bevacizumab may not be used concomitantly with Sutent due to risk of microangiopathic hemolytic anemia (MAHA). Bevacizumab should not be continued or					

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		restarted after disease progression constituting treatment failure, with the exception of metastatic colorectal cancer. The following coverage limitations apply to intravitreal use of bevacizumab: Bevacizumab may not be used in conjunction with other VEGF inhibitors in the absence of documentation indicating that individual products are to be used in different eyes.					
AVELOX	All FDA		Member must have a previous treatment, intolerance or		Licensed	plan year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D.		contraindication to an AB-rated generic equivalent product.		Practitioner		
AVELOX ABC PACK	All FDA approved indications not otherwise excluded from Part D.		Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
AVONEX	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with similar interferon products such as Betaseron or Rebif.	The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.		Licensed Practitioner	Plan Year Duration	
AVONEX (WITH ALBUMIN)	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with similar interferon products such as Betaseron or Rebif.	The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
AZACITIDINE	All FDA approved indications not otherwise excluded from Part D.	Vidaza (azacitidine) may not be used in conjunction with Dacogen (decitabine)-(both are DNA hypomethylators. The member must not have a diagnosis of advanced malignant hepatic tumors.	Myelodysplastic Syndromes (MDS).The member has a diagnosis of one of the following MDS subtypes: Refractory anemia, Refractory anemia with ringed sideroblasts, Refractory anemia with excess blasts, Refractory anemia with excess blasts in transformation, Chronic myelomonocytic leukemia. With deletion 5q chromosomal abnormality.The member has a diagnosis of lower risk MDS (according to the International Prognostic Scoring System—IPSS, lower risk members include IPSS Low and Intermediate-1 categories) AND The member has failed to achieve response (transfusion independence—defined in background*) with Revlimid (lenalidomide) OR With NO deletion 5q abnormality. The member has a diagnosis of lower risk MDS (according to the International Prognostic Scoring System—IPSS, lower risk members include IPSS Low and Intermediate-1 categories) AND The member has symptomatic anemia and serum erythropoietin levels greater the 500 mU/mL and a low probability of response to immunosuppressive therapy OR The member has symptomatic anemia and has failed initial treatment with erythropoietins or immunosuppressive therapy OR The member has thrombocytopenia or neutropenia OR The member has a diagnosis of high risk MDS (according to the International Prognostic Scoring System—IPSS) with clinically significant		Licensed Practitioner	6 month duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			cytopenia (s) and the member is not a candidate for high intensity therapy. Acute Myelogenous Leukemia (AML) with multilineage dysplasia (previously RAEB-t). The member has a diagnosis of AML with multilineage dysplasia (previously RAEB-t). Untreated Acute Myelogenous Leukemia (AML)in Elderly Patients. The member has a diagnosis of AML.				
BANZEL	All FDA approved indications not otherwise excluded from Part D.	Patients with familial short QT syndrome.	New Starts Only. Banzel (rufinamide) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Patient has diagnosis of seizures associated with Lennox-Gastaut Syndrome.		Licensed Practitioner	plan year	
BELEODAQ	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced significant disease progression while on Beleodaq (belinostat). Members on concomitant Istodax (romidepsin), Zolinza (vorinostat), or Folotyn	Peripheral T-Cell Lymphoma (PTCL). The member must have a diagnosis of relapsed OR refractory peripheral T-cell lymphoma (PTCL).		Licensed Practitioner	six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(pralatrexate) therapy.					
BENLYSTA	All FDA approved indications not otherwise excluded from Part D.	Benlysta (belimumab) therapy is not considered medically necessary for members with the following concomitant conditions: severe active lupus nephritis, severe active central nervous system lupus, combination with other biologic products (examples include Humira, Enbrel, Remicade, Rituxan, Stelara, Cimzia, Kineret, Orencia, Simponi,	Benlysta (belimumab) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Systemic Lupus Erythematosus (SLE). The member must have a diagnosis of active systemic lupus erythematosus (SLE).The member must be auto-antibody positive in the absence of any drugs for SLE defined as: ANA titer greater than or equal 1:80 or anti-dsDNA level greater than or equal 30 I/mL.The member must be utilizing Benlysta (belimumab)in combination with standard treatment regimens for SLE which may include: corticosteroids (ex:prednisone), hydroxychloroquine, azathioprine.		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Actemra), combination with cyclophosphamide.					
BENZTROPINE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
BETHKIS	All FDA approved indications not otherwise excluded from Part D. Bronchiectasis		Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with P.aeruginosa, E coli, Klebsiella spp, Enterobacter spp, or Serratia spp.		Licensed Practitioner	Plan year duration	
BEXAROTENE	All FDA approved indications not otherwise	Women who are pregnant or lactating (FDA pregnancy category	Cutaneous T-cell Lymphoma (CTCL). Targretin (bexarotene) capsules). The member will be using Targretin as primary treatment or adjuvant therapy OR Member has experienced disease progression, contraindication, or intolerance to at least		Licensed Practitioner	plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.	X).Members on concomitant retinoid therapy.	one prior systemic therapy for cutaneous manifestations of cutaneous T-cell lymphoma. Cutaneous T-cell Lymphoma. Targretin (bexarotene) 1% topical gel/jelly). The member will be using Targretin as primary treatment or adjuvant therapy OR Member has experienced disease progression, contraindications, or intolerance to at least one prior CTCL therapy.				
BOSULIF	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors.Members that have experienced significant disease progression while on Bosulif (bosutinib).	Chronic Myelogenous Leukemia. The member has a diagnosis Philadelphia chromosome positive chronic myelogenous leukemia AND The member has not achieved treatment goals or has an intolerance to dasatinib or nilotinib therapy.		Licensed Practitioner	6 month duration	
BUPRENORPHINE HCL	All FDA approved indications not otherwise excluded from Part D.	Diagnosis of pain may review for injectable only. Concurrent use of ANY narcotic painkillers or methadone.	Treatment of Opioid Dependence Withdrawal: (Subutex and Suboxone). Prescribing physician must have a unique identification Number and a DEA number. For induction, members should have discontinued the use of illicit opioids. Exhibiting early symptoms of withdrawal. Monthly drug screenings must be performed and accompany the Prior Authorization request. Evidence of active substance abuse		Licensed Practitioner	6 month duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			counseling must accompany the Prior authorization request. Buprenex/buprenorphine injectable Must have diagnosis of Moderate to Severe Pain.				
BUTALBITAL-ACETAMINOPHEN	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
BUTALBITAL-ACETAMINOPHEN-CAFF	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
BUTALBITAL-ASPIRIN-	All FDA approved		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the	Automatic approval if		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CAFFEINE	indications not otherwise excluded from Part D.		specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	member is less than 65 years of age.Prior Auth required for age 65 or older.			
BUTISOL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
CAPRELSA	All FDA approved indications not otherwise excluded from Part D.	Vandetanib therapy is not considered medically necessary for members with the following concomitant conditions:Members	Vandetanib will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Thyroid Cancer. The member has a diagnosis of locally advanced or metastatic medullary thyroid cancer AND The member has symptomatic or progressive disease.		Licensed Practitioner	three month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		on concomitant tyrosine kinase inhibitors. Members that have experienced disease progression while on Vandetanib.					
CARBAGLU	All FDA approved indications not otherwise excluded from Part D.		Carbaglu (carglumic acid) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Acute hyperammonemia due to the deficiency of hepatic enzyme N-acetylglutamate synthase (NAGS). Chronic hyperammonemia due to the deficiency of hepatic enzyme N-acetylglutamate synthase (NAGS)		Licensed Practitioner	3 Month Duration	
CARISOPRODOL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
CAYSTON	All FDA-		Cayston/aztreonam inhalation solution will require prior		Licensed	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D.		authorization. This agent may be considered medically necessary when the following criteria are met:Cystic Fibrosis. The member must have a diagnosis of cystic fibrosis (CF). The member is colonized with Pseudomonas aeruginosa. The member must have a beta-agonist bronchodilator (short- or long-acting), and will be utilized prior to Cayston.		Practitioner		
CERDELGA	All FDA approved indications not otherwise excluded from Part D.	Concurrent use of a strong or moderate CYP2D6 inhibitor (eg. paroxetine, terbinafine) with a strong or moderate CYP3A inhibitor (eg. ketoconazole in patients who are EMs or IMs.Concurrent use of a strong CYP3A inhibitor in patients who are IMs or PMs (eg. ketoconazole, fluconazole).	Type 1 Gaucher's disease:The member has a diagnosis of type 1 Gaucher's disease AND Member is a CYP2D6 poor metabolizer (PM), extensive metabolizer (EM), or intermediate metabolizer (IM) as confirmed by an FDA-approved genetic test.		Licensed Practitioner	plan year duration	
CEREZYME	All FDA-		Cerezyme (imiglucerase) will require prior authorization. These		Licensed	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D.		agents may be considered medically necessary when the following criteria are met: Confirmed diagnosis of Type 1 Gaucher disease, resulting in one or more of the following conditions: Anemia, Thrombocytopenia, Bone disease, Hepatomegaly, Splenomegaly.		Practitioner		
CHENODAL	All FDA approved indications not otherwise excluded from Part D.	Contraindicated in patients with radiopaque stones. Contraindicated with pregnant women	Cholelithiasis: The member has a diagnosis of radiolucent gallstones and is not a surgical candidate AND the member must have had previous treatment with, contraindication, or intolerance to ursodiol		Licensed Practitioner	Plan year duration	
CHORIONIC GONADOTROPIN, HUMAN	All FDA approved indications not otherwise excluded from Part D.	Obesity, Female or male infertility, Erectile Dysfunction, Precocious puberty, Prostatic carcinoma or other androgen-dependent neoplasm.	Hypogonadotropic hypogonadism secondary to pituitary deficiency in males. Prepubertal cryptorchidism secondary to organic dysfunction and not due to anatomical obstruction. AIDS related Kaposi's sarcoma. Hypospadias.		Licensed Practitioner	Plan Year Duration	
CINRYZE	All FDA approved indications not otherwise		Diagnosis of Hereditary Angioedema based on laboratory verification of C1 inhibitor deficiency. The patient has no signs of current acute angioedema. The patient has previous treatment, contraindication, or intolerance with danazol,or		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.		other appropriately dosed anabolic steroid/androgen for HAE prophylaxis.				
CLEMASTINE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
CLOMIPRAMINE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
COMETRIQ	All FDA approved indications not	The member has experienced disease progression	Metastatic Medullary Thyroid Carcinoma. The member has a diagnosis of progressive, metastatic medullary thyroid carcinoma MTC.		Licensed Practitioner	six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.	constituting treatment failure while on Cometriq (cabozantinib). Members on concomitant tyrosine kinase inhibitors.					
COPAXONE	All FDA approved indications not otherwise excluded from Part D.		The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.		Licensed Practitioner	Plan Year Duration	
COSENTYX	All FDA approved indications not otherwise excluded from Part D.	Combination therapy with other biologics used in the treatment of moderate to severe chronic plaque psoriasis such as: Humira, Enbrel, Stelara, and	Moderate to Severe Chronic Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis.The member has previous treatment, contraindication, or intolerance to Humira AND Enbrel.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Remicade.					
COSENTYX (2 SYRINGES)	All FDA approved indications not otherwise excluded from Part D.	Combination therapy with other biologics used in the treatment of moderate to severe chronic plaque psoriasis such as: Humira, Enbrel, Stelara, and Remicade.	Moderate to Severe Chronic Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis.The member has previous treatment, contraindication, or intolerance to Humira AND Enbrel.		Licensed Practitioner	Plan year duration	
COSENTYX PEN	All FDA approved indications not otherwise excluded from Part D.	Combination therapy with other biologics used in the treatment of moderate to severe chronic plaque psoriasis such as: Humira, Enbrel, Stelara, and Remicade.	Moderate to Severe Chronic Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis.The member has previous treatment, contraindication, or intolerance to Humira AND Enbrel.		Licensed Practitioner	Plan year duration	
COSENTYX PEN (2 PENS)	All FDA approved	Combination therapy with other	Moderate to Severe Chronic Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis.The member		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.	biologics used in the treatment of moderate to severe chronic plaque psoriasis such as: Humira, Enbrel, Stelara, and Remicade.	has previous treatment, contraindication, or intolerance to Humira AND Enbrel.				
CRESEMBA	All FDA approved indications not otherwise excluded from Part D.	Familial short QT syndrome. Coadministration with strong CYP3A4 inhibitors, such as ketoconazole or high dose ritonavir. Coadministration with strong CYP3A4 inducers, such as rifampin, carbamazepine, St.John's wort, or long acting barbiturates.	Invasive Aspergillosis and Invasive Mucormycosis: Member must have diagnosis of invasive aspergillosis or invasive mucormycosis.	must be 18 years of age or older.	Licensed Practitioner	plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
CYCLOBENZAPRINE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
CYKLOKAPRON	All FDA approved indications not otherwise excluded from Part D.	Members with acquired defective color vision, since this prohibits measuring one endpoint that should be followed as a measure of toxicity (changes in vision).Members with subarachnoid hemorrhage. Members with active intravascular	Hemophilia–Hemorrhage.Prophylaxis for Tooth extraction.Members with Hemophilia undergoing dental extraction.		Licensed Practitioner	30 day duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		clotting.					
CYPROHEPTADINE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
CYRAMZA	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced disease progression while on Cyramza (ramuciruma).	Gastric Cancer:The member has a diagnosis of advanced or metastatic gastric cancer or gastro-esophageal adenocarcinoma AND The member has progressive disease or intolerance on or following treatment with platinum-based and/or fluoropyrimidine-based chemotherapy.Non Small Cell Lung Cancer:The member has a diagnosis of metastatic non-small cell lung cancer AND The member has progressive disease or intolerance on or following platinum-based chemotherapy AND For members with EGFR or ALK genomic aberrations, the member has disease progression on FDA-approved therapy for these aberrations.		Licensed Practitioner	six month duration	
CYSTARAN	All FDA approved		Cystinosis: The member has a diagnosis of cystinosis AND The member is using Cystaran (cysteamine ophthalmic solution) in		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.		the treatment of corneal cystine crystal accumulation.				
CYTOGAM	All FDA approved indications not otherwise excluded from Part D.	Cytogam therapy is not considered medically necessary for members with the following concomitant conditions:Members with selective immunoglobulin A deficiency.	Cytomegalovirus infection.Prophylaxis.Transplantation of heart, pancreas,kidney,lung.Member is CMV seronegative.Organ donor is CMV seropositive. Cytomegalovirus infection.Prophylaxis.Transplantation of liver.Member is CMV seronegative.Organ donor is CMV seropositive. Concomitant prophylaxis with ganciclovir.		Licensed Practitioner	6 month duration	
DACOGEN	All FDA approved indications not otherwise excluded from Part D.	In conjunction with Vidaza (azacitidine)-both are DNA hypomethylators).	Myelodysplastic Syndromes.The member has a diagnosis of one of the following MDS subtypes: Refractory anemia, Refractory anemia with ringed sideroblasts, Refractory anemia with excess blasts, Refractory anemia with excess blasts in transformation, Chronic myelomonocytic leukemia. The member has an International Prognostic Scoring System (IPSS) score placing the member in the intermediate-1, intermediate-2, or high risk group. With deletion 5q chromosomal abnormality. The member has a diagnosis of lower risk MDS (according to the		Licensed Practitioner	6 month duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			International Prognostic Scoring System—IPSS, lower risk members include IPSS Low and Intermediate-1 categories) AND The member has failed to achieve response (transfusion independence—defined in background*) with Revlimid (lenalidomide) OR With NO deletion 5q abnormality. The member has a diagnosis of lower risk MDS (according to the International Prognostic Scoring System—IPSS, lower risk members include IPSS Low and Intermediate-1 categories) AND The member has symptomatic anemia and serum erythropoietin levels greater the 500 mU/mL and a low probability of response to immunosuppressive therapy OR The member has symptomatic anemia and has failed initial treatment with erythropoietins or immunosuppressive therapy OR The member has thrombocytopenia or neutropenia. Untreated Acute Myelogenous Leukemia (AML)in Elderly Members. The member has a diagnosis of AML.				
DECITABINE	All FDA approved indications not otherwise excluded from Part D.	In conjunction with Vidaza (azacitidine)-both are DNA hypomethylators).	Myelodysplastic Syndromes.The member has a diagnosis of one of the following MDS subtypes: Refractory anemia, Refractory anemia with ringed sideroblasts, Refractory anemia with excess blasts, Refractory anemia with excess blasts in transformation, Chronic myelomonocytic leukemia. The member has an International Prognostic Scoring System (IPSS) score placing the member in the intermediate-1, intermediate-2, or high risk		Licensed Practitioner	6 month duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			group. With deletion 5q chromosomal abnormality. The member has a diagnosis of lower risk MDS (according to the International Prognostic Scoring System—IPSS, lower risk members include IPSS Low and Intermediate-1 categories) AND The member has failed to achieve response (transfusion independence—defined in background*) with Revlimid (lenalidomide) OR With NO deletion 5q abnormality. The member has a diagnosis of lower risk MDS (according to the International Prognostic Scoring System—IPSS, lower risk members include IPSS Low and Intermediate-1 categories) AND The member has symptomatic anemia and serum erythropoietin levels greater the 500 mU/mL and a low probability of response to immunosuppressive therapy OR The member has symptomatic anemia and has failed initial treatment with erythropoietins or immunosuppressive therapy OR The member has thrombocytopenia or neutropenia. Untreated Acute Myelogenous Leukemia (AML)in Elderly Members. The member has a diagnosis of AML.				
DELESTROGEN	All FDA approved indications not otherwise excluded from		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The	Automatic approval if member is less than 65 years of		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.		physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	age.Prior Auth required for age 65 or older.			
DEPO-ESTRADIOL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
DETROL LA	All FDA approved indications not otherwise excluded from Part D.		Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
DIGITEK	All FDA approved indications not otherwise		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must	Automatic approval if member is less than 65		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.		document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	years of age.Prior Auth required for age 65 or older.			
DIGOX	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
DIGOXIN	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
DIOVAN	All FDA approved indications not otherwise excluded from Part D.		Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
DIPHENHYDRAMINE HCL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
DISOPYRAMIDE PHOSPHATE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
				older.			
DOXEPIN	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
DUAVEE	All FDA approved indications not otherwise excluded from Part D.	Abnormal uterine bleeding. Known or past history of breast cancer. Active or past history of venous thromboembolism (e.g. pulmonary embolism, deep vein thrombosis). Known estrogen-dependent neoplasia. Active or past history of	Treatment of moderate to severe vasomotor symptoms associated with menopause:Diagnosis of moderate to severe vasomotor symptoms associated with menopause AND The member must have had previous treatment, intolerance or contraindication to a SSRI [e.g. citalopram, fluoxetine, paroxetine hydrochloride] or venlafaxine. Prevention of osteoporosis: For the prevention of osteoporosis in postmenopausal women AND The member must have had previous treatment, intolerance, or contraindication to either alendronate or Evista (raloxifene).		Licensed practitioner	Plan year duration	For members 65 years of age and older: The provider has documented the indication for the continued use of the HRM with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk AND The provider has an ongoing monitoring plan for the agent AND patient

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		arterial thromboembolism (e.g. stroke and myocardial infarction). Duavee should not be used in pregnant or lactating women. Known hepatic impairment or liver disease. Known protein C, protein S, or antithrombin deficiency or other known thrombophilic disorders. Concurrent use with estrogens, progestins, or estrogen agonists/antagonists.					counseling has and will continue to take place outlining the risks and potential side effects of the medication.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
EGRIFTA	All FDA approved indications not otherwise excluded from Part D.	Egrifta (tesamorelin) therapy is not considered medically necessary for members with the following concomitant conditions: The member must not have an active malignancy. Pregnancy.	Egrifta (tesamorelin) will require prior authorization. This agent may be considered medically necessary when the following criteria are met:HIV-Associated Lipodystrophy. The member must have a diagnosis of HIV-associated lipodystrophy. The member must utilize Egrifta (tesamorelin) to reduce excess fat for the abdominal area. The member must be/have been on a protease inhibitor (PI) and/or nucleoside reverse transcriptase inhibitor (NRTI).		Licensed Practitioner	Plan Year	
ELELYSO	All FDA approved indications not otherwise excluded from Part D.		Gaucher Disease. Confirmed diagnosis of Type 1 Gaucher disease.		Licensed Practitioner	Plan Year Duration	
ELITEK	All FDA approved indications not otherwise excluded from	Members deficient in glucose-6-phosphate dehydrogenase (G6PD).Members	Hyperuricemia.The member has a diagnosis of leukemia, lymphoma or solid tumor malignancy AND The member is receiving anti-cancer chemotherapy regimen that is expected to cause tumor lysis syndrome (TLS).		Licensed Practitioner	30 day duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.	who have developed hemolytic reactions or methemoglobinemia related to the use of rasburicase.					
EMEND	All FDA approved indications not otherwise excluded from Part D.	Members not receiving concurrent moderate to highly emetogenic chemotherapy — fosaprepitant is only indicated for prevention of chemotherapy induced nausea at this time.Concurrent use with oral Emend (aprepitant) capsules if taking the150mg dose.Emend IV (fosaprepitant) monotherapy	Prophylaxis of Chemotherapy-induced nausea and vomiting. The member must be on concomitant corticosteroid (usually dexamethasone) and a 5HT3 antagonist (ondansetron, dolasetron, palonosetron, or granisetron) if no contraindication. The member is receiving at least one of the following chemotherapy medications: azacitidine, bendamustine, carboplatin, carmustine,cisplatin, clofarabine, cyclophosphamide, cytarabine greater than 200 mg/m2, dacarbazine, dactinomycin, daunorubicin, doxorubicin, epirubicin, idarubicin, ifosfamide, irinotecan, lomustine, mechlorethamine, melphalan, Methotrexate greater than or equal to 250mg/m2, oxaliplatin, streptozocin.		Licensed Practitioner	Plan Year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(Emend should be used in conjunction with a 5HT3 antagonist and dexamethasone).					
ENBREL	All FDA approved indications not otherwise excluded from Part D.	Combination therapy with other biologicals such as Humira, Remicade, Orencia, or Kineret.	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had previous treatment, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAIDs) (examples include ibuprofen, meloxicam, naproxen). Adult Plaque Psoriasis. Diagnosis of chronic moderate to severe, chronic plaque psoriasis. Member has had previous treatment, contraindication, or intolerance with one or more oral systemic treatments (e.g. acitretin, methotrexate, hydroxyurea, cyclosporine, and sulfasalazine).Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had previous treatment, contraindication, or intolerance with a: NSAID (examples include meloxicam, ibuprofen, naproxen) AND a DMARD: Hydroxychloroquine, Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD(examples include methotrexate, sulfasalazine,		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of with moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide).				
ENBREL SURECLICK	All FDA approved indications not otherwise excluded from Part D.	Combination therapy with other biologicals such as Humira, Remicade, Orencia, or Kineret.	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had previous treatment, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAIDs) (examples include ibuprofen, meloxicam, naproxen). Adult Plaque Psoriasis. Diagnosis of chronic moderate to severe, chronic plaque psoriasis. Member has had previous treatment, contraindication, or intolerance with one or more oral systemic treatments (e.g. acitretin, methotrexate, hydroxyurea, cyclosporine, and sulfasalazine).Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had previous treatment, contraindication, or intolerance with a: NSAID (examples include meloxicam, ibuprofen, naproxen) AND a DMARD: Hydroxychloroquine, Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had previous treatment, contraindication, or intolerance with a		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			DMARD(examples include methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of with moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide).				
EPOGEN	All FDA approved indications not otherwise excluded from Part D. Myelodysplastic Syndrome, Hepatitis C, Rheumatoid Arthritis.	Concomitant use of another Recombinant Erythropoietin Product.	Anemia of CKD: Diagnosis of anemia associated with chronic kidney disease.Hgb level less than 10.0 g/dL or HCT less than 30- within last 4 weeks. Continue Therapy: Current- within last 4 weeks Hgb level less than 11 g/dL.Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Anemia in Zidovudine-treated HIV-infected: Diagnosed with HIV (and AZT induced anemia) and receiving zidovudine treatment corresponding with HAART. Endogenous serum erythropoietin levels less than or equal to 500 mUnits/mL.The total zidovudine dose must not exceed 4200mg/wk. Must have Hgb level less than or equal to 10.0 g/dL or HCT less than 30-within the last four weeks. Continue Therapy:Zidovudine dose must not exceed 4200mg/wk.Must meet one of the following criteria:Current-within last 4 weeks Hgb level less than 12.0 g/dL OR Documented dose adjustment of therapy with corresponding		Licensed Practitioner	3 months for chemo induced anemia,HIV,HCV,RA,MDS,surgery and 6 months for CKD.	Anemia in Surgery Members .Must be scheduled to undergo elective, noncardiac, nonvascular surgery. Must have Hgb level of greater than 10 g/dL and less than or equal 13 g/dL-within last 4 weeks. Anemia in Myelodysplastic Syndromes . Diagnosis of symptomatic anemia associated with MDS. Must have a serum erythropoietin level less than or equal to 500 mUnits/mL .Must have Hgb

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL. Anemia in Chemotherapy Treated Cancer -first 4 weeks. Diagnosis with a non-myeloid, non-erythroid malignancy.Must be receiving concurrent chemotherapy treatment for incurable disease with palliative intent. Must have Hgb level less than10.0 g/dL or HCT less than 30-within last 4 weeks. Maint. Phase after first 4 weeks.Must have had a response of no less than 1 g/dL increase in Hgb levels in any prior use of epoetin therapy—can't be a documented failure on previous epoetin therapy with a similar myelosuppressive chemotherapy regimen. Must meet ALL of the following criteria: Current-within the last 4 weeks Hgb level is low enough to necessitate transfusion (and Hgb is less than 11 g/dL).Has received iron therapy if indicated. Epoetin should be stopped if after six-eight weeks the member has not experienced a greater than or equal 1 g/dL rise in Hgb. Epoetin should not be continued after completion of myelosuppressive chemotherapy.				level less than or equal to 10.0 g/dL or HCT less than 30-within last four weeks. Is receiving iron therapy if indicated. Continue Therapy:If no response after 6 to 8 weeks of therapy (or after 3 to 4 months if 5Q deletion MDS on Revlimid and after trial of concomitant Neupogen —discontinue epoetin and consider other treatment options (NCCN MDS guidelines 2013).A response is defined as a 1.5 g/dL rise in Hgb or a decrease in RBC transfusion requirement (NCCN MDS guidelines 2013). Current-within the last 4 weeks Hgb less than or equal to 12 g/dL.Anemia associated with

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							Management of Hepatitis C. Diagnosis of anemia in management of chronic Hepatitis C. Receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV. Must have Hgb level less than or equal to 10.0 gm/dL or HCT less than 30 during combination therapy as defined above-within the last 4 weeks.Continue Therapy: Must be receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV.Must have been able to maintain previous ribavirin dosing without

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							dose reduction due to symptomatic anemia. Must meet one of the following criteria: Current-within the last 4 weeks Hgb level less than 12.0g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL.Anemia associated with Rheumatoid Arthritis (RA)Treatment. Diagnosis of anemia associated with pharmaceutical treatment of RA. Receiving active therapy known to cause anemia.Must have Hgb level less than 10 g/dL or HCT less than 30-within the last 4 weeks.Continue

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							Therapy: Receiving active RA pharmaceutical treatment.Current-within the last 4 weeks Hgb less than 11 g/dL. For all listed indications: Prior to initiation of therapy, the member's iron scores should be evaluated. Transferrin saturation should be at least 20% and ferritin at least 100 ng/mL. If member is on supplemental iron therapy, a transferrin saturation of at least 18% and a ferritin of at least 90ng/ml will be required. Other causes of anemia including iron, B-12, folate deficiencies, hemolysis, and bleeding have been ruled out. Continuation of therapy

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							requires documented Transferrin saturation of at least 20% and ferritin of at least 100 ng/ mL within the last 12 months for all indications.Procrit is preferred epoetin agent for all indications except Anemia of CKD.
EPOPROSTENOL (GLYCINE)	All FDA approved indications not otherwise excluded from Part D.		Pulmonary Arterial Hypertension (PAH). Higher Risk: Member has a diagnosis of pulmonary arterial hypertension (WHO Group I) AND Member has WHO/NYHA FC IV symptoms or is classified as high risk. Determinants of high risk include: Clinical evidence of RV failure, Rapid progression of symptoms, Shorter 6MW distance (less than300m), Peak VO2 less than 10.4 mL/kg/min for CPET, Pericardial effusion, significant RV enlargement/dysfunction, or right atrial enlargement on echocardiography, RAP greater than 20mmHg, CI less than 2.0 L/min/m2 and/or Significantly elevated BNP. Lower Risk: Member diagnosis of pulmonary arterial hypertension (WHO Group I) with WHO/NYHA Functional Class II or III symptoms. AND member must have had prior therapy, intolerance or contraindication to Adcirca (tadalafil) or Revatio (sildenafil) or		Licensed Practitioner	Plan Year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Tracleer (bosentan) or Letairis (ambrisentan)or Opsumit (macitentan).				
ERBITUX	All FDA approved indications not otherwise excluded from Part D.	Metastatic colorectal cancer patients with KRAS mutations should not receive cetuximab due to known lack of response and possible worse outcomes in this population. Cetuximab and panitumumab are only indicated for patients with tumors that express the wild type (normal) KRAS gene.Member has disease progression on Vectibix or Eribtux.Erbitux may	Metastatic Colorectal Cancer (mCRC). Diagnosis of Metastatic (stage IV) Colorectal Cancer.The member has mCRC that expresses verified wild-type (normal) KRAS. KRAS testing should be performed for all mCRC members that are potential candidates for cetuximab or panitumumab therapy. Applies to new starts only.Erbitux (cetuximab) may be used as monotherapy in mCRC members intolerant to irinotecan or who have experienced disease progression following therapy with both irinotecan and oxaliplatin OR Concurrently with irinotecan-based therapy in mCRC members that are initially refractory to irinotecan alone OR in combination with FOLFIRI for first line treatment. Head and Neck Cancer. Diagnosis of locally or regionally squamous cell advanced Head and Neck Cancer with concomitant XRT OR The member has recurrent or metastatic squamous cell Head and Neck Cancer and is receiving Erbitux (cetuximab) monotherapy after experiencing disease progression following platinum based therapy (may also be used in conjunction with a platinum agent).OR The member has advanced or recurrent squamous cell Head and Neck Cancer that is unresectable or the member is unfit for surgery OR The member has a diagnosis of recurrent locoregional		Licensed Practitioner.	6 month duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		not be used in conjunction with Vectibix, Tarceva, or Iressa (all are EGFR inhibitors). Erbitux may not be used in conjunction with Avastin.	disease or metastatic squamous cell carcinoma of the head and neck AND The member is receiving Erbitux (cetuximab) in combination with platinum-based therapy with 5-FU.Advanced Non-Small Cell Lung Cancer. Diagnosis of advanced NSCLC either stage IIIB with documented malignant pleural effusions or stage IV metastatic.The member has confirmed EGFR positive disease (at least one positive tumor cell).The member is not a candidate for or has failed to achieve disease response with Avastin(bevacizumab.				
ERIVEDGE	All FDA approved indications not otherwise excluded from Part D.	Erivedge (vismodegib) therapy is not considered medically necessary for members with the following concomitant conditions:Members that have experienced disease progression while on Erivedge (vismodegib).	Advanced Basal Cell Carcinoma.The member has a diagnosis of metastatic basal cell carcinoma OR The member has a diagnosis of locally advanced basal cell carcinoma AND one of the following applies: The member has disease that has recurred following surgery (defined as a lesion in the same area recurring following greater than or equal to 2 surgical procedures) OR the member is not a candidate for surgery AND radiation.		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Members that are using Erivedge (vismodegib) as neoadjuvant therapy.					
ERWINAZE	All FDA approved indications not otherwise excluded from Part D.	Erwinaze (asparaginase Erwinia chrysanthemi) therapy is not considered medically necessary for members with the following concomitant conditions:Members with a history of serious pancreatitis with prior asparaginase based therapy,Members with a history of serious thrombosis	Erwinaze (asparaginase Erwinia chrysanthemi) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Acute Lymphoblastic Leukemia (ALL).The member has a diagnosis of ALL. The member has documented, Grade 2 – 4 hypersensitivity (based on Common Terminology Toxicity Criteria) as a result of prior treatment with Oncaspar (pegaspargase).The member is using Erwinaze (asparaginase Erwinia chrysanthemi) as a component of a multi-agent chemotherapeutic regimen.		Licensed Practitioner	Six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		with prior asparaginase based therapy,Members with a history of serious hemorrhagic events with prior asparaginase based therapy,Members that have experienced disease progression while on asparaginase based therapy.					
ESTRADIOL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
ESZOPICLONE	All FDA		The physician has documented the indication for the continued	Automatic		Plan year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D.		use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		duration.	
EVISTA	All FDA approved indications not otherwise excluded from Part D.		Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
EXJADE	All FDA approved indications not otherwise excluded from Part D.	Deferasirox is considered experimental and investigational for all other indications that are not discussed in the Coverage Determination	Ferritin levels. Exjade will require prior authorization and may be considered medically necessary when the following criteria are met for the following indication(s):Chronic Iron Toxicity (hemosiderosis) Secondary to Transfusional Iron Overload.The patient has a diagnosis of chronic iron overload (hemosiderosis) secondary to multiple RBC transfusions.For initial approval: Ferritin level greater than 1000 mcg/L (ferritin should consistently be above 1000 mcg/L to necessitate treatment).For reauthorizations: Ferritin level must be consistently above		Licensed Practitioner.	Plan Year Duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		section of this document, or when the following criteria are met: Patients on concomitant deferoxamine, The member has platelet counts less 50 x 10/L.	500mcg/L-deferasirox should be stopped if Ferritin level is consistently below 500 mcg/L.The patient has a diagnosis of hereditary hemochromatosis.The patient has failed or is not a candidate for management via phlebotomy.Ferritin level greater than 1000 mcg/L (ferritin should consistently be above 1000 mcg/L to necessitate treatment).Chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes: The member has a diagnosis of chronic iron overload with non-transfusion dependent thalassemia (NTDT) syndrome AND The member has liver iron (Fe) concentration of at least 5mg/gm of drug body weight AND The member has a serum ferritin greater than 300 mcg/L.				
FABRAZYME	All FDA-approved indications not otherwise excluded from Part D.		Fabrazyme (agalsidase beta) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: The member has a documented diagnosis of Fabry disease.		Licensed Practitioner	Plan Year	
FANAPT	All FDA approved indications not otherwise excluded from	Bipolar I disorder, Dementia-related psychosis or behavioral disturbances, Major	Schizophrenia. The member must be utilizing it for acute treatment of schizophrenia. For new starts only: The member must have previous treatment or intolerance or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone.	18 years or older	Licensed Practitioner	Plan Year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.	depressive disorder, Pediatric/adolescent schizophrenia, Pediatric/adolescent bipolar disorder.					
FARYDAK	All FDA approved indications not otherwise excluded from Part D.	Disease progression following Farydak (panobinstat).	Multiple Myeloma:The member has a diagnosis of multiple myeloma AND The member has received at least two prior regimens,including both bortezomib and an immunomodulatory drug (thalidomide,lenalidomide, pomalidomide)AND The member will be using Farydak(panobinostat)in combination with bortezomib and dexamethasone.		Licensed Practitioner	Plan year duration	
FENTANYL CITRATE	All FDA approved indications not otherwise excluded from Part D.Cancer breakthough pain.		The member is currently taking opioid therapy and is opioid tolerant. Tolerance is defined as any of the following: Greater than or equal to 60mg morphine/day, 25 mcg transdermal fentanyl/hour, Greater than or equal 30 mg oral oxycodone/day for Greater than or equal 1 week, Greater than or equal 8 mg oral hydromorphone/day for Greater than or equal 1 week, Greater than or equal 25 mg oral oxymorphone day for Greater than or equal 1 week, An equianalgesic dose of another opioid for greater than 1 week.		Licensed Practitioner	Plan Year Duration	
FETZIMA	All FDA approved	Uncontrolled narrow-angle	Major depressive disorder: The member must be utilizing it for treatment of major depressive disorder. For new starts only:		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.	glaucoma, Concurrent use with a MAOI or within 14 days of stopping or 7 days of starting a MAOI.	The member must have a documentation of treatment failure, intolerance, or contraindication to a serotonin and norepinephrine reuptake inhibitor (SNRI) AND a bupropion product (IR, SR, or XL) or mirtazapine.				
FIRAZYR	All FDA approved indications not otherwise excluded from Part D.		Hereditary Angioedema.The member must have a diagnosis of acute attacks of hereditary angioedema (HAE).	The member must be 18 years or older.	Licensed Practitioner	Plan year duration	
FIRMAGON	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with other LHRH agents.	The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurence.		Licensed Practitioner	Plan Year Duration	
FIRMAGON KIT W DILUENT SYRINGE	All FDA approved indications not otherwise excluded from	Concomitant use with other LHRH agents.	The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurence.		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.						
FOLOTYN	All FDA-approved indications not otherwise excluded from Part D.	Members that have experienced significant disease progression while on pralatrexate.	Folotyn/pralatrexate will require prior authorization and may be considered medically necessary when the following criteria are met:Peripheral T-cell Lymphoma(PTCL):relapsed or refractory. Pralatrexate is being used to treat relapsed or refractory peripheral T-cell lymphoma (PTCL) (eg peripheral T-cell lymphoma, not otherwise specified: angioimmunoblastic T-cell lymphoma, anaplastic large cell lymphoma or enteropathy-associated T-cell lymphoma. Patients must start vitamin supplementation before initial pralatrexate dose: Folic acid 1-1.25 mg/day orally beginning within 10 days prior to initiating pralatrexate (continue during treatment and for 30 days after last pralatrexate dose). Vitamin B12 1000 mcg I.M. within 10 weeks prior to treatment and every eight-to-10 weeks thereafter (after initial dose, B12 may be administered on the same day as pralatrexate).		Licensed Practitioner	6 months	
FUSILEV	All FDA approved indications not otherwise excluded from Part D.	"Fusilev (levoleucovorin) is considered not medically necessary for members with the following concomitant	Fusilev/levoleucovorin will require prior authorization and may be considered medically necessary when the following criteria are met: Levoleucovorin rescue is indicated after high-dose methotrexate therapy in osteosarcoma. The patient is being treated with methotrexate for osteosarcoma. The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		conditions:Members with pernicious anemia or megaloblastic anemia secondary to the lack of vitamin B12"	calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy. Levoleucovorin is also indicated to diminish the toxicity and counteract the effects of impaired methotrexate elimination and of inadvertent overdosage of folic acid antagonists.The patient has been treated with methotrexate or other folic acid antagonist and is currently exhibiting signs of toxicity likely due to aforementioned therapy.The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy.Advanced Metastatic Colorectal Cancer.The member has advanced metastatic colorectal cancer.The member is receiving palliative treatment with combination chemotherapy with 5-fluorouracil.The member has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy.				
FYCOMPA	All FDA approved indications not otherwise		Adjunctive treatment for adult members with partial-onset seizures: Inadequately controlled partial-onset seizures. Concomitant use of at least one antiepileptic medication.	Age 12 years and older	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.						
GAMUNEX	All FDA approved indications not otherwise excluded from Part D. Hematopoietic Stem Cell Transplantation, Bone Marrow Transplant, serious bacterial infections in HIV.		Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome,X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/µL),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/µL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/µL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose		Licensed Practitioner	Plan year duration.	Infections in Low-Birthweight Neonates.Prophylaxis and treatment of infections in high-risk, preterm, low-birth weight members.Diagnosed with staphylococcal / streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, an undrainable focus is present, or has persistent oliguria with pulmonary edema. Diagnosed with autoimmune neutropenia and G-CSF therapy is not appropriate. Autoimmune Hemolytic Anemia. Is refractory to corticosteroid

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogenic hematopoeietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions:CD4+ T-cell counts greater than or equal 200/mm3 ,To prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).				therapy and splenectomy. Myasthenia Gravis. Is experiencing acute myasthenic crisis with decompensation.Other treatments have been unsuccessful (e.g., corticosteroids, azathioprine, cyclosporine, and cyclophosphamide). Guillain-Barre Syndrome. Is severely affected by the disease and requires an aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed with hyperimmunoglobulinemia E syndrome. IVIG is needed

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							to treat severe eczema. Diagnosed with multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed with relapsing-remitting multiple sclerosis and has failed conventional therapy (Betaseron, Avonex, etc.).Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. One of the following criteria are met: Electrodiagnostic evidence of demyelinating

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							neuropathy in at least two limbs, OR There is muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambart-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has not responded to diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate is diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							threatening infections. Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisista,etc. Has tried and failed conventional therapy or has rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents.Stiff-Person Syndrome. Other interventions (diazepam) have been unsuccessful. Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or in members with

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							hemolytic anemia/ thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy.
GAMUNEX-C	All FDA approved indications not otherwise excluded from Part D. Hematopoietic Stem Cell Transplantation, Bone Marrow Transplant,		Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome,X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/µL),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/µL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining		Licensed Practitioner	Plan year duration.	Infections in Low-Birthweight Neonates.Prophylaxis and treatment of infections in high-risk, preterm, low-birth weight members.Diagnosed with staphylococcal / streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, an

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	serious bacterial infections in HIV.		thrombocytopenia, Platelets persistently at or below 20,000/µL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogenic hematopoeietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions:CD4+ T-cell counts greater than or equal 200/mm3 ,To prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).				undrainable focus is present, or has persistent oliguria with pulmonary edema. Diagnosed with autoimmune neutropenia and G-CSF therapy is not appropriate. Autoimmune Hemolytic Anemia. Is refractory to corticosteroid therapy and splenectomy. Myasthenia Gravis. Is experiencing acute myasthenic crisis with decompensation.Other treatments have been unsuccessful (e.g., corticosteroids, azathioprine, cyclosporine, and cyclophosphamide). Guillain-Barre Syndrome. Is severely affected by the disease and requires an aid to walk. Diagnosed with

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed with hyperimmunoglobulinemia E syndrome. IVIG is needed to treat severe eczema. Diagnosed with multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed with relapsing-remitting multiple sclerosis and has failed conventional therapy (Betaseron, Avonex, etc.).Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. One of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two limbs, OR There is muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambart-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has not responded to diaminopyridine, azathioprine, corticosteroids, or

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							anticholinesterases. Neonate is diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections. Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisista,etc. Has tried and failed conventional therapy or has rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							agents.Stiff-Person Syndrome. Other interventions (diazepam) have been unsuccessful. Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or in members with hemolytic anemia/ thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy.
GATTEX 30-VIAL	All FDA approved indications not		Diagnosis of Short Bowel Syndrome. Member is dependent on parenteral support (ie. parenteral nutrition and/or intravenous fluids). Member does not have active gastrointestinal		Licensed Practitioner	6 Month Duration	Reauthorization criteria for additional 180 days are as follows: Member does not

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.		malignancy. Member does not have biliary and/or pancreatic disease.				have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Need for parenteral support (ie. parenteral nutrition and/or intravenous fluids) has decreased in volume (mL) from baseline weekly requirement at start of Gattex treatment.
GATTEX ONE-VIAL	All FDA approved indications not otherwise excluded from Part D.		Diagnosis of Short Bowel Syndrome. Member is dependent on parenteral support (ie. parenteral nutrition and/or intravenous fluids). Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease.		Licensed Practitioner	6 Month Duration	Reauthorization criteria for additional 180 days are as follows: Member does not have active gastrointestinal malignancy. Member does not have biliary and/or pancreatic disease. Need for parenteral support (ie. parenteral nutrition and/or intravenous fluids) has decreased in volume (mL) from baseline weekly

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							requirement at start of Gattex treatment.
GAZYVA	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced significant disease progression while on Gazyva (obinutuzumab).	Chronic Lymphocytic Leukemia: The member must have a diagnosis of chronic lymphocytic leukemia AND The member is treatment naïve AND The member is using Gazyva (obinutuzumab) in combination with Chlorambucil.		Licensed Practitioner	Six month Duration	
GILENYA	All FDA approved indications not otherwise excluded from Part D.	Combination use with other disease modifying drugs for MS including Avonex, Betaseron, Extavia, Copaxone, Rebif, Tysabri, Aubagio or Tecfidera. Treatment with Class Ia or Class III anti-arrhythmic drugs.	The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.		Licensed Practitioner	plan year duration	
GILOTRIF	All FDA approved indications not		Non-small cell lung cancer (NSCLC): The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND the following apply. The member has a		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.		known epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation AND The member is using Gilotrif (afatinib) as monotherapy (without concomitant chemotherapy).				
GLASSIA	All FDA approved indications not otherwise excluded from Part D.	IgA deficient members or presence of antibodies against IgA.	Congenital Alpha1-antitrypsin Deficiency: The member has a diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed. The member has an alpha1-antitrypsin phenotype of PiZZ, PiZ(null), or Pi (null, null) or phenotypes associated with serum alpha 1-antitrypsin concentrations of less than 50mg/dL if/when measured by laboratories using nephelometry instead of radial immunodiffusion. Otherwise, a deficiency is shown at 80mg/dL. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema).		Licensed Practitioner	Plan Year Duration	
GLEEVEC	All FDA approved indications not otherwise excluded from Part D.	Patients on concomitant tyrosine kinase inhibitors. Patients that have experienced significant disease	Imatinib may be considered medically necessary when the following criteria are met for their respective indications:For New Starts only--The member has a diagnosis of Ph+ CML that is newly diagnosed in the chronic phase. OR The member has a diagnosis of Ph+ CML that is in accelerated phase or blast crisis. 2. Acute lymphoid leukemia (ALL)The member has a diagnosis of Ph+ ALL that is relapsed, refractory, or newly diagnosed and	The patient is at least 2 years of age.	Licensed Practitioner	plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		progression while on imatinib.	imatinib is being added to consolidation or induction therapy.3.The member has a diagnosis of Kit (CD117)-positive GIST.4. The member has a diagnosis of DFSP that is unresectable, recurrent, and/or metastatic.5. The member has a diagnosis of chronic eosinophilic leukemia or hypereosinophilic syndrome. 6. The member has a diagnosis of MDS or chronic MPD that is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangement. (ex. Chronic myelomonocyte leukemia, atypical chronic myeloid leukemia, juvenile myelomonocyte leukemia) 7. The member has a diagnosis of aggressive systemic mastocytosis. The member must not have a diagnosis of cutaneous mastocytosis, indolent systemic mastocytosis, SM with an associated clonal hematological non mast cell lineage, mast cell leukemia, mast cell carcinoma, or extracutaneous mastocytoma.The member must not harbor the D816v mutation of C-kit 8. Pediatric indications: The patient has a diagnosis of Philadelphia chromosome positive (Ph+) CML that is newly diagnosed in chronic phase. OR The patient has a diagnosis of Ph+ CML that is in chronic phase with disease recurrence after stem cell transplant. OR The patient has a diagnosis of Ph+ CML that is in chronic phase after failure of interferon-alpha therapy. Acute Lymphoid Luekemia (ALL). The member is newly diagnosed with				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Ph+ ALL AND the member will be using Gleevec in combination with chemotherapy.				
GLYBURIDE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
GLYBURIDE MICRONIZED	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
GLYBURIDE-METFORMIN	All FDA approved indications not		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that	Automatic approval if member is		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.		benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	less than 65 years of age.Prior Auth required for age 65 or older.			
GRANIX	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with filgrastim, sargramostim (unless part of stem cell mobilization protocol) or pegfilgrastim (within seven days of pegfilgrastim dose).Same day administration with myelosuppressive chemotherapy or radiation.	Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following myelosuppressive chemotherapy. Diagnosis of non-myeloid malignancy and has received or will receive myelosuppressive chemotherapy at least 24 hours prior to starting Granix (tbo-filgrastim) injections. The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) is 20% or greater based on current chemotherapy regimen (as calculated in current ASCO and NCCN guidelines for myeloid growth factors).Previous neutropenic complication from a prior cycle of similar chemotherapy. A risk of febrile neutropenia of less than 20% based on chemotherapy regimen, but at high risk due to other risk factors including member age greater than 65 years, poor performance status, previous episodes of FN,extensive prior treatment including large radiation ports, cytopenias due to bone marrow involvement by tumor, the presence of active infections, or other serious comorbidities.The member is		Licensed Practitioner	120 day duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			receiving a dose-dense chemotherapy regimen in Breast Cancer, Small Cell Lung Cancer (SCLC), OR Non-Hodgkin's Lymphoma (NHL).				
GUANFACINE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
HALAVEN	All FDA approved indications not otherwise excluded from Part D		Breast Cancer. The member has a diagnosis of metastatic breast cancer AND The member has progressive disease following at least two chemotherapeutic regimens for the treatment of metastatic disease AND The member has had prior therapy, contraindication or intolerance with an anthracycline and a taxane in either the adjuvant or metastatic setting.		Licensed Practitioner	Plan Year Duration	
HARVONI	All FDA approved indications not otherwise excluded from	Concomitant use with other Direct Acting Antivirals (e.g. HCV protease inhibitors,	Chronic Hepatitis C:Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 1 infection. HCV RNA level must be documented prior to therapy.	Member must be 18 years of age or older	Licensed Practitioner	Treatment-naïve with or without cirrhosis for 12 weeks.	Treatment-experienced without cirrhosis for 12 weeks.Treatment-experienced with cirrhosis for 24 weeks.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.	polymerase inhibitors, NS5A inhibitors).					
HERCEPTIN	All FDA approved indications not otherwise excluded from Part D.		Herceptin (trastuzumab) will require prior authorization and may be considered medically necessary when the following criteria are met: Diagnosis of breast cancer (adjuvant tx or tx of metastatic disease) with tumors that over express the HER2 (human epidermal growth factor receptor2)protein. A positive HER2 is defined as either an IHC HER2 3+ (defined as uniform intense membrane staining of greater than 30% of invasive tumor cells) or FISH amplified (ratio of HER2 to CEP17 of greater than 2 or average HER2 gene copy number greater than six signals/nucleus for those test systems without an internal control probe).The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarinoma, with tumors that over express the HER2 (human epidermal growth factor receptor2) protein and Herceptin (trastuzumab)is being used in combination with systemic chemotherapy. A positive HER2 is defined as either an IHC HER2 3+ (defined as strong complete, basolateral or lateral membranous reactivity in greater than or equal to 10% of tumor cells) or FISH amplified (ratio of HER2 to CEP17 of greater than 2 or average HER2 gene copy number greater than six signals/nucleus for those test systems without		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			an internal control probe).				
HIZENTRA	All FDA approved indications not otherwise excluded from Part D. Hematopoietic Stem Cell Transplantation, Bone Marrow Transplant, serious bacterial infections in HIV.		Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome,X-linked immunodeficiency with hyperimmunoglobulin, etc)OR Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30,000/µL),To increase platelet counts prior major surgical procedures, Severe thrombocytopenia (platelets less than 20,000/µL), at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met:Prior treatment has included corticosteroids, No concurrent illness explaining thrombocytopenia, Platelets persistently at or below 20,000/µL.Chronic Lymphocytic Leukemia (CLL, B-cell).With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL),Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease.IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms.Bone		Licensed Practitioner	Plan year duration.	Infections in Low-Birthweight Neonates.Prophylaxis and treatment of infections in high-risk, preterm, low-birth weight members.Diagnosed with staphylococcal / streptococcal toxic shock syndrome. Infection is refractory to several hours of aggressive therapy, an undrainable focus is present, or has persistent oliguria with pulmonary edema. Diagnosed with autoimmune neutropenia and G-CSF therapy is not appropriate. Autoimmune Hemolytic Anemia. Is refractory to corticosteroid therapy and splenectomy.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogenic hematopoeietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions:CD4+ T-cell counts greater than or equal 200/mm3 ,To prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).				Myasthenia Gravis. Is experiencing acute myasthenic crisis with decompensation.Other treatments have been unsuccessful (e.g., corticosteroids, azathioprine, cyclosporine, and cyclophosphamide). Guillain-Barre Syndrome. Is severely affected by the disease and requires an aid to walk. Diagnosed with biopsy-proven polymyositis OR dermatomyositis and has failed treatment with corticosteroids and azathioprine or methotrexate. Diagnosed with hyperimmunoglobulinemia E syndrome. IVIG is needed to treat severe eczema.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							Diagnosed with multifocal motor neuropathy confirmed by electrophysiologic studies. Diagnosed with relapsing-remitting multiple sclerosis and has failed conventional therapy (Betaseron, Avonex, etc.).Parvovirus B19 Infection, chronic. Chronic Parvovirus B19 infection with severe anemia associated with bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. One of the following criteria are met: Electrodiagnostic evidence of demyelinating neuropathy in at least two

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							limbs, OR There is muscle weakness and diagnostic testing was conducted in accordance with AAN diagnostic criteria. Diagnosis of Lambart-Eaton myasthenic syndrome confirmed by electrophysiologic studies. Has not responded to diaminopyridine, azathioprine, corticosteroids, or anticholinesterases. Neonate is diagnosed with isoimmune hemolytic disease. Allosensitized Solid Organ Transplantation. Allosensitized members who are awaiting solid organ transplant. Multiple Myeloma. Has life-threatening infections.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							Autoimmune Blistering Diseases. Biopsy-proven diagnosis of an autoimmune blistering disease such as epidermolysis bullosa acquisista,etc. Has tried and failed conventional therapy or has rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents.Stiff-Person Syndrome. Other interventions (diazepam) have been unsuccessful. Systemic Lupus Erythematosus. Active/chronic SLE that is refractory to corticosteroid therapy or in members with hemolytic anemia/

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members. Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy.
HUMIRA	All FDA approved indications not otherwise excluded from Part D	Combination therapy with other biologics such as Enbrel, Remicade, Orencia, or Kineret.	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had previous treatment, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (examples include ibuprofen, meloxicam, naproxen). Crohn's Disease. Diagnosis of moderate to severely active Crohn's disease OR Crohn's disease with one or more draining fistulas. Member has had previous treatment, contraindication, or intolerance with one or more 5-aminosalicylic acids (5-ASA) , examples include mesalamine, olsalazine. Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had previous treatment, contraindication, or intolerance with an NSAIDs (examples include meloxicam, ibuprofen, naproxen) AND a DMARDs:	The member must be at least 18 years of age for the following indications: Crohn's Disease, Rheumatoid Arthritis,Moderate to severe Chronic	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis.The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had previous treatment, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (5-ASAs) OR Corticosteroids OR Immunomodulators

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe, extensive chronic plaque psoriasis. Member Member has had previous treatment, contraindication, or intolerance with conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, and sulfasalazine).	Plaque Psoriasis.The member must be four years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis.			(e.g. azathioprine or 6-mercaptopurine)
HUMIRA CROHN'S DIS START PCK	All FDA approved indications not otherwise excluded from Part D	Combination therapy with other biologics such as Enbrel, Remicade, Orencia, or Kineret.	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had previous treatment, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (examples include ibuprofen, meloxicam, naproxen). Crohn’s Disease. Diagnosis of moderate to severely active Crohn’s disease OR Crohn’s disease with one or more draining fistulas. Member has had previous treatment, contraindication, or intolerance with one or more 5-	The member must be at least 18 years of age for the following indications: Crohn’s Disease,	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis.The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had previous treatment, contraindication, or intolerance to one or more

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			aminosalicylic acids (5-ASA) , examples include mesalamine, olsalazine. Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had previous treatment, contraindication, or intolerance with an NSAIDs (examples include meloxicam, ibuprofen, naproxen) AND a DMARDs: Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe, extensive chronic plaque psoriasis. Member Member has had previous treatment, contraindication, or intolerance with conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, and sulfasalazine).	Rheumatoid Arthritis,Moderate to severe Chronic Plaque Psoriasis.The member must be four years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis.			of the following conventional therapies: 5-aminosalicylic acids (5-ASAs) OR Corticosteroids OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine)
HUMIRA PED CROHN'S STARTER PK	All FDA approved indications not	Combination therapy with other biologics such as	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had previous treatment, contraindication, or intolerance with a non-steroidal anti-	The member must be at least 18 years	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis.The member has a diagnosis of moderate to severely active

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D	Enbrel, Remicade, Orencia, or Kineret.	inflammatory drug (NSAIDs) (examples include ibuprofen, meloxicam, naproxen). Crohn's Disease. Diagnosis of moderate to severely active Crohn's disease OR Crohn's disease with one or more draining fistulas. Member has had previous treatment, contraindication, or intolerance with one or more 5-aminosalicylic acids (5-ASA) , examples include mesalamine, olsalazine. Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had previous treatment, contraindication, or intolerance with an NSAIDs (examples include meloxicam, ibuprofen, naproxen) AND a DMARDs: Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe, extensive chronic plaque psoriasis. Member Member has had previous treatment, contraindication, or intolerance with conventional therapy including one or more oral systemic	of age for the following indications: Crohn's Disease, Rheumatoid Arthritis,Moderate to severe Chronic Plaque Psoriasis.The member must be four years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile			ulcerative colitis. The member has had previous treatment, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (5-ASAs) OR Corticosteroids OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine)

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, and sulfasalazine).	idiopathic arthritis.			
HUMIRA PEN	All FDA approved indications not otherwise excluded from Part D	Combination therapy with other biologics such as Enbrel, Remicade, Orencia, or Kineret.	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had previous treatment, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (examples include ibuprofen, meloxicam, naproxen). Crohn's Disease. Diagnosis of moderate to severely active Crohn's disease OR Crohn's disease with one or more draining fistulas. Member has had previous treatment, contraindication, or intolerance with one or more 5-aminosalicylic acids (5-ASA) , examples include mesalamine, olsalazine. Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had previous treatment, contraindication, or intolerance with an NSAIDs (examples include meloxicam, ibuprofen, naproxen) AND a DMARDs: Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate,	The member must be at least 18 years of age for the following indications: Crohn's Disease, Rheumatoid Arthritis,Moderate to severe Chronic Plaque Psoriasis.The member must be four years of age or older and have a diagnosis of	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis.The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had previous treatment, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (5-ASAs) OR Corticosteroids OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine)

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			sulfasalazine, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe, extensive chronic plaque psoriasis. Member Member has had previous treatment, contraindication, or intolerance with conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, and sulfasalazine).	moderately to severely active polyarticular juvenile idiopathic arthritis.			
HUMIRA PSORIASIS STARTER PACK	All FDA approved indications not otherwise excluded from Part D	Combination therapy with other biologics such as Enbrel, Remicade, Orencia, or Kineret.	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had previous treatment, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (examples include ibuprofen, meloxicam, naproxen). Crohn's Disease. Diagnosis of moderate to severely active Crohn's disease OR Crohn's disease with one or more draining fistulas. Member has had previous treatment, contraindication, or intolerance with one or more 5-aminosalicylic acids (5-ASA) , examples include mesalamine, olsalazine. Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had previous treatment, contraindication, or intolerance with an NSAIDs (examples include meloxicam, ibuprofen, naproxen) AND a DMARDs: Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide. Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had previous	The member must be at least 18 years of age for the following indications: Crohn's Disease, Rheumatoid Arthritis,Moderate to severe Chronic Plaque Psoriasis.The member	Licensed Practitioner	Plan Year Duration	Ulcerative Colitis.The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had previous treatment, contraindication, or intolerance to one or more of the following conventional therapies: 5-aminosalicylic acids (5-ASAs) OR Corticosteroids OR Immunomodulators (e.g. azathioprine or 6-mercaptopurine)

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe, extensive chronic plaque psoriasis. Member Member has had previous treatment, contraindication, or intolerance with conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, and sulfasalazine).	must be four years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis.			
HYDROXYZINE HCL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
IBRANCE	All FDA approved	Members that have experienced disease	Metastatic Breast Cancer:The member has a diagnosis of estrogen receptor-positive and human epidermal growth factor		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.	progression while on Ibrance (palbociclib).	receptor 2-negative metastatic breast cancer AND The member will be using Ibrance as initial endocrine-based therapy for their metastatic disease AND The member will be taking Ibrance (palbociclib) in combination with letrozole.				
ICLUSIG	All FDA approved indications not otherwise excluded from Part D.	The member has experienced disease progression constituting treatment failure while on Iclusig (ponatinib). Members on concomitant tyrosine kinase inhibitors.	Chronic Myeloid Leukemia:The member has a diagnosis of Philadelphia chromosome positive chronic, accelerated, or blast phase chronic myeloid leukemia (CML) AND one of the following apply: The member has not achieved treatment goals, has an intolerance, or resistance to at least two available tyrosine kinase inhibitors indicated for the treatment of CML.The member has a documented T315I mutation. Acute Lymphoblastic Leukemia: The member has a diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) AND one of the following apply: The member has not achieved treatment goals, has an intolerance, or resistance to at least two available tyrosine kinase inhibitors indicated for the treatment of Ph+ ALL. The member has a documented T315I mutation.		Licensed Practitioner	6 month duration	
IMBRUVICA	All FDA approved indications not otherwise excluded from	Members that have experienced significant disease progression while on Imbruvica (ibrutinib).	Mantle Cell Lymphoma: The member has a diagnosis of Mantle Cell Lymphoma (MCL) AND The member has received at least one prior therapy for the treatment of MCL AND The member is using Imbruvica (ibrutinib) as monotherapy.Chronic Lymphocytic Leukemia (CLL).The member has a diagnosis of		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.		Chronic Lymphocytic Leukemia (CLL) AND The member has received at least one prior therapy for the treatment of CLL AND The member is using Imbruvica (ibrutinib) as monotherapy. Chronic Lymphocytic Leukemia (CLL) with 17p deletion:The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL) AND The member has documented 17p deletion AND The member is using Imbruvica (ibrutinib) as monotherapy.Waldenstrom's Macroglobulinemia:The member has a diagnosis of Waldenstrom's macroglobulinemia AND The member is using Imbruvica (ibrutinib) as monotherapy.				
IMIPRAMINE HCL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
IMIPRAMINE PAMOATE	All FDA approved indications not otherwise		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must	Automatic approval if member is less than 65		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.		document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	years of age.Prior Auth required for age 65 or older.			
INCIVEK	All FDA approved indications not otherwise excluded from Part D.	Member has previously failed therapy with a treatment regimen that includes Incivek (telaprevir) or other HCV NS3/4A protease inhibitors (boceprevir or simeprevir).Coadministration with any one of the following medications that are either potent CYP3A4/5 inducers or CYP3A4/5 inhibitors: alfuzosin, rifampin,	Chronic Hepatitis C: Treatment Naïve (Previously Untreated). Diagnosis of chronic hepatitis C with compensated liver disease. Must have documented genotype 1 HCV infection.Must be treatment naïve. Must utilize Incivek (telaprevir) in combination with peginterferon alfa, and ribavirin (triple therapy).Prior to Incivek (telaprevir) therapy, baseline HCV RNA level and complete blood count must be documented.Chronic Hepatitis C: Previously Treated. Diagnosis of chronic hepatitis C with compensated liver disease. Must have documented genotype 1 HCV infection. Must have failed to achieve SVR on prior therapy with interferon and ribavirin(including prior null responders and partial responders) or experienced a relapse. The member must utilize Incivek (telaprevir) in combination with peginterferon alfa, and ribavirin (triple therapy).Prior to Incivek (telaprevir) therapy, baseline HCV RNA level and complete blood count must be documented.	Must be 18 years of age	Licensed Practitioner	12 weeks	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		dihydroergotamine, ergonovine, ergotamine, methylergonovine, cisapride, St. John's Wort, atorvastatin, lovastatin, simvastatin, pimozide,Revatio (sildenafil) or Adcirca (tadalafil) when used for the treatment of pulmonary arterial hypertension, triazolam, orally administered midazolam. Concurrent use with other HCV NS3/4A protease inhibitors					
INCRELEX	All FDA approved indications not	Insulin-like growth factor therapy is considered NOT	Diagnosis, Labs (IGF-1, GH). Insulin-like Growth Factor therapy with Increlex (mecasermin) requires a prior authorization and is considered medically necessary if the following criteria are met:	The patient is between 2 years -18	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.	medically necessary when any of the following criteria are met: Final adult height has been reached as determined by the 5th percentile of adult height OR The bone epiphyses are closed OR The patient is older than 18 years of age or increase in height velocity is less than 2 cm total growth in one year of therapy.	The patient's bone epiphyses are not closed.The patient has a diagnosis of severe primary IGF-1 deficiency. Severe primary IGF-1 deficiency is defined by:height standard deviation score below -3.0 and basal IGF-1 standard deviation score below -3.0 and normal or elevated growth hormone. Severe primary IGF-1 deficiency includes patients with mutations in the GH receptor (GHR), post-GHR signaling pathway, and IGF-1 defects (e.g. primary GH insensitivity, Laron Syndrome). Patients are not GH deficient OR the patient has a diagnosis of GH gene deletion with development of neutralizing antibodies to GH.	years old for Increlex therapy.			
INLYTA	All FDA approved indications not otherwise excluded from Part D.	Inlyta (axitinib) therapy is not considered medically necessary for members with the following	Renal Cell Carcinoma.The member has a diagnosis of advanced renal cell carcinoma AND The member has failed one prior systemic treatment.		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		concomitant conditions: Members on concomitant tyrosine kinase inhibitors. Members on concomitant mTOR inhibitors.Members that have experienced significant disease progression while on Inlyta /axitinib.					
INTRON A	All FDA approved indications not otherwise excluded from Part D.		Chronic Hepatitis C. Diagnosis of chronic hepatitis C with compensated liver disease (without jaundice, ascites, active gastrointestinal bleeding, encephalopathy). Documentation of quantitative HCV RNA (viral load). For members 18 years of age older: For treatment naïve members with Hepatitis C, the member must first consider pegylated products (Pegasys or Peg-Intron plus ribavirin) or have a contraindication or other clinical circumstance preventing them from using before the member will be eligible to receive Intron A. For members 3 – 17	Chronic Hep C must 3 years or older. Must be 18 years or older for Hairy Cell Leukemia, Malignant	Licensed Practitioner	HepC,Melanoma,lymphoma Plan year,Leukemia 6months,Hep B 16 week,Condylomata 3	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			years of age: Intron A must be used in combination with ribavirin. Chronic Hepatitis B: Diagnosis of chronic HBeAG-positive hepatitis B with compensated liver. Must have ALT greater than 2x the upper limit of normal and have HBV DNA greater than 20,000 IU/ml. Hairy Cell Leukemia. Diagnosis of hairy cell leukemia. Malignant Melanoma. Diagnosis of malignant melanoma and utilizing Intron A as an adjuvant therapy to surgical treatment. Follicular Non-Hodgkin's Lymphoma. Diagnosis of follicular non-Hodgkin's lymphoma.Must be utilizing Intron A in conjunction with anthracycline-containing combination chemotherapy. Condylomata Acuminata. Diagnosis of condylomata acuminata involving external surfaces of the genital and perianal areas. AIDS-Related Kaposi's Sarcoma. Diagnosis of AIDS-related Kaposi's sarcoma. Must not have systemic symptoms.Must have limited lymphadenopathy and relatively intact immune system as indicated by total CD4 count.	Melanoma, Follicular Non-Hodkins Lymphoma, Condylomata Acuminata, AIDS-related Kaposi¿s Sacroma. 1 year or older for Chronic Hep B.		weeks,Kaposis 4 months.	
IRESSA	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors	Non-small cell lung cancer (NSCLC): The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND the following criteria applies: The member has a documented epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation as detected by an FDA approved test AND The member is using		Licensed Practitioner	Six month durartion	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Iressa (gefitinib) as monotherapy (without concomitant chemotherapy)				
ISTODAX	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced significant disease progression, constituting treatment failure, while on Istodax (romidepsin).Members on concomitant Zolinza (vorinostat) therapy.	Cutaneous T-cell Lymphoma (CTCL).Istodax (romidepsin) is being used to treat relapsed or refractory cutaneous T-cell lymphoma.The member has failed to meet goals of treatment with first-line therapy. Peripheral T-cell Lymphoma (PTCL).Istodax (romidepsin) is being used to treat relapsed or refractory peripheral T-cell lymphoma.The member has failed to meet goals of treatment with first-line therapy.		Licensed Practitioner.	6 month duration.	
IXEMPRA	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced severve (CTC grade 3/4)hypersensitivity reactions to medications formulated with Cremophor EL/ polyoxyethylated castor oil. Ixempra	Breast Cancer.The member has a diagnosis of locally advanced or metastatic breast cancer and one of the following: When used as monotherapy: the member has disease that is refractory or resistant to an anthracycline, a taxane, and Xeloda (capecitabine)OR When used in conjunction with Xeloda (capecitabine) (or 5-FU/fluorouracil): the member has disease that is refractory to both an anthracycline and a taxane (or further anthracycline therapy is contraindicated and disease is refractory to a taxane).		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(ixabepilone) should be discontinued after disease progression constituting treatment failure.					
JAKAFI	All FDA approved indications not otherwise excluded from Part D.	Jakafi (ruxolitinib) therapy is not considered medically necessary for members with the following concomitant conditions:Members that have experienced disease progression while on Jakafi (ruxolitinib).Members on concomitant tyrosine kinase inhibitors or immunomodulatory	Jakafi (ruxolitinib) will require prior authorization.This agent may be considered medically necessary when the following criteria are met: Myelofibrosis.The member has a documented diagnosis of primary myelofibrosis, post-polycythemia vera myelofibrosis or post-essential thrombocythemia myelofibrosis AND The member meets two or more of the following criteria:Age greater than 65,Documented Hemoglobin less than 10g/dL,Documented WBC greater than 25 x 109 /L,Circulating Blasts greater than or equal to 1%,Presence of Constitutional Symptoms (weight loss greater than 10% from baseline or unexplained fever or excessive sweats persisting for more than 1 month) AND The member will be using Jakafi (ruxolitinib) as monotherapy (excludes medically necessary supportive agents).Myelofibrosis Reauthorization Criteria.The member has achieved a reduction from pretreatment baseline of at least 50% in palpable spleen length or a 35% in spleen volume as measured by CT or MRI OR The member has achieved a 50% or		Licensed Practitioner	6 months for Myelofibrosis and 8 months Polycythemia Vera	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		medications (example: Revlimid/lenalidomide)	greater reduction in the Total Symptom Score from baseline as measured by the modified Myelofibrosis Symptom Assessment Form(MFSAF).Polycythemia Vera: The member has a diagnosis of polycythemia vera AND The member has not achieved treatment goals, has an intolerance, or contraindication to hydroxyurea. Polycythemia Vera Reauthorization Criteria: The member has achieved a reduction from pretreatment baseline of 35% in spleen volume as measured by CT or MRI AND The member has achieved hematocrit control and is no longer eligible for phlebotomy. Phlebotomy eligibility defined as: Hematocrit greater than 45% and at least 3 percentage points higher than baseline OR Hematocrit greater than 48%.				
JEVTANA	All FDA approved indications not otherwise excluded from Part D.	Jevtana should not be administered to patients with neutrophils less than or equal to 1,500/mm3. Jevtana should not be given to patients with hepatic impairment (total bilirubin greater than or	Hormone-Refractory Metastatic Prostate Cancer. The member must have a diagnosis of hormone-refractory metastatic prostate cancer. The member must have previously been treated with a docetaxol-containing treatment regimen. The member must be taking Jevtana in combination with prednisone.		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		equal to ULN, or AST and/or ALT greater than or equal to 1.5 × ULN). Concomitant use with Zytiga (abiraterone acetate) is not recommended at this time due to lack of evidence supporting safety and efficacy.					
KADCYLA	All FDA approved indications not otherwise excluded from Part D.	The member has experienced disease progression constituting treatment failure while on Kadcyla (ado-trastuzumab emtansine. Use in the adjuvant setting.Members on concomitant	Metastatic Breast Cancer. The member has a diagnosis of metastatic breast cancer AND The member has over expression of the HER2 (human epidermal growth factor receptor2) protein as defined by one of the following: IHC HER2 3+ (defined as uniform intense membrane staining of greater than 30% of invasive tumor cells) OR FISH amplified (ratio of HER2 to CEP17 of greater than 2 or average HER2 gene copy number greater than six signals/nucleus for those test systems without an internal control probe) AND The member is using Kadcyla (ado-trastuzumab emtansine) as monotherapy AND The member has received prior treatment with trastuzumab and a		Licensed Practitioner	Six month Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Herceptin (trastuzumab), Tykerb (lapatinib), or Perjeta (pertuzumab).	taxane, separately or in combination and one of the following applies: Received prior treatment for metastatic disease. Recurrence occurred during or within six months of completing adjuvant therapy.				
KALYDECO	All FDA approved indications not otherwise excluded from Part D.		Cystic Fibrosis. The member has a diagnosis of Cystic Fibrosis. The member has a documentation of one of the following mutations in the CFTR gene:G551D,G1244E,G1349D,G178R,G551S,S1251N,S1255P,S549N,R117H or S549R.	2 years of age or older.	Licensed Practitioner	Plan Year Duration.	
KEYTRUDA	All FDA approved indications not otherwise excluded from Part D.	Disease progression following prior anti-PD-1 therapy.	Melanoma:The member must have a diagnosis of unresectable or metastatic melanoma AND Disease progression following Yervoy (ipilimumab) AND For BRAF V600 mutation, the member must also meet the following criteria:Disease progression following a BRAF inhibitor (e.g. Zelboraf [vemurafenib], Tafinlar [dabrafenib].		Licensed Practitioner	plan year duration	
KORLYM	All FDA approved indications not otherwise excluded from Part D.	Pregnancy. Women with a history of unexplained vaginal bleeding. Women with endometrial hyperplasia with	Hyperglycemia secondary to hypercortisolism. Diagnosis of endogenous Cushing's syndrome. AND Type 2 diabetes mellitus or glucose intolerance. AND Failed surgery or are not candidates for surgery.		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		atypia or endometrial carcinoma.Concurrent long-term corticosteroid use.					
KUVAN	All FDA approved indications not otherwise excluded from Part D.		Sapropterin will require a prior authorization and may be considered medically necessary when the following criteria are met for their respective indication(s):BH4 (Sapropterin) responsive PKU. Phe-restricted diet. Diagnosis of PKU that is responsive to BH4. Response is defined as a 30% or greater reduction of blood Phe level from baseline during treatment for one to two months.		Licensed Practitioner	First approval: three months. if response is positive extended for nine months to total 1 yr	
LANOXIN	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LANOXIN PEDIATRIC	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
LATUDA	All FDA approved indications not otherwise excluded from Part D.	Dementia-related psychosis or behavioral disturbances, Major depressive disorder, Pediatric/adolescent schizophrenia, Pediatric/adolescent bipolar disorder, Concurrent use with strong CYP3A4 inhibitors (ketoconazole) or inducers (rifampin).	Schizophrenia.For new starts only:The member must have previous treatment or intolerance to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone.Bipolar Depression:For new starts only:The member must have documentation of previous treatment, intolerance, or contraindication to quetiapine.		Licensed Practitioner	Plan Year Duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
LAZANDA	All FDA approved indications not otherwise excluded from Part D.	Treatment of acute or post-operative pain.	The member is currently diagnosed with cancer. Fentanyl citrate is required to manage breakthrough cancer pain. The member is currently taking opioid therapy and is opioid tolerant. The member has a trial or intolerance to generic oral transmucosal fentanyl citrate. Tolerance is defined as any of the following: greater than or equal 60 mg oral morphine/day, 25 mcg transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day for greater than or equal 1 week, An equianalgesic dose of another opioid for greater than or equal 1 week.		Licensed Practitioner	Plan Year Duration.	
LENVIMA	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors.Members that have experienced significant disease progression while on Lenvima (lenvatinib).	Thyroid Cancer:The member has a diagnosis of locally recurrent or metastatic, progressive differentiated thyroid cancer (i.e. papillary carcinoma, follicular carcinoma or Hürthle cell carcinoma) AND The tumors are not responsive to radio-iodine treatment AND Lenvima (lenvatinib) will be used as monotherapy.		Licensed Practitioner	Plan year duration	
LETAIRIS	All FDA-approved indications not otherwise	Ambrisentan is considered experimental and investigational for all	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) with WHO/NYHA Functional Class II and III.		Licensed Practitioner	Plan year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.	other indications that are not listed above and is NOT considered medically necessary for members with the following concomitant conditions:The patient is concomitantly taking endothelin receptor antagonist (e.g., Tracleer®). Member has a diagnosis of idiopathic pulmonary fibrosis.					
LEUKINE	All FDA approved indications not otherwise excluded from Part D. Febrile	Routine use as prophylaxis in patients/chemotherapy regimens without significant risk of febrile	Allogeneic, HLA-matched related donors, Myeloid reconstitution. The member has recently completed an allogeneic bone marrow or peripheral-blood progenitor cell (PBPC) transplantation. Myeloid reconstitution in non-Hodgkin's lymphoma, Hodgkin's disease, and acute lymphoblastic lymphoma. The member has recently completed		Licensed Practitioner	4 month duration	Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following myelosuppressive chemotherapy. The patient must have a diagnosis of

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	neutropenia prophylaxis in non-myeloid malignancies, treatment of severe febrile neutropenia, Neutropenia in MDS, Malignant Melanoma,Agranulocytosis,Aplastic Anemia,Neutropenia in HIV or AIDS members.	neutropenia.Treatment of neutropenic patients who are afebrile unless chronic symptomatic neutropenic disorder.Concomitant use with filgrastim (unless part of stem cell mobilization protocol) or pegfilgrastim (within seven days of pegfilgrastim dose).Same day administration with myelosuppressive chemotherapy.	an autologous bone marrow transplantation. Delay or failure of myeloid engraftment. The member must have had a bone marrow or peripheral-blood progenitor cell (PBPC) transplantation. Febrile Neutropenia Prophylaxis, In acute myelogenous leukemia following induction chemotherapy. The member must have a diagnosis Acute Myeloid Leukemia (AML).The member will receive Leukine following either induction chemotherapy OR consolidation chemotherapy (in patients in complete remission).Harvesting of peripheral blood stem cells.The member must be scheduled for autologous peripheral-blood stem cell (PBSC) transplantation or donating stem cells for an allogeneic or syngeneic PBSC transplant. Peripheral blood stem cell graft, Autologous, myeloid reconstitution following transplant in patients mobilized with granulocyte macrophage colony stimulating factor. The member has recently completed an autologous peripheral blood stem cell (PBSC) transplantation and was mobilized with GM-CSF. Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following myelosuppressive chemotherapy.				non-myeloid malignancy and has received or will receive myelosuppressive chemotherapy 24-72 hours prior to starting sargramostim injections.The member must also meet ONE OR MORE of the following criteria: A risk of febrile neutropenia (FN) is 20% or greater based on current chemotherapy regimen (as calculated in current ASCO and NCCN guidelines for myeloid growth factors). Previous neutropenic complication from a prior cycle of similar chemotherapy. A risk of febrile neutropenia of less than 20% based on chemotherapy regimen, but at high risk due to other risk

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							factors including patient age greater than 65 years, poor performance status, previous episodes of FN, extensive prior treatment including large radiation ports, cytopenias due to bone marrow involvement by tumor, the presence of active infections, or other serious comorbidities. Patient is receiving a dose-dense chemotherapy regimen in Breast Cancer, Small Cell Lung Cancer (SCLC), OR Non-Hodgkin¿s Lymphoma (NHL).Treatment of Severe Febrile Neutropenia. The member must have a diagnosis of severe febrile neutropenia. Sargramostim must be used in adjunct

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							with appropriate antibiotics in high risk patients. Neutropenia in Myelodysplastic Syndromes. The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Malignant melanoma.The member must have a diagnosis of malignant melanoma.Treatment of agranulocytosis. The member must have a diagnosis of congenitial or drug induced agranulocytosis. Treatment of Aplastic Anemia. The member must have a diagnosis of aplastic anemia. Neutropenia in HIV or AIDS members. The

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							member must have a diagnosis of HIV or AIDS with neutropenia.
LEUPROLIDE	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Ddiagnosis of endometriosis. Uterine leiomyoma. The patient must have a diagnosis of anemia due to uterine leiomyoma. The patient has had previous treatment with iron therapy.Lupron must be given in conjunction with iron supplement therapy. Central Precocious Puberty: The patient must have a diagnosis of central precocious puberty (idiopathic or neurogenic) with onset of secondary sexual characteristics earlier than age 8 in females and age 9 in males. Diagnosis is confirmed by a pubertal response to a GnRH stimulation test and by bone age advanced one year beyond the chronological age. Baseline evaluation should include: LHRH test, Plasma level of sex steroids, Bone age evaluation, Height and weight measurements, Beta-HCG test to rule out gonadotropin releasing tumors, Adrenal steroid level to exclude congenital adrenal hyperplasia, Pelvic/Adrenal ultrasound to screen for tumors. CT scan to rule out intracranial tumor.Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent	Endometriosis: The patient must be age 18 or older.	Licensed Practitioner	Plan year duration for all except for Endometriosis: 6 months and Uterine Leiomyoma 3 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).				
LEVOLEUCOVORIN CALCIUM	All FDA approved indications not otherwise excluded from Part D.	"Fusilev (levoleucovorin) is considered not medically necessary for members with the following concomitant conditions:Members with pernicious anemia or megaloblastic anemia secondary to the lack of vitamin B12"	Fusilev/levoleucovorin will require prior authorization and may be considered medically necessary when the following criteria are met: Levoleucovorin rescue is indicated after high-dose methotrexate therapy in osteosarcoma. The patient is being treated with methotrexate for osteosarcoma. The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy. Levoleucovorin is also indicated to diminish the toxicity and counteract the effects of impaired methotrexate elimination and of inadvertent overdosage of folic acid antagonists.The patient has been treated with methotrexate or other folic acid antagonist and is currently exhibiting signs of toxicity likely due to aforementioned therapy.The patient has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy.Advanced Metastatic Colorectal Cancer.The member		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			has advanced metastatic colorectal cancer.The member is receiving palliative treatment with combination chemotherapy with 5-fluorouracil.The member has been treated with leucovorin calcium and has experienced documented side effects either due to lack of leucovorin calcium efficacy or due to leucovorin calcium formulation necessitating a change in therapy.				
LIDOCAINE	All FDA approved indications not otherwise excluded from Part D.		Post-Herpetic Neuralgia. The member must have a diagnosis of post-herpetic neuralgia.Diabetic Neuropathy.The member must have a diagnosis of diabetic neuropathy.Brand Lidoderm request only: Members must have previous treatment with generic Lidocaine patch (generic Lidoderm) or who have had contraindications or intolerance with generic Lidocaine patch (generic Lidoderm).		Licensed Practitioner	6 months duration	
LOVAZA	All FDA approved indications not otherwise excluded from Part D.		Member must have a previous treatment, intolerance or contraindication to an AB-rated generic equivalent product.		Licensed Practitioner	plan year	
LUMIZYME	All FDA-approved indications not		Alglucosidase alpha (Lumizyme) will require prior authorization. These agents may be considered medically necessary when the following criteria are met: Members must have a diagnosis of		Licensed Practitioner.	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.		Pompe disease. Lumizyme: Members must have late-onset (non-infantile) acid alpha-glucosidase deficiency (Pompe disease).				
LUNESTA	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
LUPRON DEPOT	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Ddiagnosis of endometriosis. Uterine leiomyoma. The patient must have a diagnosis of anemia due to uterine leiomyoma. The patient has had previous treatment with iron therapy.Lupron must be given in conjunction with iron supplement therapy. Central Precocious Puberty: The patient must have a diagnosis of central precocious puberty (idiopathic or neurogenic) with onset of secondary sexual characteristics earlier than age 8 in females and age 9 in males. Diagnosis is confirmed by a pubertal response to a GnRH stimulation test and by bone age advanced	Endometriosis: The patient must be age 18 or older.	Licensed Practitioner	Plan year duration for all except for Endometriosis: 6 months and Uterine Leiomyoma 3 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			one year beyond the chronological age. Baseline evaluation should include: LHRH test, Plasma level of sex steroids, Bone age evaluation, Height and weight measurements, Beta-HCG test to rule out gonadotropin releasing tumors, Adrenal steroid level to exclude congenital adrenal hyperplasia, Pelvic/Adrenal ultrasound to screen for tumors. CT scan to rule out intracranial tumor.Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).				
LUPRON DEPOT (3 MONTH)	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Ddiagnosis of endometriosis. Uterine leiomyoma. The patient must have a diagnosis of anemia due to uterine leiomyoma. The patient has had previous treatment with iron therapy.Lupron must be given in conjunction with iron supplement therapy. Central Precocious Puberty: The patient must have a diagnosis of central precocious puberty (idiopathic or neurogenic) with onset of secondary sexual characteristics earlier than age 8 in females and age 9 in males. Diagnosis is confirmed by a pubertal	Endometriosis: The patient must be age 18 or older.	Licensed Practitioner	Plan year duration for all except for Endometriosis: 6 months and Uterine Leiomyoma 3 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			response to a GnRH stimulation test and by bone age advanced one year beyond the chronological age. Baseline evaluation should include: LHRH test, Plasma level of sex steroids, Bone age evaluation, Height and weight measurements, Beta-HCG test to rule out gonadotropin releasing tumors, Adrenal steroid level to exclude congenital adrenal hyperplasia, Pelvic/Adrenal ultrasound to screen for tumors. CT scan to rule out intracranial tumor.Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).				
LUPRON DEPOT (4 MONTH)	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Ddiagnosis of endometriosis. Uterine leiomyoma. The patient must have a diagnosis of anemia due to uterine leiomyoma. The patient has had previous treatment with iron therapy.Lupron must be given in conjunction with iron supplement therapy. Central Precocious Puberty: The patient must have a diagnosis of central precocious puberty (idiopathic or neurogenic) with onset of secondary sexual characteristics earlier than age 8 in females	Endometriosis: The patient must be age 18 or older.	Licensed Practitioner	Plan year duration for all except for Endometriosis: 6 months and Uterine Leiomyoma 3 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			and age 9 in males. Diagnosis is confirmed by a pubertal response to a GnRH stimulation test and by bone age advanced one year beyond the chronological age. Baseline evaluation should include: LHRH test, Plasma level of sex steroids, Bone age evaluation, Height and weight measurements, Beta-HCG test to rule out gonadotropin releasing tumors, Adrenal steroid level to exclude congenital adrenal hyperplasia, Pelvic/Adrenal ultrasound to screen for tumors. CT scan to rule out intracranial tumor.Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).				
LUPRON DEPOT (6 MONTH)	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Ddiagnosis of endometriosis. Uterine leiomyoma. The patient must have a diagnosis of anemia due to uterine leiomyoma. The patient has had previous treatment with iron therapy.Lupron must be given in conjunction with iron supplement therapy. Central Precocious Puberty: The patient must have a diagnosis of central precocious puberty (idiopathic or neurogenic) with onset of	Endometriosis: The patient must be age 18 or older.	Licensed Practitioner	Plan year duration for all except for Endometriosis: 6 months and Uterine Leiomyoma 3 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			secondary sexual characteristics earlier than age 8 in females and age 9 in males. Diagnosis is confirmed by a pubertal response to a GnRH stimulation test and by bone age advanced one year beyond the chronological age. Baseline evaluation should include: LHRH test, Plasma level of sex steroids, Bone age evaluation, Height and weight measurements, Beta-HCG test to rule out gonadotropin releasing tumors, Adrenal steroid level to exclude congenital adrenal hyperplasia, Pelvic/Adrenal ultrasound to screen for tumors. CT scan to rule out intracranial tumor.Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).				
LUPRON DEPOT-PED	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Ddiagnosis of endometriosis. Uterine leiomyoma. The patient must have a diagnosis of anemia due to uterine leiomyoma. The patient has had previous treatment with iron therapy.Lupron must be given in conjunction with iron supplement therapy. Central Precocious Puberty: The patient must have a diagnosis of central	Endometriosis: The patient must be age 18 or older.	Licensed Practitioner	Plan year duration for all except for Endometriosis: 6 months and Uterine Leiomyoma 3	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			precocious puberty (idiopathic or neurogenic) with onset of secondary sexual characteristics earlier than age 8 in females and age 9 in males. Diagnosis is confirmed by a pubertal response to a GnRH stimulation test and by bone age advanced one year beyond the chronological age. Baseline evaluation should include: LHRH test, Plasma level of sex steroids, Bone age evaluation, Height and weight measurements, Beta-HCG test to rule out gonadotropin releasing tumors, Adrenal steroid level to exclude congenital adrenal hyperplasia, Pelvic/Adrenal ultrasound to screen for tumors. CT scan to rule out intracranial tumor.Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).			months	
LUPRON DEPOT-PED (3 MONTH)	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Ddiagnosis of endometriosis. Uterine leiomyoma. The patient must have a diagnosis of anemia due to uterine leiomyoma. The patient has had previous treatment with iron therapy.Lupron must be given in conjunction with iron supplement therapy. Central Precocious	Endometriosis: The patient must be age 18 or older.	Licensed Practitioner	Plan year duration for all except for Endometriosis: 6 months and Uterine	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Puberty: The patient must have a diagnosis of central precocious puberty (idiopathic or neurogenic) with onset of secondary sexual characteristics earlier than age 8 in females and age 9 in males. Diagnosis is confirmed by a pubertal response to a GnRH stimulation test and by bone age advanced one year beyond the chronological age. Baseline evaluation should include: LHRH test, Plasma level of sex steroids, Bone age evaluation, Height and weight measurements, Beta-HCG test to rule out gonadotropin releasing tumors, Adrenal steroid level to exclude congenital adrenal hyperplasia, Pelvic/Adrenal ultrasound to screen for tumors. CT scan to rule out intracranial tumor.Invasive Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) invasive breast cancer.The patient must be pre or perimenopausal. Recurrent Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).			Leiomyoma 3 months	
LYNPARZA	All FDA approved indications not otherwise excluded from	Members that have experienced significant disease progression while on Lynparza (olaparib).	Germline BRCA-mutated advanced ovarian cancer:The member has a diagnosis of advanced ovarian cancer AND The member has deleterious or suspected deleterious germline BRCA mutation(as detected by an FDA-approved test) AND The member has been treated with three or more prior lines of		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.		chemotherapy AND The member will be using Lynparza as monotherapy.				
MEGESTROL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
MEKINIST	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant Yervoy (ipilimumab),Zelboraf (vemurafenib). Members that have experienced significant disease progression while on Mekinist (trametinib).	Melanoma:The member has a diagnosis of stage IIIC unresectable or stage IV metastatic melanoma AND The member has a BRAFV600E or BRAFV600K mutation as detected by an FDA-approved test AND The member will be using Mekinist as a single-agent (member has not received prior BRAF-inhibitor therapy) OR in combination with Tafinlar (dabrafenib).		Licensed Practitioner	180 days.	
MEMANTINE	All FDA approved			An automatic approval if	Licensed Practitioner	Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.			member is greater than 26 years of age.Prior Auth required for age 26 or younger.			
MENEST	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
METHOCARBAMOL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side	Automatic approval if member is less than 65 years of age.Prior Auth required		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			effects of the medication.	for age 65 or older.			
MIMVEY	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
MODAFINIL	All FDA approved indications not otherwise excluded from Part D. Drug induced Somnolence, Steinert myotonic dystrophy syndrome.		Excessive Daytime Sleepiness.For the treatment of excessive daytime sleepiness or hypersomnolence associated with Narcolepsy. With obstructive sleep apnea, or due to sleep problems resulting from circadian rhythm disruption (i.e., shift-work sleep disorder).Drug induced Somnolence.For the treatment of somnolence due to Parkinson's therapy with the following medications: Levodopa and/or Dopamine agonist therapy.Steinert myotonic dystrophy syndrome.Member must have hypersomnia due to Steinert myotonic dystrophy syndrome. All indications require previous treatment of modafinil(generic Provigil).		Licensed Practitioner	Plan Year Duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
MOZOBIL	All FDA approved indications not otherwise excluded from Part D.	Treatment or prophylaxis of neutropenia or febrile neutropenia.Concomitant use with sargramostim or within seven days of pegfilgrastim dose.Same day administration with myelosuppressive chemotherapy or radiation.Use beyond four consecutive days or use after completion of stem cell harvest/apheresis.Mozobil is not intended for stem cell mobilization and harvest in patients	Diagnosis of Non-Hodgkin's Lymphoma and/or Multiple Myeloma. Mozobil must be used in combination with Neupogen/filgrastim. Mozobil must be a component of an autologous stem cell transplant mobilization protocol.		Licensed Practitioner	30 days. Mozobil will be approved for a 30-day interval once per transplant	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		with leukemia.					
MYALEPT	All FDA approved indications not otherwise excluded from Part D.	Partial lipodystrophy, Liver disease including non-alcoholic steatohepatitis (NASH), HIV related lipodystophy, Diabetes mellitus and hypertriglyceridemia without concurrent evidence of congenital or acquired generalized lipodystrophy, Generalized obesity not associated with congenital leptin deficiency.	Congenital of Acquired Lipodystrophy: The member has a diagnosis of congenital OR acquired lipodystrophy.The member is using Myalept as an adjunct to diet as replacement therapy to treat complications of leptin deficiency.		Licensed Practitioner	Plan year duration	
MYOZYME	All FDA-approved indications not		Alglucosidase alpha (Myozyme) will require prior authorization. These agents may be considered medically necessary when the following criteria are met: Pompe Disease. Members must have		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.		a diagnosis of Pompe disease. Myozyme:Members must have infantile-onset Pompe disease.				
NAGLAZYME	All FDA-approved indications not otherwise excluded from Part D.		Mucopolysaccharidosis VI (MPS VI, Maroteaux-Lamy syndrome).The member must have a diagnosis of mucopolysaccharidosis VI (MPS VI,Maroteaux-Lamy syndrome).		Licensed Practitioner	Plan Year	
NAMENDA	All FDA approved indications not otherwise excluded from Part D.			An automatic approval if member is greater than 26 years of age.Prior Auth required for age 26 or younger.	Licensed Practitioner	Plan year duration.	
NAMENDA TITRATION PAK	All FDA approved indications not otherwise excluded from			An automatic approval if member is greater than 26 years of	Licensed Practitioner	Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.			age.Prior Auth required for age 26 or younger.			
NAMENDA XR	All FDA approved indications not otherwise excluded from Part D.			An automatic approval if member is greater than 26 years of age.Prior Auth required for age 26 or younger.	Licensed Practitioner	Plan year duration.	
NEULASTA	All FDA approved indications not otherwise excluded from Part D.	Concomitant use (within seven days of pegfilgrastim dose) with filgrastim, tbo-filgrstim or sargramostim.Same day administration with myelosuppressive chemotherapy or	Febrile Neutropenia Prophylaxis:The patient must have a diagnosis of non-myeloid malignancy and has received or will receive myelosuppressive chemotherapy 24-72 hours prior to pegfilgrastim injection. The member must also meet ONE OR MORE of the following criteria:A risk of febrile neutropenia (FN) is 20% or greater based on current chemotherapy regimen (as calculated in current ASCO and NCCN guidelines for myeloid growth factors).A risk of febrile neutropenia of less than 20% based on chemotherapy regimen, but at high risk due to other risk factors including patient age greater than 65 years, poor		Licensed Practitioner	4 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		radiation. Cannot be given more than once per chemotherapy cycle and cannot be given more often than every 14 days (cannot be utilized in myelosuppressive chemotherapy regimens that are administered more frequently than every two weeks).	performance status, previous episodes of FN, extensive prior treatment including large radiation ports, cytopenias due to bone marrow involvement by tumor, the presence of active infections, or other serious comorbidities.				
NEUPOGEN	All FDA approved indications not otherwise excluded from Part D.	Treatment of neutropenic patients who are afebrile unless chronic symptomatic neutropenic disorder. Same day administration with myelosuppressive	Febrile Neutropenia Prophylaxis:In non-myeloid malignancies following myelosuppressive chemotherapy.The patient must have a diagnosis of non-myeloid malignancy and has received or will receive myelosuppressive chemotherapy 24-72 hours prior to starting filgrastim injections.The member must also meet ONE OR MORE of the following criteria:A risk of febrile neutropenia (FN) is 20% or greater based on current chemotherapy regimen (as calculated in current ASCO and NCCN guidelines for myeloid growth factors). Previous		Licensed Practitioner	4 months	Harvesting of peripheral blood stem cells.The member must be scheduled for autologous peripheral-blood stem cell (PBSC) transplantation or donating stem cells for an allogeneic or syngeneic PBSC transplant. Neutropenic

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		chemotherapy.Concomitant use with tbo-filgratim, sargramostim (unless part of stem cell mobilization protocol) or pegfilgrastim (within seven days of pegfilgrastim dose)	neutropenic complication from a prior cycle of similar chemotherapy. A risk of febrile neutropenia of less than 20% based on chemotherapy regimen, but at high risk due to other risk factors including patient age greater than 65 years, poor performance status, previous episodes of FN, extensive prior treatment including large radiation ports, cytopenias due to bone marrow involvement by tumor, the presence of active infections, or other serious comorbidities.Patient is receiving a dose-dense chemotherapy regimen in Breast Cancer, Small Cell Lung Cancer (SCLC), OR Non-Hodgkin's Lymphoma (NHL).Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following progenitor-cell transplantation.The member must have had a peripheral-blood progenitor cell (PBPC)transplantation for a non-myeloid malignancy.Febrile Neutropenia Prophylaxis, In patients with acute myeloid leukemia receiving chemotherapy.The member must have a diagnosis Acute Myeloid Leukemia (AML).The member must be scheduled to receive either induction chemotherapy OR consolidation chemotherapy (in patients in complete remission).				disorder, chronic (Severe), Symptomatic. The member must have a diagnosis of congenital, cyclic, or idiopathic neutropenia.Neutropenia in Myelodysplastic Syndromes.The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome.Treatment of Severe Febrile Neutropenia.The member must have a diagnosis of severe febrile neutropenia.Filgrastim must be used in adjunct with appropriate antibiotics in high risk patients. Neutropenia in AIDS patients.The member must have a diagnosis of AIDS

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							with neutropenia.Treatment of Aplastic Anemia.The member must have a diagnosis of Aplastic Anemia.Treatment of Agranulocytosis.The member must have a diagnosis of congenital or drug induced agranulocytosis.
NEXAVAR	All FDA approved indications not otherwise excluded from Part D.Gastrointestinal stromal tumor (GIST)	Members on concomitant tyrosine kinase inhibitors. Members that have experienced significant disease progression while on Nexavar (sorafenib).	Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma (stage IV) AND he member has experienced disease progression with Inlyta (axitinib) which requires a trial with a first-line agent. Liver Carcinoma: Diagnosis of unresectable hepatocellular (liver) carcinoma. Thyroid Carcinoma. Diagnosis of advanced metastatic medullary carcinoma (thyroid carcinoma) OR The member has a diagnosis of advanced, clinically progressive and/or symptomatic papillary carcinoma, follicular carcinoma or Hürthle cell carcinoma AND Tumors are not responsive to radio-iodine treatment. Gastrointestinal stromal tumor (GIST). Diagnosis of gastrointestinal stromal tumor (GIST) AND The member experienced disease		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			progression with Gleevec (imatinib) or Sutent (sunitinib).				
NITROFURANTOIN	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
NITROFURANTOIN MACROCRYSTAL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
NITROFURANTOIN MONOHYD/ M-CRYST	All FDA approved indications not otherwise		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must	Automatic approval if member is less than 65		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.		document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	years of age.Prior Auth required for age 65 or older.			
NOXAFIL	All FDA approved indications not otherwise excluded from Part D.	Noxafil/(posaconazole) is not considered medically necessary for members with the following concomitant conditions: Coadministration with sirolimus,ergot alkaloids (ergotamine and dihydroergotamine), with CYP3A4 substrates terfenadine, astemizole, cisapride, pimozide, halofantrine, or	Noxafil/posaconazole oral suspension will require prior authorization. This agent may be considered medically necessary when the following criteria is met: Prophylaxis against Invasive Aspergillus and Candida Infections. The member must be using it for prophylaxis against invasive Aspergillus or Candida infections, and The member must be severely immunocompromised (such as hematopoietic stem cell transplant recipient with graft-vs-host disease, or neutropenic patients with acute myelogenous leukemia (AML) or myelodysplastic syndromes (MDS).Treatment of invasive Aspergillus or fungal infections caused by Scedosporium apiospermum, Fusarium, and/or Zygomycetes. The member must have documentation for treatment of invasive Aspergillus or fungal infections caused by Scedosporium apiospermum, Fusarium and/or Zygomycetes, and The member must have documented resistant strains of or clinically refractory to standard antifungal agents or those who can not receive other antifungal agents due to potential toxicities, intolerance, or	Must be 13 years of age or older	Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		quinidine can lead to QT prolongation and simvastatin.	contraindications.Treatment of Oropharyngeal or Esophageal Candidiasis.The member must have a diagnosis for orpharnygeal or esophageal candidiasis and The member has a documented inadequate response/refractory or intolerant to itraconazole and fluconazole				
NULOJIX	All FDA approved indications not otherwise excluded from Part D.	Nulojix (belatacept) therapy is not considered medically necessary for members with the following concomitant conditions:Treatment of kidney rejection.Liver transplant rejection prophylaxis.Treatment of Liver transplant rejection. Members who are Epstein-Barr virus (EBV) seronegative, or have unknown EBV	Nulojix (belatacept) will require prior authorization. This agent may be considered medically necessary when the following criteria are met:Kidney Transplant Rejection Prophylaxis.Member must have received a kidney transplant.Member must be using belatacept for rejection prophylaxis.Member must have had exposure to the Epstein-Barr virus.		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		serostatus.					
NUVIGIL	All FDA approved indications not otherwise excluded from Part D.		Excessive Daytime Sleepiness.For the treatment of excessive daytime sleepiness or hypersomnolence associated narcolepsy, obstructive sleep apnea, or due to sleep problems resulting from circadian rhythm disruption (i.e., shift-work sleep disorder).		Licensed Practitioner	Plan year duration	
OCTREOTIDE ACETATE	All FDA approved indications not otherwise excluded from Part D.		Acromegaly: The member must have a diagnosis of Acromegaly. Mmust have had an inadequate response to surgery/radiation or for whom surgical resection/radiation is not an option. Treatment of metastatic carcinoid tumors. Must have a diagnosis of a carcinoid tumor. Patient must have severe diarrhea and flushing resulting from carcinoid tumor. Treatment of vasoactive intestinal peptide tumors (VIPomas). Patient must be diagnosed with a vasoactive intestinal peptide tumor. Patient must have diagnosis of profuse watery diarrhea associated with VIP-secreting tumor. Treatment of chemotherapy or radiation induced diarrhea. Patient must have above grade 3 diarrhea according to NCI common toxicity. Patient must have NCI grade 1 or 2 diarrhea and have failed treatment with loperamide or diphenoxylate and atropine.. Treatment of severe secretory diarrhea in acquired immune deficiency syndrome (AIDS) patients. Patient must have		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			diagnosis of severe diarrhea resulting from acquired immune deficiency syndrome (AIDS). Patient must have tried and failed antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine) within 30 days of the last 6 months. Reversal of life-threatening hypotension due to carcinoid crisis during induction of anesthesia. Patient must have life-threatening hypotension due to carcinoid crisis. For all Indications: The member has had previous treatment with generic octreotide S.C. (applicable to brand Sandostatin S.C. requests only).				
OFEV	All FDA approved indications not otherwise excluded from Part D.	Clinically significant environmental exposure known to cause pulmonary fibrosis, including but not limited to drugs, asbestos, beryllium, radiation, and domestic birds. Known explanation for interstitial lung disease, including but not limited to	Idiopathic Pulmonary Fibrosis (IPF): The member has a diagnosis of idiopathic pulmonary fibrosis confirmed by one of the following: High-resolution computed tomography (HRCT) scan is indicative of usual interstitial pneumonia (UIP) OR A surgical lung biopsy.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		radiation, sarcoidosis, hypersensitivity pneumonitis, bronchiolitis, obliterans organizing pneumonia, human immunodeficiency virus (HIV), viral hepatitis, and cancer.					
OMNITROPE	All FDA approved indications not otherwise excluded from Part D. Growth hormone deficiency, Growth failure, Turner's Syndrome, Noonan	Pediatric growth hormone discontinuation. Increase in height velocity is less than 2 cm total growth in one year of therapy: OR Final adult height has been achieved (member's calculated mid-parental height).The	GH Therapy in Adults (18 years of age or older). Must have previous tx with Omnitrope.Adult-onset GHD either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma OR has a diagnosis of childhood-onset GHD. A subnormal response to two standard GH stimulation tests (one must be insulin tolerance test). If contraindication to insulin tolerance test, a subnormal response to a standardized stimulation test must be provided along with Insulin like growth factor. Acceptable tests are ITT, GHRH+ARG test, the glucagon test, and the ARG test. If ITT is not desirable and when recombinant GHRH is not available, the glucagon test is		Licensed Practitioner	Plan year duration	GHT in Children (less than 18 years). GH failure associated with GH deficiency. Bone age is at least 1 year or 2 SDs delayed compared to chronological age AND epiphyses not closed. Growth rate is less than: 4.5 cm/yr for age over 4 years, 7cm/yr for ages 2-4 years, 9 cm/yr for ages 1-2 years.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Syndrome, Prader Willi syndrome, SHOX deficiency, Small for gestational age, Adult onset GH deficiency, Childhood onset GH deficiency in adults, Growth retardation with Chronic Renal insufficiency.	epiphyses have closed. Constitutional delay of growth and development. Skeletal dysplasias (e.g., achondroplasia, kyphomelic dysplasia). Osteogenesis imperfect. "Somatopause" in older adults.Infertility. Burn injuries. Obesity/morbid obesity. Hypophosphatemia (hypophosphatemic rickets). Muscular dystrophy. Cystic fibrosis. Spina bifida.	alternative, but not levodopa/clonidine tests. Assay type must be documented. Subnormal response to ITT is defined as peak serum GH level less than or equal to 3ng/ml when measured by RIA or less than or equal to 2.5 ng/ml when measured by IRMA . Subnormal response to glucagon stimulation test is less than or equal to 3ng/ml and to arginine stimulation test is less than or equal to 4ng/ml. Subnormal response to GHRH+ARG is: less than or equal to 11 ng/ml in members with a BMI less than 25kg/m2, less than or equal to 8 ng/ml in members with a BMI greater than or equal to 25 and less than 30kg/m2, less than or equal to 4 ng/ml in members with a BMI greater than 30kg/m2. For insulin tolerance tests, an appropriate blood glucose nadir of less than 40mg/dL must be documented. Members with irreversible hypothalamic-pituitary structural lesions and those with evidence of panhypopituitarism and serum IGF-I levels below the age- and sex appropriate reference range when off GH therapy are deemed to be GH deficient.				Two pharmacological GH stimulation test results with GH secretion less than 10 ng/ml. Acceptable tests include L-dopa, arginine, clonidine, glucagon, exercise, insulin-induced hypoglycemia. Small for gestational age. Born small for gestational age, defined as birth weight or length 2 or more SDs below the mean for gestational age: and fails to catch up growth by age 2 years, defined as height 2 or more SDs below the mean for age and sex.Short Stature Homeobox-Containing Gene (SHOX) Deficiency. Children with SHOX deficiency whose epiphyses are not closed. Chronic

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Juvenile rheumatoid arthritis. Osteoporosis. Post-traumatic stress disorder. Depression. Hypertension. Corticosteroid-induced pituitary ablation. Precocious puberty. Chronic fatigue syndrome. Crohn's disease . Anti-aging . Growth retardation due to amphetamines. Chronic catabolic states, including respiratory failure, pharmacologic glucocorticoid administration, and inflammatory bowel					Renal insufficiency. Children with CRI and growth retardation who meet both: nutritional status has been optimized, metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum:and At least 1 of the following criteria is met: has severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over one year below 25th percentile for age and sex): OR Child

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		disease. Down syndrome and other syndromes associated with short stature and increased susceptibility to neoplasms (Bloom syndrome, Fanconi syndrome).					exhibits severe deceleration in growth rate (GV measured over one year -2 SDS below the mean for age and sex).Prader-Willi Syndrome. Confirmed by genetic testing: AND At least 1 of the following: severe growth retardation with height SDS more than 3 SDS below the mean for chronological age and sex: OR Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (GV measured over one year below 25th percentile for age and sex): OR Child exhibits severe deceleration in growth rate (GV

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							measured over 1 year -2 SDS below the mean for age and sex). Is not severely obese or has a severe respiratory impairment. Turner’s Syndrome. Turner's syndrome with growth retardation and who meet all of the following: Confirmed by chromosome analysis: AND At least one of the following is met: SAME as Prader Willi soon above. Noonan Syndrome.Height 2 SDS or more below the mean for chronological age and sex: AND GV measured over one year prior to initiation of therapy of 1 or more SDS below the mean for age and sex. Pediatric GH discontinuation warranted

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							when Increase in height velocity is less than 2 cm total growth in 1 year of therapy: OR Final adult height has been achieved (member's calculated mid-parental height): The epiphyses have closed.
ONFI	All FDA approved indications not otherwise excluded from Part D.		Onfi (clobazam) will require prior authorization. This agent may be considered medically necessary when the following criteria are met:Lennox-Gastaut Syndrome.Member has diagnosis of seizures associated with LGS.	Member is 2 years of age or older	Licensed Practitioner	Plan Year	
OPDIVO	All FDA approved indications not otherwise excluded from Part D.	Disease progression while on anti-PD-1 therapy (e.g. Opdivo [nivolumab], Keytruda [pembrolizumab]).	Melanoma: The member must have a diagnosis of unresectable or metastatic melanoma AND The member will be using Opdivo (nivolumab) as monotherapy AND One of the following criteria applies: Disease progression following Yervoy (ipilimumab) OR If BRAF V600 mutation, disease progression following a BRAF inhibitor (e.g.Zelboraf [vemurafenib], Tafinlar [dabrafenib]) OR as first-line therapy.Non-Small Cell Lung Cancer: The member must have a diagnosis of metastatic squamous or non-squamous non-small cell lung cancer AND The member has		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			experienced disease progression on or after chemotherapy AND The member will be using Opdivo (nivolumab) as monotherapy.				
OPSUMIT	All FDA approved indications not otherwise excluded from Part D.	The member is concomitantly taking endothelin receptor antagonist (e.g., Letairis, Tracleer).	Pulmonary Arterial Hypertension (PAH): The member must have a diagnosis of pulmonary arterial hypertension (WHO Group 1) with WHO/NYHA Functional Class II or III.		Licensed Practitioner	Plan year duration	
ORKAMBI	All FDA approved indications not otherwise excluded from Part D.		Cystic Fibrosis:The member has a diagnosis of Cystic Fibrosis.The member has documentation of a homozygous F508del mutation in the CFTR gene.	member is 12 years of age or older	Licensed Practitioner	Plan year duration	
ORPHENADRINE CITRATE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PEGASYS	All FDA approved indications not otherwise excluded from Part D.	Pegasys monotherapy in a pegylated interferon-experienced member.	Chronic Hepatitis C (CHC): Members Treatment Naive to Peginterferon Alfa Therapy: Diagnosis of chronic hepatitis C with compensated liver disease. Viral genotype and baseline HCV RNA level must be documented prior to therapy.Members 18 years of age and older: Pegasys will be used in one of the following regimens: Sofosbuvir Triple therapy. Pegasys + ribavirin + sofosbuvir. Protease Inhibitor Triple therapy (GT 1 and 4 only). Pegasys + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual therapy: Pegasys + ribavirin for members that have a contraindication or intolerance to protease inhibitor therapy or sofosbuvir therapy. Monotherapy: Pegasys monotherapy for members that have a contraindication or intolerance to ribavirin therapy. Members 5 to 17 years of age (all genotypes): Must use Pegasys in combination with ribavirin	Member must age 5 or above	Licensed Practitioner	24 to 120 week treatment course depending on the disease state and/or genotype	Chronic Hepatitis C: Treatment-experienced : Diagnosis of chronic hepatitis C with compensated liver disease. Member has received prior therapy with a pegylated interferon containing regimen. Member has not failed to achieve SVR on the prescribed regimen (e.g. using dual therapy after previous treatment failure with dual therapy). =18 years: Member will be initiating therapy with one of the following regimens: Sofosbuvir Triple Therapy: Pegasys + ribavirin + sofosbuvir. Protease Inhibitor Triple Therapy (GT 1 and 4 only): Pegasys + ribavirin + a protease

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual Therapy: Pegasys + ribavirin for members that have a contraindication or intolerance to protease inhibitor or sofosbuvir therapy OR For requests to extend current peginterferon therapy beyond standard treatment length: Member is a slow or late responder to peginterferon and ribavirin defined as one of the following: GT 1: The member must have a documented negative/undetectable HCV RNA between weeks 12-24. 5-17 years: Member will be initiating therapy with Pegasys and ribavirin OR

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							For requests to extend current peginterferon therapy beyond standard treatment length: Member is a slow or late responder to peginterferon and ribavirin defined as one of the following: GT 1: The member must have a documented negative/undetectable HCV RNA between weeks 12-24. Chronic Hepatitis C (CHC) with clinically stable HIV disease: Diagnosis of chronic hepatitis C with compensated liver disease co-infected with HIV. The member must receive anti-HCV testing with a positive response prior to therapy. The member must undergo HCV RNA (reverse

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							transcriptase polymerase chain reaction RT-PCR) testing to confirm HCV and eliminate false-positive anti-body results. The member must be at least 18 years of age. Member will be initiating therapy with one of the following regimens: Sofosbuvir Triple Therapy: Pegasys + ribavirin + or sofosbuvir. Protease Inhibitor Triple Therapy (GT 1 only): Pegasys + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual Therapy: Pegasys + ribavirin for members that have a contraindication or intolerance to protease inhibitor or sofosbuvir therapy. Chronic hepatitis B

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							either HBeAG-positive or HBeAG-negative: The member must have a diagnosis of chronic HBeAG-positive or HBeAG-negative hepatitis B. The member must be treatment naïve to pegylated interferon therapy. The member must be at least 18 years of age.
PEGASYS CONVENIENCE PACK	All FDA approved indications not otherwise excluded from Part D.	Pegasys monotherapy in a pegylated interferon-experienced member.	Chronic Hepatitis C (CHC): Members Treatment Naive to Peginterferon Alfa Therapy: Diagnosis of chronic hepatitis C with compensated liver disease. Viral genotype and baseline HCV RNA level must be documented prior to therapy.Members 18 years of age and older: Pegasys will be used in one of the following regimens: Sofosbuvir Triple therapy. Pegasys + ribavirin + sofosbuvir. Protease Inhibitor Triple therapy (GT 1 and 4 only). Pegasys + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual therapy: Pegasys + ribavirin for members that have a contraindication or intolerance to protease inhibitor therapy or sofosbuvir therapy. Monotherapy: Pegasys monotherapy for members that have a contraindication or intolerance to ribavirin therapy. Members 5	Member must age 5 or above	Licensed Practitioner	24 to 120 week treatment course depending on the disease state and/or genotype	Chronic Hepatitis C: Treatment-experienced : Diagnosis of chronic hepatitis C with compensated liver disease. Member has received prior therapy with a pegylated interferon containing regimen. Member has not failed to achieve SVR on the prescribed regimen (e.g. using dual therapy after previous treatment failure

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			to 17 years of age (all genotypes): Must use Pegasys in combination with ribavirin				with dual therapy). =18 years: Member will be initiating therapy with one of the following regimens: Sofosbuvir Triple Therapy: Pegasys + ribavirin + sofosbuvir. Protease Inhibitor Triple Therapy (GT 1 and 4 only): Pegasys + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual Therapy: Pegasys + ribavirin for members that have a contraindication or intolerance to protease inhibitor or sofosbuvir therapy OR For requests to extend current peginterferon therapy beyond standard treatment length: Member is a slow or late responder to

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							peginterferon and ribavirin defined as one of the following: GT 1: The member must have a documented negative/undetectable HCV RNA between weeks 12-24. 5-17 years: Member will be initiating therapy with Pegasys and ribavirin OR For requests to extend current peginterferon therapy beyond standard treatment length: Member is a slow or late responder to peginterferon and ribavirin defined as one of the following: GT 1: The member must have a documented negative/undetectable HCV RNA between weeks 12-24. Chronic Hepatitis C (CHC)

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							with clinically stable HIV disease: Diagnosis of chronic hepatitis C with compensated liver disease co-infected with HIV. The member must receive anti-HCV testing with a positive response prior to therapy. The member must undergo HCV RNA (reverse transcriptase polymerase chain reaction RT-PCR) testing to confirm HCV and eliminate false-positive anti-body results. The member must be at least 18 years of age. Member will be initiating therapy with one of the following regimens: Sofosbuvir Triple Therapy: Pegasys + ribavirin + or sofosbuvir. Protease Inhibitor Triple Therapy (GT

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							1 only): Pegasys + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual Therapy: Pegasys + ribavirin for members that have a contraindication or intolerance to protease inhibitor or sofosbuvir therapy. Chronic hepatitis B either HBeAG-positive or HBeAG-negative: The member must have a diagnosis of chronic HBeAG-positive or HBeAG-negative hepatitis B. The member must be treatment naïve to pegylated interferon therapy. The member must be at least 18 years of age.
PEGASYS PROCLICK	All FDA approved indications not	Pegasys monotherapy in a pegylated	Chronic Hepatitis C (CHC): Members Treatment Naive to Peginterferon Alfa Therapy: Diagnosis of chronic hepatitis C with compensated liver disease. Viral genotype and baseline	Member must age 5 or above	Licensed Practitioner	24 to 120 week treatment	Chronic Hepatitis C: Treatment-experienced : Diagnosis of chronic

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.	interferon-experienced member.	HCV RNA level must be documented prior to therapy.Members 18 years of age and older: Pegasys will be used in one of the following regimens: Sofosbuvir Triple therapy. Pegasys + ribavirin + sofosbuvir. Protease Inhibitor Triple therapy (GT 1 and 4 only). Pegasys + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual therapy: Pegasys + ribavirin for members that have a contraindication or intolerance to protease inhibitor therapy or sofosbuvir therapy. Monotherapy: Pegasys monotherapy for members that have a contraindication or intolerance to ribavirin therapy. Members 5 to 17 years of age (all genotypes): Must use Pegasys in combination with ribavirin			course depending on the disease state and/or genotype	hepatitis C with compensated liver disease. Member has received prior therapy with a pegylated interferon containing regimen. Member has not failed to achieve SVR on the prescribed regimen (e.g. using dual therapy after previous treatment failure with dual therapy). =18 years: Member will be initiating therapy with one of the following regimens: Sofosbuvir Triple Therapy: Pegasys + ribavirin + sofosbuvir. Protease Inhibitor Triple Therapy (GT 1 and 4 only): Pegasys + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual Therapy: Pegasys + ribavirin

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							for members that have a contraindication or intolerance to protease inhibitor or sofosbuvir therapy OR For requests to extend current peginterferon therapy beyond standard treatment length: Member is a slow or late responder to peginterferon and ribavirin defined as one of the following: GT 1: The member must have a documented negative/undetectable HCV RNA between weeks 12-24. 5-17 years: Member will be initiating therapy with Pegasys and ribavirin OR For requests to extend current peginterferon therapy beyond standard

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							treatment length: Member is a slow or late responder to peginterferon and ribavirin defined as one of the following: GT 1: The member must have a documented negative/undetectable HCV RNA between weeks 12-24. Chronic Hepatitis C (CHC) with clinically stable HIV disease: Diagnosis of chronic hepatitis C with compensated liver disease co-infected with HIV. The member must receive anti-HCV testing with a positive response prior to therapy. The member must undergo HCV RNA (reverse transcriptase polymerase chain reaction RT-PCR) testing to confirm HCV and

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							eliminate false-positive anti-body results. The member must be at least 18 years of age. Member will be initiating therapy with one of the following regimens: Sofosbuvir Triple Therapy: Pegasys + ribavirin + or sofosbuvir. Protease Inhibitor Triple Therapy (GT 1 only): Pegasys + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual Therapy: Pegasys + ribavirin for members that have a contraindication or intolerance to protease inhibitor or sofosbuvir therapy. Chronic hepatitis B either HBeAG-positive or HBeAG-negative: The member must have a

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							diagnosis of chronic HBeAG-positive or HBeAG-negative hepatitis B. The member must be treatment naïve to pegylated interferon therapy. The member must be at least 18 years of age.
PEGINTRON	All FDA approved indications not otherwise excluded from Part D.	PegIntron monotherapy in a pegylated interferon-experienced member.	Chronic Hepatitis C (CHC): Members Treatment Naive to Peginterferon Alfa Therapy: Diagnosis of chronic hepatitis C with compensated liver disease. Viral genotype and baseline HCV RNA level must be documented prior to therapy. Members 18 years of age and older: PegIntron will be used in one of the following regimens: Sofosbuvir Triple Therapy: PegIntron + ribavirin + sofosbuvir. Protease Inhibitor Triple Therapy (GT 1 and 4 only). PegIntron + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual Therapy: PegIntron + ribavirin for members that have a contraindication or intolerance to protease inhibitor or sofosbuvir therapy. Monotherapy: PegIntron monotherapy for members that have a contraindication or intolerance to ribavirin therapy.Members 3 to 17 years of age (all genotypes): Must use PegIntron in combination with ribavirin.	must be age 3 or older	Licensed Practitioner	total of 12 to 120 weeks depending on disease state and genotype, one year for monotherapy	Chronic Hepatitis C: Treatment-experienced :Diagnosis of chronic hepatitis C with compensated liver disease. Member has received prior therapy with a pegylated interferon containing regimen. Member has not failed to achieve SVR on the prescribed regimen (e.g. using dual therapy after previous treatment failure with dual therapy). =18 years: Member will be initiating therapy with one

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							of the following regimens: Sofosbuvir Triple Therapy: PegIntron + ribavirin + sofosbuvir. Protease Inhibitor Triple Therapy (GT 1 and 4 only): PegIntron + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual Therapy: PegIntron + ribavirin for members that have a contraindication or intolerance to protease inhibitor or sofosbuvir therapy OR For requests to extend current peginterferon therapy beyond standard treatment length: member is a slow or late responder to peginterferon and ribavirin defined as one of the following: GT 1: The

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							member must have a documented negative/undetectable HCV RNA between weeks 12-24. 3-17 years: Member will be initiating therapy with PegIntron and ribavirin OR For requests to extend current peginterferon therapy beyond standard treatment length: Member is a slow or late responder to peginterferon and ribavirin defined as one of the following: GT 1: The member must have a documented negative/undetectable HCV RNA between weeks 12-24.
PEGINTRON REDIPEN	All FDA approved indications not otherwise	PegIntron monotherapy in a pegylated interferon-	Chronic Hepatitis C (CHC): Members Treatment Naive to Peginterferon Alfa Therapy: Diagnosis of chronic hepatitis C with compensated liver disease. Viral genotype and baseline HCV RNA level must be documented prior to therapy. Members	must be age 3 or older	Licensed Practitioner	total of 12 to 120 weeks depending on disease state	Chronic Hepatitis C: Treatment-experienced :Diagnosis of chronic hepatitis C with

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.	experienced member.	18 years of age and older: PegIntron will be used in one of the following regimens: Sofosbuvir Triple Therapy: PegIntron + ribavirin + sofosbuvir. Protease Inhibitor Triple Therapy (GT 1 and 4 only). PegIntron + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual Therapy: PegIntron + ribavirin for members that have a contraindication or intolerance to protease inhibitor or sofosbuvir therapy. Monotherapy: PegIntron monotherapy for members that have a contraindication or intolerance to ribavirin therapy.Members 3 to 17 years of age (all genotypes): Must use PegIntron in combination with ribavirin.			and genotype, one year for monotherapy	compensated liver disease. Member has received prior therapy with a pegylated interferon containing regimen. Member has not failed to achieve SVR on the prescribed regimen (e.g. using dual therapy after previous treatment failure with dual therapy). =18 years: Member will be initiating therapy with one of the following regimens: Sofosbuvir Triple Therapy: PegIntron + ribavirin + sofosbuvir. Protease Inhibitor Triple Therapy (GT 1 and 4 only): PegIntron + ribavirin + a protease inhibitor (e.g. boceprevir, telaprevir, simeprevir). Dual Therapy: PegIntron + ribavirin for members that

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							have a contraindication or intolerance to protease inhibitor or sofosbuvir therapy OR For requests to extend current peginterferon therapy beyond standard treatment length: member is a slow or late responder to peginterferon and ribavirin defined as one of the following: GT 1: The member must have a documented negative/undetectable HCV RNA between weeks 12-24. 3-17 years: Member will be initiating therapy with PegIntron and ribavirin OR For requests to extend current peginterferon therapy beyond standard treatment length: Member

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							is a slow or late responder to peginterferon and ribavirin defined as one of the following: GT 1: The member must have a documented negative/undetectable HCV RNA between weeks 12-24.
PERFOROMIST	All FDA approved indications not otherwise excluded from Part D.	Concurrent use with other medications containing Long-acting beta2-adrenergic agonists.Acute deteriorations of COPD. Asthma, in the absence of concurrent medication containing inhaled corticosteroid and comorbid COPD diagnosis.	Chronic Obstructive Pulmonary Disease (COPD).Diagnosis of Chronic Obstructive Pulmonary Disease (COPD), including chronic bronchitis and emphysema, requiring maintenance treatment of bronchoconstriction.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
PERJETA	All FDA approved indications not otherwise excluded from Part D.		Breast Cancer. The member has a diagnosis of metastatic breast cancer AND The member has over expression of the HER2 (human epidermal growth factor receptor2) protein as defined by one of the following:IHC HER2 3+ (defined as uniform intense membrane staining of greater than 30% of invasive tumor cells) OR FISH amplified (ratio of HER2 to CEP17 of greater than 2.0 or average HER2 gene copy number greater than six signals/nucleus for those test systems without an internal control probe) AND The member will be receiving Perjeta (pertuzumab) in combination with trastuzumab and docetaxel AND The member has not received prior anti-HER2 therapy or chemotherapy for metastatic disease (when used, must be used first line for metastatic disease)OR The member has a diagnosis of locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive) AND The member has over expression of the HER2 (human epidermal growth factor receptor2) protein as defined by one of the following: IHC HER2 3+ (defined as uniform intense membrane staining of greater than 30% of invasive tumor cells) OR FISH amplified (ratio of HER2 to CEP17 of greater than 2 or average HER2 gene copy number greater than six signals/nucleus for those test systems without an internal control probe) AND Perjeta (pertuzumab) will be used		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			in combination with trastuzumab and docetaxel as neoadjuvant treatment OR Perjeta (pertuzumab) will be used as adjuvant treatment if a pertuzumab containing regime was not use as neoadjuvant therapy.				
PERPHENAZINE-AMITRIPTYLINE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
PHENOBARBITAL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
POMALYST	All FDA	Members receiving	Multiple Myeloma: The member has a diagnosis of Multiple		Licensed	Six month	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D.	concomitant therapy with an immunomodulator or proteasome inhibitor.The member has experienced disease progression constituting treatment failure while on Pomalyst (pomalidomide).	Myeloma AND The member has failed two previous regimens AND The member has failed therapy with Revlimid (lenalidomide) AND The member has failed therapy with Velcade (bortezomib) AND The member demonstrated disease progression on or within 60 days of completion of the last therapy regimen.		Practitioner	duration	
POTIGA	All FDA approved indications not otherwise excluded from Part D.		Adjunctive treatment for adult members with partial-onset seizures. Inadequately controlled partial-onset seizures. Concomitant use of at least one antiepileptic medication.		Licensed Practitioner	Plan year duration	
PROCRIT	All FDA approved indications not otherwise excluded from	Concomitant use of another Recombinant Erythropoietin Product	Anemia of CKD: Diagnosis of anemia associated with chronic kidney disease.Hgb level less than 10.0 g/dL or HCT less than 30- within last 4 weeks. Continue Therapy: Current- within last 4 weeks Hgb level less than 11 g/dL.Documented dose adjustment of therapy with corresponding documented Hgb		Licensed Practitioner	3 months for chemo induced anemia,HIV,HCV,MDS,RA,s	Anemia in Surgery Members .Must be scheduled to undergo elective, noncardiac, nonvascular surgery. Must

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D. Myelodysplastic Syndrome, Hepatitis C, Rheumatoid Arthritis.		levels to indicate maintenance therapy. Anemia in Zidovudine-treated HIV-infected: Diagnosed with HIV (and AZT induced anemia) and receiving zidovudine treatment corresponding with HAART. Endogenous serum erythropoietin levels less than or equal to 500 mUnits/mL.The total zidovudine dose must not exceed 4200mg/wk. Must have Hgb level less than or equal to 10.0 g/dL or HCT less than 30-within the last four weeks. Continue Therapy:Zidovudine dose must not exceed 4200mg/wk.Must meet one of the following criteria:Current-within last 4 weeks Hgb level less than 12.0 g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed 12.0g/dL.Anemia in Chemotherapy Treated Cancer (first 4 weeks).Diagnosis with a non-myeloid, non-erythroid malignancy.Must be receiving concurrent chemotherapy treatment for incurable disease with palliative intent. Must have Hgb level less than10.0 g/dL or HCT less than 30-within last 4 weeks. Maint. Phase after first 4 weeks.Must have had a response of no less than 1 g/dL increase in Hgb levels in any prior use of epoetin therapy—can't be a documented failure on previous epoetin therapy with a similar myelosuppressive chemotherapy regimen. Must meet ALL of the following criteria: Current-within the last 4 weeks Hgb level			urgery and 6 months for CKD	have Hgb level of greater than 10 g/dL and less than or equal 13 g/dL-within last 4 weeks. Anemia in Myelodysplastic Syndromes. Diagnosis of symptomatic anemia associated with MDS. Must have a serum erythropoietin level less than or equal to 500 mUnits/mL .Must have Hgb level less than or equal to 10.0 g/dL or HCT less than 30-within last four weeks. Is receiving iron therapy if indicated. Continue Therapy:If no response after 6 to 8 weeks of therapy (or after 3 to 4 months if 5Q deletion MDS on Revlimid and after trial of concomitant Neupogen —discontinue epoetin and

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			is low enough to necessitate transfusion (and Hgb is less than 11 g/dL).Has received iron therapy if indicated. Epoetin should be stopped if after six-eight weeks the member has not experienced a greater than or equal 1 g/dL rise in Hgb. Epoetin should not be continued after completion of myelosuppressive chemotherapy.				consider other treatment options (NCCN MDS guidelines 2010).A response is defined as a 1.5 g/dL rise in Hgb or a decrease in RBC transfusion requirement (NCCN MDS guidelines 2010). Current-within the last 4 weeks Hgb less than or equal to 12 g/dL.Anemia associated with Management of Hepatitis C. Diagnosis of anemia in management of chronic Hepatitis C. Receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV. Must have Hgb level less than or equal to 10.0 gm/dL or HCT less than 30 during combination

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							therapy as defined above-within the last 4 weeks.Continue Therapy: Must be receiving combination treatment for chronic Hepatitis C with interferon (IFN)/ribavirin (RBV) or pegylated (PEG) IFN/RBV.Must have been able to maintain previous ribavirin dosing without dose reduction due to symptomatic anemia. Must meet one of the following criteria: Current-within the last 4 weeks Hgb level less than 12.0g/dL OR Documented dose adjustment of therapy with corresponding documented Hgb levels to indicate maintenance therapy. Goal Hgb level should not exceed

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							12.0g/dL.Anemia associated with Rheumatoid Arthritis (RA)Treatment. Diagnosis of anemia associated with pharmaceutical treatment of RA. Receiving active therapy known to cause anemia.Must have Hgb level less than 10 g/dL or HCT less than 30-within the last 4 weeks. Continue Therapy: Receiving active RA pharmaceutical treatment. Current-within the last 4 weeks Hgb less than 11 g/dL. For all listed indications: Prior to initiation of therapy, the member's iron scores should be evaluated. Transferrin saturation should be at least 20% and ferritin at least 100 ng/mL.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							If member is on supplemental iron therapy, a transferrin saturation of at least 18% and a ferritin of at least 90ng/ml will be required.Other causes of anemia including iron, B-12, folate deficiencies, hemolysis, and bleeding have been ruled out. Continuation of therapy requires documented Transferrin saturation of at least 20% and ferritin of at least 100 ng/ mL within the last 12 months for all indications.Procrit is preferred epoetin agent for all indications except Anemia of CKD.
PROLIA	All FDA approved indications not	Uncorrected Pre-existing hypocalcemia.	Osteoporosis: The member has a diagnosis of osteoporosis AND one of the following: The member has failed to achieve therapeutic goals after previous treatment with,		Licensed Practitioner	Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.		contraindication or intolerance to an oral bisphosphonate OR The member has a history of osteoporotic fracture. Nonmetastatic Prostate Cancer: The member is a male with a diagnosis of nonmetastatic prostate cancer AND The member is receiving androgen deprivation therapy AND The member is at high risk for fracture. Hormone-Receptor-Positive Breast Cancer: The member has a diagnosis of hormone-receptor-positive breast cancer AND The member is receiving an aromatase inhibitor as adjuvant therapy AND The member is at high risk for fracture.				
PROMACTA	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with other platelet stimulating factors such as Nplate (romiplostim) or Neumega (oprelvekin).Eltrombopag should not be used to normalize platelet counts. ITP members with previous documented failure	Chronic Idiopathic Thrombocytopenic Purpura. Initial Approval:The member has a diagnosis of relapsed/refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) AND The member has a platelet count of less than 50 x 109/L. The member is not a candidate for splenectomy, and has had an insufficient response or is intolerant to corticosteroids AND immunoglobulins (IVIG) OR The member has had a splenectomy with an inadequate response AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. Reauthorizations. The member has a platelet count of less than 400 x 109/L AND The member remains at risk for bleeding complications AND The member is responding to therapy as evidenced by increased platelet counts. Thrombocytopenia in		Licensed Practitioner	3 month duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		of eltrombopag.	Patients with Hepatitis C Infection: Initial Approval: The member has a diagnosis of chronic hepatitis C. The member has a platelet count of less than 75 x 109/L. The degree of thrombocytopenia is preventing the initiation of interferon therapy OR limits the ability to maintain optimal interferon based therapy. Reauthorization: The member has a platelet count of less than 400 x 109/L AND The member is responding to therapy as evidenced by increased platelet counts AND The member continues to receive interferon based therapy. Aplastic Anemia:Initial Approval:The member has a diagnosis of aplastic anemia AND The member has previous treatment, contraindication or intolerance with immunosuppressive therapy including combination therapy with cyclosporine AND antithymocyte immune globulin. Reauthorization: The member has a platelet count of less than 400 x 109/L AND The member is responding to therapy as evidenced by increased platelet counts.				
PROMETHAZINE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will	Automatic approval if member is less than 65 years of age.Prior		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			continue to take place outlining the risks and potential side effects of the medication.	Auth required for age 65 or older.			
PROMETHEGAN	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
QUININE SULFATE	All FDA approved indications not otherwise excluded from Part D.	Restless leg syndrome.	Plasmodium Falciparum Malaria: Diagnosis of uncomplicated chloroquine-resistant Plasmodium falciparum malaria. Brand Qualaquin request only: Members must have had previous treatment with generic Qualaquin(Quinine)or who have had contraindications or intolerance with generic Qualaquin(Quinine).		Licensed Practitioner	Plan Year Duration	
REMICADE	All FDA approved indications not otherwise excluded from	Combination therapy with other biologicals such as Enbrel, Humira, Cimzia, Simponi,	Psoriatic arthritis: Diagnosis of active psoriatic arthritis. Member has had previous treatment, contraindication, or intolerance with an NSAIDs (examples include meloxicam, ibuprofen, naproxen) AND Member has had previous treatment, contraindication, or intolerance with ONE of the	Must be 18 years of age for Plaque Psoriasis and Rheumatoid	Licensed Practitioner	Plan Year Duration	Plaque Psoriasis: Diagnosis of moderate to severe, extensive chronic plaque psoriasis. Member has had previous treatment,

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.	Orencia, or Kineret.	following DMARDs: Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide. Ulcerative colitis: Diagnosis of moderately to severely active ulcerative colitis. Member has had previous treatment, contraindication, or intolerance with a conventional therapy including: 5-aminosalicylic acids (5-ASAs) or corticosteroids or immunomodulators (e.g. azathioprine, 6-mercaptopurine, etc.). Ankylosing Spondylitis: Diagnosis of highly persistent, active ankylosing spondylitis. Member has had previous treatment, contraindication, or intolerance with at least one non-steroidal anti-inflammatory drugs (NSAIDs) (examples include ibuprofen, meloxicam, naproxen). Crohn's Disease: Diagnosis of moderate to severely active Crohn's disease OR Crohn's disease with one or more draining fistulas.Member has had previous treatment, contraindication, or intolerance with a corticosteroid OR immunosuppressive agents (examples include 5-aminosalicylic acid (5-ASA), mesalamine, olsalazine, azathioprine, or 6-mercaptopurine).	Arthritis.			contraindication or intolerance with conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, hydroxyurea, cyclosporine, and sulfasalazine). Rheumatoid Arthritis : Diagnosis of moderately to severely active rheumatoid arthritis. Member has had previous treatment, contraindication, or intolerance with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide.). Must be on concomitant treatment with methotrexate during infliximab therapy, unless contraindicated or

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							intolerant to methotrexate.
REMODULIN	All FDA approved indications not otherwise excluded from Part D.		Pulmonary Arterial Hypertension (PAH). Higher Risk:Member has a diagnosis of pulmonary arterial hypertension (WHO Group I) AND Member has WHO/NYHA FC IV symptoms OR is classified as high risk. Determinants of high risk include: Clinical evidence of RV failure, Rapid progression of symptoms, Shorter 6MW distance (less than 300m), Peak VO2 less than 10.4 mL/kg/min for CPET, Pericardial effusion, significant RV enlargement/dysfunction, or right atrial enlargement on echocardiography, RAP greater than 20mmHg, CI less than 2.0 L/min/m2 and/or Significantly elevated BNP. Lower Risk: Member has a diagnosis of pulmonary arterial hypertension (WHO Group I) with WHO/NYHA Functional Class II or III symptoms. AND member must have had prior therapy, intolerance or contraindication to Adcirca (tadalafil) or Revatio (sildenafil) or Tracleer (bosentan) or Letairis (ambrisentan) or Opsumit (macitentan).		Licensed Practitioner	Plan Year duration	
RESERPINE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will	Automatic approval if member is less than 65 years of age.Prior		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			continue to take place outlining the risks and potential side effects of the medication.	Auth required for age 65 or older.			
REVATIO	All FDA approved indications not otherwise excluded from Part D.	Concurrent use of nitrates (e.g., nitroglycerin).Concurrent use of protease inhibitor Ritonavir.Concurrent use of another PDE5 inhibitor such as Adcirca (tadalafil).	Pulmonary Arterial Hypertension (PAH).The member must have a diagnosis of pulmonary arterial hypertension, WHO Group I.The member has had prior therapy, contraindication, or intolerance to generic Revatio (sildenafil) tablet formulation.		Licensed Practitioner	plan year duration	
REVLIMID	All medically accepted indications not otherwise excluded from Part D.	Members on concomitant Thalomid (thalidomide).Members that have experienced significant disease progression while on Revlimid (lenalidomide).	Myelodysplastic Syndromes (MDS) with 5Q deletion. Diagnosis of MDS with transfusion dependent anemia(transfusion dependent for initial approval)with a confirmed deletion 5q chromosomal abnormality. Myelodysplastic Syndromes (MDS) without 5Q deletion (non-5Q deletion). Diagnosis of MDS with transfusion dependent anemia ('transfusion dependent' for initial approval) without 5q deletion abnormality.The member has symptomatic anemia (for initial approval) with serum erythropoietin levels greater than 500 mU/mL or has failed either Procrit or Aranesp.The member has failed or has a low probability of response to immunosuppressive therapy (such as		Licensed Practitioner	6 month duration.	Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin lymphoma AND The member has relapsed or refractory disease AND At least one of the following apply:The member has experienced disease progression with two prior regimens. The member will be using as

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			ATG or cyclosporine) AND a hypomethylating agent (such as Dacogen or Vidaza) - new starts only.Multiple Myeloma. Diagnosis of Multiple Myeloma, Solitary plasmacytoma, or Smoldering Multiple Myeloma.Primary induction Revlimid (lenalidomide) therapy should be utilized in conjunction with dexamethasone if no contraindication. For Reauthorizations: The approval duration may be continued for six additional months if benefit is shown via no evidence of disease progression/treatment failure. Chronic lymphoid leukemia. Diagnosis of relapsed or refractory Chronic Lymphocytic Leukemia (CLL) and the member has failed purine-analog based therapy (fludarabine, cladribine, or pentostatin) - new starts only.For Reauthorizations: The approval duration may be continued for six additional months if benefit is shown via no evidence of disease progression/treatment failure. Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma (MCL) AND the member has relapsed disease and the following apply: The member has disease progression after two therapies. One of the therapies must have included Velcade (bortezomib).				salvage therapy prior to autologous stem cell rescue. Non-Hodgkin Lymphoma: The member has one of the following diagnoses: AIDS-related B-cell lymphoma, diffuse large B-cell lymphoma, follicular lymphoma, mucosa-associated lymphoid tissue (MALT) lymphoma [either gastric or nongastric], primary cutaneous B-cell lymphoma, or splenic marginal zone lymphoma AND The member has relapsed or refractory disease .
REXULTI	All FDA approved indications not otherwise		Major depressive disorder:The member must have clinically diagnosed major depressive disorder AND The member must have documentation of previous treatment, intolerance, or contraindication to aripiprazole AND at least one	Members must 18 years of age or older	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.		antidepressant therapy (ADT) AND Rexulti must be used as adjunctive or add-on treatment to ADT and not as monotherapy. Schizophrenia:The member must have clinically diagnosed schizophrenia AND The member must have documentation of previous treatment, intolerance, or contraindication to aripiprazole AND one of the following: risperidone or olanzapine or quetiapine or ziprasidone.				
RITUXAN	All medically accepted indications not otherwise excluded from Part D.	Rituxan (rituximab) therapy is not considered medically necessary for members with the following concomitant conditions: 'High dose' CLL therapies (doses greater than 500mg/m²).	For new starts only. for the following indications: Chronic Lymphocytic Leukemia.For CLL must be in combination with Fludara®/fludarabine +/- Cytoxan/cyclophosphamide unless contraindication or intolerance. The member has a diagnosis of CD-20 positive/B-cell Non-Hodgkin's lymphoma.(Other B-Cell lymphomas include:Precursor B-cell acute lymphoblastic leukemia, Lymphoblastic lymphoma, B-cell CLL/small lymphocytic lymphoma, B-cell prolymphocytic leukemia, Lymphoplasmacytic lymphoma/immunocytoma, Mantle cell lymphoma, Follicular lymphoma, Nodal marginal zone lymphoma, Splenic marginal zone lymphoma, Hairy cell leukemia, Plasmacytoma/plasma cell myeloma, Diffuse large B-cell lymphoma, Burkitt lymphoma, Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue (MALT) type. Primary cutaneous B-cell lymphoma, Nongastric MALT lymphoma, Gastric MALT Lymphoma.Relapsed or Progressive		Licensed Practitioner	Plan Year	The member must have a diagnosis of Waldenström's macroglobulinemia. Post-transplant lymphoproliferative disorder.The member has a diagnosis of Post-transplant Lymphoproliferative disease. Immune or Idiopathic Thrombocytopenic Purpura. The member must have a diagnosis of refractory primary immune or idiopathic thrombocytopenic purpura.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Hodgkin¿s Disease (Hodgkin's Lymphoma). The patient has failed initial induction therapy (usually ABVD) and currently has a diagnosis of relapsed or progressive Hodgkin¿s Disease. Disease has confirmed CD20 positivity. Rheumatoid Arthritis. For moderately- to severely-active rheumatoid arthritis. The member has had previous treatment with a DMARD (examples include methotrexate, sulfasalazine, cyclosporine, leflunomide.) unless contraindicated or intolerant, AND The member has had previous treatment with one or more tumor-necrosis-factor antagonist therapies including infliximab. The member must be on concomitant treatment with methotrexate during rituximab therapy, unless contraindicated or intolerant to methotrexate. Waldenström's Macroglobulinemia. See other criteria for more indications.				Member has not had a splenectomy, but has had an insufficient response or is intolerant to corticosteroids, AND immunoglobulins (IVIG), OR has had a splenectomy with an inadequate response or is intolerant to procedure AND had an insufficient response or is intolerant to post-splenectomy corticosteroids. Refractory response is characterized as EITHER:Platelet count less than 25,000/µL OR Active bleeding due to inadequate platelet function.The member must have had an inadequate response to post-splenectomy corticosteroid therapy for four consecutive weeks

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							within the last three months.Diagnosis of Wegener's Granulomatosis OR Microscopic Polyangiitis. Must be taking Rituxan (rituximab) in combination with glucocorticoids. See required for more indications.
SABRIL	All FDA approved indications not otherwise excluded from Part D.		Diagnosis of refractory complex partial seizure or infantile spasms, tried and failed therapies with antiepileptic drugs (AEDs). For New Starts Only. Sabril/vigabatrin will require prior authorization. This agent may be considered medically necessary when the following criteria are met:1. Complex Partial Seizure.Documented diagnosis of refractory complex partial seizure. Unsuccessful treatment with atleast two concomitant antiepileptic drugs (AEDs)(ex.Lamictal, depakote, topamax, dilantin, gabatril, Neurontin, Tegretol, Trileptal, Keppra) 2. Infantile Spasms.Documented diagnosis of infantile spasms.		Licensed Practitioner	Plan Year	
SANDOSTATIN	All FDA approved indications not		Acromegaly: The member must have a diagnosis of Acromegaly. Mmust have had an inadequate response to surgery/radiation or for whom surgical resection/radiation is not an option.		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.		Treatment of metastatic carcinoid tumors. Must have a diagnosis of a carcinoid tumor. Patient must have severe diarrhea and flushing resulting from carcinoid tumor. Treatment of vasoactive intestinal peptide tumors (VIPomas). Patient must be diagnosed with a vasoactive intestinal peptide tumor. Patient must have diagnosis of profuse watery diarrhea associated with VIP-secreting tumor. Treatment of chemotherapy or radiation induced diarrhea. Patient must have above grade 3 diarrhea according to NCI common toxicity. Patient must have NCI grade 1 or 2 diarrhea and have failed treatment with loperamide or diphenoxylate and atropine.. Treatment of severe secretory diarrhea in acquired immune deficiency syndrome (AIDS) patients. Patient must have diagnosis of severe diarrhea resulting from acquired immune deficiency syndrome (AIDS). Patient must have tried and failed antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine) within 30 days of the last 6 months. Reversal of life-threatening hypotension due to carcinoid crisis during induction of anesthesia. Patient must have life-threatening hypotension due to carcinoid crisis. For all Indications: The member has had previous treatment with generic octreotide S.C. (applicable to brand Sandostatin S.C. requests only).				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SANDOSTATIN LAR DEPOT	All FDA approved indications not otherwise excluded from Part D.		Acromegaly: The member must have a diagnosis of Acromegaly. Mmust have had an inadequate response to surgery/radiation or for whom surgical resection/radiation is not an option. Treatment of metastatic carcinoid tumors. Must have a diagnosis of a carcinoid tumor. Patient must have severe diarrhea and flushing resulting from carcinoid tumor. Treatment of vasoactive intestinal peptide tumors (VIPomas). Patient must be diagnosed with a vasoactive intestinal peptide tumor. Patient must have diagnosis of profuse watery diarrhea associated with VIP-secreting tumor. Treatment of chemotherapy or radiation induced diarrhea. Patient must have above grade 3 diarrhea according to NCI common toxicity. Patient must have NCI grade 1 or 2 diarrhea and have failed treatment with loperamide or diphenoxylate and atropine.. Treatment of severe secretory diarrhea in acquired immune deficiency syndrome (AIDS) patients. Patient must have diagnosis of severe diarrhea resulting from acquired immune deficiency syndrome (AIDS). Patient must have tried and failed antimicrobial agents (eg. ciprofloxacin or metronidazole) and/or anti-motility agents (eg. loperamide or diphenoxylate and atropine) within 30 days of the last 6 months. Reversal of life-threatening hypotension due to carcinoid crisis during induction of anesthesia. Patient must have life-threatening hypotension		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			due to carcinoid crisis. For all Indications: The member has had previous treatment with generic octreotide S.C. (applicable to brand Sandostatin S.C. requests only).				
SAPHRIS	All FDA approved indications not otherwise excluded from Part D.	Dementia-related psychosis or behavioral disturbances,Major depressive disorder,Pediatric/adolescent schizophrenia, Pediatric/adolescent bipolar I disorder.	Schizophrenia/Bipolar I Disorder, manic or mixed episodes.The member must be utilizing it for treatment of schizophrenia,or bipolar I disorder.For new starts only: The member must have previous treatment or intolerance or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone.Bipolar I disorder (monotherapy) Pediatrics: The member must be utilizing Saphris for the treatment of bipolar I disorder as monotherapy AND The member must be aged 10 years or older AND The member must have documentation of previous treatment, intolerance, or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone.	18 years or older for Schizophrenia. 10 years and older for Bipolar Disorder.	Licensed Practitioner	Plan Year Duration.	
SAPHRIS (BLACK CHERRY)	All FDA approved indications not otherwise excluded from Part D.	Dementia-related psychosis or behavioral disturbances,Major depressive disorder,Pediatric/adolescent schizophrenia,	Schizophrenia/Bipolar I Disorder, manic or mixed episodes.The member must be utilizing it for treatment of schizophrenia,or bipolar I disorder.For new starts only: The member must have previous treatment or intolerance or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone.Bipolar I disorder (monotherapy) Pediatrics: The member must be utilizing Saphris for the treatment of bipolar I disorder as monotherapy AND The member must be aged 10	18 years or older for Schizophrenia. 10 years and older for Bipolar Disorder.	Licensed Practitioner	Plan Year Duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Pediatric/adolescent bipolar I disorder.	years or older AND The member must have documentation of previous treatment, intolerance, or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone.				
SEROSTIM	All FDA approved indications not otherwise excluded from Part D.		Appropriate labs (IGF-1, GH). Growth hormone replacement therapy is considered medically necessary if the following criteria are met: The patient is diagnosed with wasting due to HIV or acquired immunodeficiency syndrome (AIDS). The patient has failed therapy with Marinol and/or Megace Growth hormone therapy is for a single, 12-week course of treatment. Treatment may continue on a monthly basis if there has been a positive response to therapy (2% increase in body weight and/or body cell mass) and wasting is still evident.Once body cell mass stores are normalized, the clinician stops growth hormone therapy and observes the patient for an 8-week period. During this time, the clinician needs to monitor body weight, body cell mass, and the clinical symptoms of wasting. If, after eight weeks, clinical signs of wasting reappear, re-treatment with growth hormone may be started.		Licensed Practitioner	12 weeks	
SIGNIFOR	All FDA approved indications not otherwise		Cushing's disease: Diagnosis of Cushing's disease AND Pituitary surgery is not an option or has not been curative AND No severe hepatic impairment (Child-Pugh C).		Licensed Practitioner	6 months for initial approval.	Reauthorization criteria for additional 180 days are as follows: No severe hepatic impairment (Child-Pugh C

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.						AND Urinary Free Cortisol (UFC) level has decreased from baseline at start of Signifor (pasireotide) treatment.
SILDENAFIL	All FDA approved indications not otherwise excluded from Part D.	Concurrent use of nitrates (e.g., nitroglycerin). Concurrent use of protease inhibitor Ritonavir.Concurrent use of another PDE5 inhibitor such as Adcirca (tadalafil).	Pulmonary Arterial Hypertension(PAH): The member must have a diagnosis of pulmonary arterial hypertension, WHO Group I.		Licensed Practitioner	Plan Year Duration.	
SIMPONI	All FDA approved indications not otherwise excluded from Part D.	Combinations with other immunosuppresant's Kineret, Enbrel, Orencia, Rituxan, Humira and Remicade.	Ulcerative Colitis: The member has a diagnosis of moderate to severely active ulcerative colitis. The member has had previous treatment, contraindication, or intolerance with one of the following conventional therapies: Oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine.	The member is 18 years of age.	Licensed Practitioner	Plan year duration	
SIRTURO	All FDA approved	Concomitant use with a systemic	Multidrug-resistant tuberculosis (MDR-TB). The member must have a diagnosis of pulmonary multidrug-resistant tuberculosis		Licensed Practitioner	24 weeks duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.	strong CYP3A4 inhibitor for longer than 14 days. Concomitant use with a strong CYP3A4 inducer.	(MDR-TB) confirmed by drug susceptibility testing (DST. Susceptibility to bedaquiline has been confirmed by DST. Bedaquiline will be used as part of a multidrug regimen.				
SOMATULINE DEPOT	All FDA Approved indications not otherwise excluded from part D.		Diagnosis of acromegaly, IGF-1 levels, GH levels.Lanreotide/Octreotide may be considered medically necessary when the following criteria are met for the following indication: The patient has a diagnosis of acromegaly. The patient has had an inadequate response to or cannot be treated with surgical resection OR The patient has had an inadequate response to or cannot be treated with radiation therapy.Gastroenteropancreatic Neuroendocrine Tumors (GEP-NETs): The member has a diagnosis of unresectable, well- or moderately-differentiated, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumors.		Licensed Practitioner	Plan year	
SOMAVERT	All FDA approved indications not otherwise excluded from Part D.		Pegvisomant may be considered medically necessary when the following criteria are met for their respective indication(s): Acromegaly. The member must have a diagnosis of acromegaly. The member had inadequate response to surgery or radiation therapy, AND one dopamine agonists (i.e. bromocriptine)or one somatostatin analogues (i.e. octreotide, lanreotide).		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
SOVALDI	All FDA approved indications not otherwise excluded from Part D.	Monotherapy with Sovaldi. Coadministration with a potent P-glycoprotein (P-gp) inducer (e.g. rifampin, St. John's wort.	Chronic Hepatitis C. Must have a diagnosis of chronic hepatitis C with compensated liver disease.Baseline HCV RNA must be documented. HCV genotype has been documented.Genotype 1: Sovaldi will be used in combination with peginterferon and ribavirin OR Sovaldi will be used in combination with simeprevir or in combination with ribavirin for an interferon ineligible member defined as one of the following:Known hypersensitivity or intolerance to peginterferon alfa. Autoimmune hepatitis or other autoimmune disorders.Hepatic decompensation. Pregnant females or male partners of pregnant females.History of depression or clinical features consistent with depression.A baseline neutrophil count below 1500/¿L, a baseline platelet count below 90,000/¿L or a baseline hemoglobin below 10g/dL. History of preexisting cardiac disease. Previous intolerance to a peginterferon alfa containing regimen resulting in discontinuation of therapy. Genotype 2:Sovaldi will be used in combination with ribavirin. Genotype 3: Sovaldi will be used in combination with ribavirin or in combination with peginterferon and ribavirin.Genotype 4: Sovaldi will be used in combination with peginterferon and ribavirin OR Sovaldi will be used in combination with ribavirin for an interferon ineligible member defined as one of the following: Known hypersensitivity or intolerance to peginterferon alfa.	Must be 18 years of age or older.	Licensed Practitioner	GT 1,3,4= 12-24 wks.GT 2,5,6=12 wks. Cirrhosis=48 wks.Post liver transplant= 12-48 wks	Genotype 5/6:Sovaldi will be used in combination with peginterferon and ribavirin.Chronic Hepatitis C with HIV co-infection. Must have a diagnosis of chronic hepatitis C with compensated liver disease. Member has HIV co-infection.Baseline HCV RNA must be documented.HCV genotype has been documented. Genotype 1:Sovaldi will be used in combination with peginterferon and ribavirin OR Sovaldi will be used in combination with simeprevir or in combination with ribavirin for an interferon ineligible member defined as one of the following:Known

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Autoimmune hepatitis or other autoimmune disorders.Hepatic decompensation. Pregnant females or male partners of pregnant females. History of depression or clinical features consistent with depression.A baseline neutrophil count below 1500/¿L, a baseline platelet count below 90,000/¿L or a baseline hemoglobin below 10g/dL.History of preexisting cardiac disease.Previous intolerance to a peginterferon alfa containing regimen resulting in discontinuation of therapy.				hypersensitivity to peginterferon alfa. Autoimmune hepatitis or other autoimmune disorders.Hepatic decompensation.Pregnant females or male partners of pregnant females.History of depression or clinical features consistent with depression.A baseline neutrophil count below 1500/µL, a baseline platelet count below 90,000/µL or a baseline hemoglobin below 10g/dL. History of preexisting cardiac disease. Previous intolerance to a peginterferon alfa containing regimen resulting in discontinuation of therapy.Genotype 2: Sovaldi will be used in

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							combination with ribavirin.Genotype 3: Sovaldi will be used in combination with ribavirin or in combination with peginterferon and ribavirin.Genotype 4:Sovaldi will be used in combination with peginterferon and ribavirin OR Sovaldi will be used in combination with ribavirin for an interferon ineligible member defined as one of the following:Known hypersensitivity to peginterferon alfa. Autoimmune hepatitis or other autoimmune disorders.Hepatic decompensation.Pregnant females or male partners of pregnant females.History of

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							depression or clinical features consistent with depression.A baseline neutrophil count below 1500/µL, a baseline platelet count below 90,000/µL or a baseline hemoglobin below 10g/dL. History of preexisting cardiac disease.Previous intolerance to a peginterferon alfa containing regimen resulting in discontinuation of therapy.Genotype 5/6:Sovaldi will be used in combination with peginterferon and ribavirin.Decompensated Cirrhosis: Must have a diagnosis of chronic hepatitis C with decompensated

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							cirrhosis.HCV genotype has been documented. Sovaldi will be used in combination with ribavirin.Post-Liver Transplant: Must have a received a liver transplant. Must have experienced recurrent HCV infection post-transplant in the allograft liver. Has documented genotype 1, 2 or 3 infection. Genotype 1: Sovaldi will be used in combination with simeprevir and/or ribavirin or in combination with peginterferon alfa and ribavirin for members with compensated liver disease. Sovaldi will be used in combination with ribavirin for members with decompensated liver

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							disease.Genotype 2, 3:Sovaldi will be used in combination with ribavirin.
SPRYCEL	All medically accepted indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors, Members that have experienced significant disease progression while on dasatinib.	Chronic Myelogenous Leukemia (CML): The member has CML (Philadelphia Chromosome or BCR-ABL positive) AND is being used for: Primary treatment for newly diagnosed members OR the treatment of members with chronic, accelerated, or myeloid or lymphoid blast phase CML with resistance or intolerance to prior therapy. Acute Lymphoblastic Leukemia (ALL): The member has ALL (Philadelphia Chromosome positive)and Sprycel is being used for induction or consolidation treatment in combination with chemotherapy or corticosteriods OR the treatment of members with resistance or intolerance to previous therapy, including Gleevec (imatinib). Advanced Gastrointestinal Stromal Tumor (GIST): The member has a diagnosis of advanced unresectable GIST.The member has progressive disease or is intolerant to prior therapy with Gleevec (imatinib) or Sutent (sunitinib).		Licensed Practitioner	Plan Year Duration	
STIVARGA	All FDA approved indications not otherwise excluded from	The member has experienced disease progression constituting treatment failure	Metastatic Colorectal Cancer.The member has a diagnosis of metastatic colorectal cancer AND The member is using Stivarga (regorafenib) as monotherapy AND The member has documented intolerance, contraindication or has failed previous treatment with ALL of the following therapies:		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.	while on Stivarga (regorafenib).Members on concomitant tyrosine kinase inhibitors.	fluoropyrimidine (regimens include 5-FU/capecitabine),oxaliplatin-based chemotherapy,irinotecan-based chemotherapy, and anti-VEGF therapy (bevacizumab or ziv-aflibercept) AND If the member is KRAS wild-type and has documented intolerance, contraindication or has failed previous treatment with anti-EGFR therapy (cetuximab or panitumumab).Gastrointestinal Stromal Tumor.The member has a diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor AND The member has experienced treatment failure, intolerance, or contraindication with imatinib mesylate and sunitinib malate.				
STRATTERA	All FDA approved indications not otherwise excluded from Part D.	Concomitant use of monoamine oxidase inhibitors or a CNS stimulant. Narrow Angle Glaucoma. Pheochromocytoma or history of pheochromocytoma.	Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD): Member must has had previous treatment with, contraindication, or intolerance to two of the following: a regular/immediate-acting stimulant OR a long-acting stimulant.	member must be 6 years of age or above.	Licensed Practitioner	plan year duration	
SUBOXONE	All FDA approved indications not otherwise	Diagnosis of pain may review for injectable only. Concurrent use of	Treatment of Opioid Dependence Withdrawal: (Subutex and Suboxone). Prescribing physician must have a unique identification Number and a DEA number. For induction, members should have discontinued the use of illicit opioids.		Licensed Practitioner	6 month duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.	ANY narcotic painkillers or methadone.	Exhibiting early symptoms of withdrawal. Monthly drug screenings must be performed and accompany the Prior Authorization request. Evidence of active substance abuse counseling must accompany the Prior authorization request. Buprenex/buprenorphine injectable Must have diagnosis of Moderate to Severe Pain.				
SURMONTIL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
SUTENT	All FDA approved indications not otherwise excluded from Part D.Advanced Thyroid	Members on concomitant tyrosine kinase inhibitors. Members that have experienced significant disease progression while on	Gastrointestinal stromal tumor (GIST). Diagnosis of gastrointestinal stromal tumor (GIST)AND the member has disease progression on or intolerance to Gleevec (imatinib mesylate). Advanced renal cell carcinoma(RCC).Diagnosis of advanced renal cell carcinoma (stage IV). Pancreatic neuroendocrine tumors (PNET). Diagnosis of Progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) AND The member has unresectable locally advanced or metastatic		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Carcinoma,Advanced/Metastatic Angiosarcoma.	Sutent.	disease. Advanced Thyroid Carcinoma. Diagnosis of advanced/metastatic follicular carcinoma, Hürthle cell carcinoma, papillary or medullary carcinoma (types of thyroid carcinoma) and clinical trials are not available or appropriate. Follicular, papillary, or Hürthle cell carcinoma are not responsive to radio-iodine treatment OR The member has a diagnosis of advanced medullary carcinoma—disseminated symptomatic disease (thyroid carcinoma)and failed to meet treatment goals or has an intolerance to Caprelsa (vandetanib)or Cometriq (cabozantinib). Advanced/Metastatic Angiosarcoma.Diagnosis of advanced/metastatic angiosarcoma AND Sutent (sunitinib) is being utilized as a single agent/monotherapy (without concomitant chemotherapy or biologics).				
SYLATRON	All FDA approved indications not otherwise excluded from Part D.	Members with hepatic decompensation (Child-Pugh score greater than 6 [class B and C]). Members that have experienced disease progression while on	Sylatron (peginterferon alfa-2b) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Melanoma. The member has a diagnosis of cutaneous melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy. Sylatron (peginterferon alfa-2b) is being used as adjuvant treatment.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Sylatron (peginterferon alfa-2b)					
SYLATRON 4-PACK	All FDA approved indications not otherwise excluded from Part D.	Members with hepatic decompensation (Child-Pugh score greater than 6 [class B and C]). Members that have experienced disease progression while on Sylatron (peginterferon alfa-2b)	Sylatron (peginterferon alfa-2b) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Melanoma. The member has a diagnosis of cutaneous melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy. Sylatron (peginterferon alfa-2b) is being used as adjuvant treatment.		Licensed Practitioner	Plan year duration	
SYLVANT	All FDA approved indications not otherwise excluded from Part D.		Multicentric Castleman's Disease:The member has a diagnosis of member has a diagnosis of multicentric Castleman's disease.The member is human immunodeficiency (HIV) and human herpes virus (HHV-8) negative.The member has an absolute neutrophil count greater than or equal to 1.0 x 109/L, a platelet count of greater than or equal to 75 x 109, and hemoglobin level less than 17 g/dL.Reauthorization Criteria:The approval duration may be continued for 6 additional months if		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			benefit is shown via no evidence of disease progression/treatment failure and the following laboratory parameters are met: The member has an absolute neutrophil count greater than or equal 1.0 x 109/L, a platelet count of greater than or equal 50 x 109, and hemoglobin level less than 17 g/dL.				
SYNAGIS	All FDA-approved indications not otherwise excluded from Part D.		RSV prophylaxis with palivizumab may be considered medically necessary in the following patients:Chronic Lung Disease (CLD). Infants and children younger than two years of age at the beginning of RSV season and all of the following: Diagnosed with CLD including bronchopulmonaryy dysplasia(BPD). Required medical treatment (e.g., oxygen therapy, bronchodilator, diuretic, or corticosteroid therapy) for CLD during the previous six months before the anticipated start of the RSV season. (Maximum of five monthly doses). Prematurity. Infants born less than or equal to 28.6 weeks gestation AND less than 12 months old (chronologic age) during the RSV season (Maximum of five monthly doses). Infants born between 29.0-31.6 weeks gestation AND less than 6 months old (chronologic age) at the beginning of RSV season (Maximum of five monthly doses). For infants born between 32.0-34.6 weeks gestation AND less than 3 months old (chronologic age) at the start of the RSV season or born during the RSV season AND	Less than 2 years old	Licensed Practitioner	6 months or CDC recommendations for area	Congenital Abnormalities of the Airway or Neuromuscular. Infants born before 35 weeks of gestation with either of these conditions that comprises handling of respiratory secretions (Maximum of five doses during the first year of life). Congenital Heart Disease.Children who are two years of age or younger with hemodynamically significant cyanotic and acyanotic congenital heart disease. Children younger

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			have at least one of the two risk factors is present: Child care attendance (i.e., in a group setting outside the infant's home). Infant has sibling younger than five years of age.(Maximum of three monthly doses, Receive prophylaxis only until they reach three months of age-administration of Synagis® not recommended after three months of age. Many may receive one or two doses.).				than 24 months of age with congenital heart disease who are most likely to be benefit from Synagis® include:Receiving medication to control congestive heart failure OR Have moderate to severe pulmonaryhypertension OR Have cyanotic heart disease (including Tetralogy of Fallot, transposition of the great vessels, Ebstein's anomaly, tricuspid atresia, total anomalous pulmonary venous return, truncus arteriosus, and hypoplastic left heart syndrome. Cardiac Transplant: Infants and children younger than two years of age who undergo cardiac transplantation during the

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							RSV season Cystic Fibrosis: Infants and children younger than one year of age with cystic fibrosis with clinical evidence of CLD and/or nutritional compromise OR Infants and children younger than two years of age with cystic fibrosis with manifestations of severe lung disease (e.g. previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable) OR weight for length less than the 10th percentile. Immunocompromised: Infants and children younger than two years of

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							age who will be profoundly immunocompromised during the RSV season.
SYNRIBO	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors.Members that have experienced significant disease progression while on Synribo (omacetaxine mepesuccinate).	Chronic Myelogenous Leukemia.The member has a diagnosis of Philadelphia chromosome positive chronic or accelerated phase chronic myeloid leukemia AND The member has had prior therapy, intolerance, or resistance to at least two of the following tyrosine kinase inhibitors: Bosulif, Gleevec, Sprycel, or Tasigna.		Licensed Practitioner	6 month duration	
TAFINLAR	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant Yervoy (ipilimumab), Zelboraf (vemurafenib). Members that have experienced significant disease progression while on	Melanoma: The member has a diagnosis of stage IIIC unresectable or stage IV metastatic melanoma AND The member has a BRAFV600E or BRAFV600K mutation as detected by an FDA-approved test AND The member will be using Tafinlar (dabrafenib) as monotherapy.		Licensed Practitioner	180 days.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Tafinlar (dabrafenib).Members that have experienced significant disease progression while on Zelboraf (vemurafenib).Members with wild-type BRAF melanoma.					
TARCEVA	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors. Concomitant Torisel (temsirolimus) or Afinitor (everolimus) is not recommended at this time due to lack of evidence supporting safe and effective use. These combinations also	Pancreatic Cancer:The member has a diagnosis of unresectable, locally advanced or metastatic pancreatic cancer. AND Tarceva is being used in combination with Gemzar(gemcitabine). New starts only. Non-small cell lung cancer. Tarceva is being utilized as monotherapy (without concomitant chemotherapy.) and one of the following applies: The member has a diagnosis of locally advanced or metastatic (stage IV) NSCLC and has received at least one prior chemotherapy regimen OR The member has a diagnosis of recurrent or metastatic (stage IV) NSCLC AND the following apply: The member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2.The member did not experience disease progression after four cycles of platinum-based first-line chemotherapy. Tarceva is being		Licensed Practitioner	6 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		demonstrate a significant 3A4 drug interaction that represents both a safety and pharmacokinetic concern.	utilized as maintenance therapy OR The member has a diagnosis of NSCLC (locally advanced or metastatic) AND the following apply: The member has known activated EGFR mutation (such as E19del in exon 19 or L858R in exon 21). Tarceva is being utilized as first-line or subsequent therapy.				
TARGRETIN	All FDA approved indications not otherwise excluded from Part D.	Women who are pregnant or lactating (FDA pregnancy category X).Members on concomitant retinoid therapy.	Cutaneous T-cell Lymphoma (CTCL). Targretin (bexarotene) capsules). The member will be using Targretin as primary treatment or adjuvant therapy OR Member has experienced disease progression, contraindication, or intolerance to at least one prior systemic therapy for cutaneous manifestations of cutaneous T-cell lymphoma. Cutaneous T-cell Lymphoma. Targretin (bexarotene) 1% topical gel/jelly). The member will be using Targretin as primary treatment or adjuvant therapy OR Member has experienced disease progression, contraindications, or intolerance to at least one prior CTCL therapy.		Licensed Practitioner	plan year duration	
TASIGNA	All FDA approved indications not otherwise excluded from	Members on concomitant tyrosine kinase inhibitors.Members that have	Chronic Myelogenous Leukemia (CML).The member has CML (Philadelphia Chromosome or BCR-ABL positive). Advanced Gastrointestinal Stromal Tumor (GIST). Diagnosis of advanced unresectable GIST.The member has progressive disease or is intolerant to prior therapy with Gleevec (imatinib) and Sutent		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.Acute Lymphoblastic Leukemia(ALL). Advanced Gastrointestinal Stromal Tumor (GIST).	experienced significant disease progression while on Tasigna (nilotinib).	(sunitinib).Acute Lymphoblastic Leukemia (ALL). The member has diagnosis of Philadelphia positive acute lymphoblastic leukemia and the member has relasped/refractory disease.				
TASMAR	All FDA approved indications not otherwise excluded from Part D.	Tolcapone therapy is not considered medically necessary for members with the following concomitant conditions: Patients with liver disease.Tasmar therapy should not be initiated if the member exhibits clinical evidence of liver disease or two SGPT/ALT or SGOT/AST values	Diagnosis of Parkinson's Disease.Tasmar(tolcapone) will require prior authorization. This agent may be considered medically necessary when the following criteria are met for the following indication: Parkinson’s disease. The patient is currently taking levodopa/carbidopa and is experiencing symptom fluctuations.The patient is not responding satisfactorily to other adjunctive therapies.The patient has not achieved adequate symptom control after adherent therapy with Comtan or Stalevo.The patient is not an appropriate candidate for other adjunctive therapies		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		greater than the upper limit of normal. Members who were previously withdrawn from tolcapone because of evidence of tolcapone-induced hepatocellular injury.					
TAZORAC	All FDA approved indications not otherwise excluded from Part D.		Acne Vulgaris: The member has a documented diagnosis of acne vulgaris, AND The member has had previous treatment with, or intolerance to generic topical tretinoin (non-micro). Plaque Psoriasis:The member has a documented diagnosis of stable plaque psoriasis, AND The member has had previous treatment with, contraindication, or intolerance to one high potency topical corticosteroid (e.g. clobetasol, betamethasone dipropionate).		Licensed Practitioner	Plan year duration	
TEMODAR	All FDA approved indications not otherwise excluded from	Temozolomide is contraindicated in member with a history of hypersensitivity to	Glioblastoma Multiforme/ Anaplastic Astrocytoma: The member is an adult with glioblastoma multiforme (GBM)or anaplastic astrocytoma and Temodar (temozolomide) is being used as the following: Newly diagnosed GBM or anaplastic astrocytoma in combination with radiotherapy OR Maintenance		Licensed Practitioner	Plan year	Neuroendocrine Tumors of the Lung: The member has stage IIIb OR stage IV low-or intermediate-grade neuroendocrine carcinoma

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.	dacarbazine.	therapy for GBM or anaplastic astrocytoma. Low Grade Gliomas: The member is an adult with low grade infiltrative supratentorial astrocytoma or oligodendroglioma AND The member has disease progression on a regimen containing carmustine, lomustine, or procarbazine AND The member must use Temodar (temozolomide) as a single agent as adjuvant or recurrent therapy. Bone Cancer: The member has Ewing's sarcoma and Temodar (temozolomide) is being used in combination with irinotecan for one of the following: Relapse therapy. Progressive disease following primary treatment. Melanoma: The member has melanoma and Temodar (temozolomide) is being used as a single agent or in combination with cisplatin and vinblastine for one of the following: Unresectable stage III in-transit metastases. Local/satellite, and/or in-transit unresectable recurrence. Incompletely resected nodal recurrence. Limited recurrence or metastatic disease. Disseminated recurrence with brain metastases in member with good performance status. Neuroendocrine Tumors of the Pancreas: The member has islet cell tumors and Temodar (temozolomide) is being used for the management of bone metastases or unresectable liver or lung metastases in members with symptoms, clinically significant tumor burden or significant progression.				and Temodar (temozolomide)is being used as a single agent or in combination with Xeloda (capecitabine). Mycosis fungoides (MF)/Sezary syndrome(SS): The member has MF/SS and Temodar (temozolomide) is being used as second-line chemotherapy for one of the following: Stage IA-IIA MF with folliculotropic or large cell transformation. Stage IIB generalized tumor disease, limited tumor disease with blood involvement, or folliculotropic or large cell transformation. Stage IV MF with bulky lymph nodes or visceral disease. Refractory or progressive stage III MF

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							or SS. Primary Central Nervous System (CNS) Lymphoma: The member has progressive primary CNS lymphoma and Temodar (temozolomide) is being used as a single agent in one of the following:In members with prior whole brain radiation therapy. In members who have received prior methotrexate-based regimen without prior radiation therapy. After prolonged response to prior regimen. In combination with radiation therapy after short or no response to prior regimen. Soft tissue sarcoma: The member has soft tissue sarcoma of the extremity/trunk OR intra-

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
							abdominal or retroperitoneal soft tissue sarcoma OR angiosarcoma and Temodar (temozolomide) is being used as a single agent. The member has solitary fibrous tumor/hemangiopericytoma and Temodar (temozolomide) is being used in combination with bevacizumab. The member has rhabdomyosarcoma. The member has a high-grade endometrial sarcoma OR uterine leiomyosarcoma and Temodar (temozolomide) is being used as a single agent.
TETRABENAZINE	All FDA approved indications not otherwise	concomitant use of an MAOI or reserpine	Tetrabenazine may be considered medically necessary when the following criteria is met: Diagnosis of chorea associated with Huntington's disease.		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D						
THALOMID	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant Revlimid (lenalidomide).Members that have experienced significant disease progression while on thalidomide.	Thalomid (thalidomide) will require prior authorization and may be considered medically necessary when the following criteria are met for the following indication(s):Erythema Nodosum Leprosum (ENL).The member is currently having acute cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) OR Thalomid (thalidomide) is prescribed for maintenance therapy for prevention and suppression of the cutaneous manifestations of (ENL) recurrence.Multiple Myeloma.The member has a diagnosis of Multiple Myeloma. Waldenstöm's Macroglobulinemia.The member has a diagnosis of Waldenstöm's macroglobulinemia or lymphoplasmacytic lymphoma AND Thalomid (thalidomide) is being used for primary therapy, progressive or relapsed disease or salvage therapy for disease that does not respond to primary therapy AND Thalomid (thalidomide) is being used as monotherapy or in combination with Rituxan (rituximab).		Licensed Practitioner	Plan Year	
THIORIDAZINE	All FDA approved indications not otherwise excluded from		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The	Automatic approval if member is less than 65 years of		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Part D.		physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	age.Prior Auth required for age 65 or older.			
TICLOPIDINE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
TOBI PODHALER	All FDA approved indications not otherwise excluded from Part D. Bronchiectasis.		Cystic Fibrosis or Bronchiectasis: The member has a diagnosis of cystic fibrosis (CF) or Bronchiectasis. The member is colonized with P.aeruginosa, E coli, Klebsiella spp, Enterobacter spp, or Serratia spp.		Licensed Practitioner	Plan Year	
TOLCAPONE	All FDA approved indications not	Tolcapone therapy is not considered medically necessary	Diagnosis of Parkinson's Disease.Tasmar(tolcapone) will require prior authorization. This agent may be considered medically necessary when the following criteria are met for the following		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.	for members with the following concomitant conditions: Patients with liver disease.Tasmar therapy should not be initiated if the member exhibits clinical evidence of liver disease or two SGPT/ALT or SGOT/AST values greater than the upper limit of normal. Members who were previously withdrawn from tolcapone because of evidence of tolcapone-induced hepatocellular injury.	indication: Parkinson's disease. The patient is currently taking levodopa/carbidopa and is experiencing symptom fluctuations.The patient is not responding satisfactorily to other adjunctive therapies.The patient has not achieved adequate symptom control after adherent therapy with Comtan or Stalevo.The patient is not an appropriate candidate for other adjunctive therapies				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TORISEL	All FDA-approved indications not otherwise excluded from Part D.	Patients that have experienced significant disease progression while on temsirolimus.	Temsirolimus will require prior authorization and may be considered medically necessary when the following criteria are met for the following indication: For new starts only The patient has a diagnosis of advanced renal cell carcinoma (stage IV).Relapsed or Refractory Mantle Cell Lymphoma.The patient has a diagnosis of relapsed or refractory Mantle Cell Lymphoma (a type of NHL).Temsirolimus is being used as a single agent/monotherapy (without concomitant chemotherapy). The patient has experienced disease progression, intolerance, or has a contraindication to at least two systemic chemotherapy regimens.Endometrial cancer: The member has a diagnosis of endometrial cancer and the member has been surgically staged and found to be stage IIIA-IVB and Torisel will be used as adjuvant therapy OR The member has a diagnosis of recurrent or metastatic endometrial cancer and the member has progressed on previous cytotoxic chemotherapy.		Licensed Practitioner	6 months	
TRACLEER	All FDA approved indications not otherwise excluded from Part D.	The member is concomitantly taking cyclosporine-A or glyburide.The member is concomitantly taking endothelin receptor	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) with WHO/NYHA Functional Class II, III or IV.		Licensed Practitioner	Plan Year Duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		antagonist (e.g., Letairis).					
TRANEXAMIC ACID	All FDA approved indications not otherwise excluded from Part D.	Members with acquired defective color vision, since this prohibits measuring one endpoint that should be followed as a measure of toxicity (changes in vision).Members with subarachnoid hemorrhage. Members with active intravascular clotting.	Hemophilia–Hemorrhage.Prophylaxis for Tooth extraction.Members with Hemophilia undergoing dental extraction.		Licensed Practitioner	30 day duration	
TRANSDERM-SCOP	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will	Automatic approval if member is less than 65 years of age.Prior		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			continue to take place outlining the risks and potential side effects of the medication.	Auth required for age 65 or older.			
TREANDA	All medically accepted indications not otherwise excluded from Part D.		Diagnosis of Chronic Lymphocytic Leukemia (CLL). Treanda (bendamustine) is being used for relapsed or refractory disease or as first line therapy for stage II-IV disease. Diagnosis of Multiple Myeloma (MM). Treanda (bendamustine) is being used for disease relapse or for progressive or refractory disease.Non-Hodgkin's Lymphoma:The member has a diagnosis of follicular lymphoma, nodal marginal zone lymphoma, gastric MALT lymphoma or nongastric MALT lymphoma and Treanda (bendamustine) is being used first-line, second-line or subsequent therapy.Diagnosis of mantle cell lymphoma and Treanda (bendamustine) is being used as one of the following:Less aggressive induction therapy, Second-line therapy for relapsed, refractory or progressive disease. Diagnosis of primary B-cell lymphoma (primary cutaneous marginal zone or follicle center B-cell lymphoma) and Treanda (bendamustine) is being used as a single agent or in combination with rituximab in one of the following:Refractory generalized cutaneous disease,Geralized extracutaneous disease as initial therapy or for relapse.The member has a diagnosis of splenic marginal zone lymphoma and Treanda		Licensed Practitioner	6 month	Hodgkin Lymphoma: Diagnosis of classical Hodgkin lymphoma and Treanda will be used one of the following: Third-line therapy for relapsed or refractory disease. As salvage therapy prior to autologous stem cell rescue.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(bendamustine) is being used as one of the following:First-line therapy for disease progression following initial treatment for splenomegaly,Second-line or subsequent therapy for progressive disease. The member has a diagnosis of diffuse large B-cell lymphoma and Treanda is being used as second-line therapy .The member has a diagnosis of AIDS-related B-cell lymphoma and Treanda is being used as second-line therapy. Waldenström's Macroglobulinemia:The member has Waldenström's macroglobulinemia or lymphoplasmacytic lymphoma and Treanda (benamustine) is being used as one of the following:Primary therapy,Progressive or relapsed disease,Salvage therapy for disease that does not respond to primary therapy.				
TRELSTAR	All FDA-approved indications not otherwise excluded from Part D.	Trelstar / triptorelin is not considered medically necessary for the following conditions: Female members who are pregnant or lacting. Concomitant use with other LHRH agonists.	Trelstar/triptorelin will require prior authorization. This agent may be considered medically necessary when the following criteria are met for the following indication: Prostate Cancer.The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. Metastatic Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) metastatic (stage IV) breast cancer. The patient must be pre or perimenopausal.		Licensed Practitioner	Plan year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
TRELSTAR DEPOT	All FDA-approved indications not otherwise excluded from Part D.	Trelstar / triptorelin is not considered medically necessary for the following conditions: Female members who are pregnant or lacting. Concomitant use with other LHRH agonists.	Trelstar/triptorelin will require prior authorization. This agent may be considered medically necessary when the following criteria are met for the following indication: Prostate Cancer.The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. Metastatic Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) metastatic (stage IV) breast cancer. The patient must be pre or perimenopausal.		Licensed Practitioner	Plan year	
TRELSTAR LA	All FDA-approved indications not otherwise excluded from Part D.	Trelstar / triptorelin is not considered medically necessary for the following conditions: Female members who are pregnant or lacting. Concomitant use with other LHRH agonists.	Trelstar/triptorelin will require prior authorization. This agent may be considered medically necessary when the following criteria are met for the following indication: Prostate Cancer.The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. Metastatic Breast Cancer.The patient has a diagnosis of hormone responsive (ER and/or PR +) metastatic (stage IV) breast cancer. The patient must be pre or perimenopausal.		Licensed Practitioner	Plan year	
TRETINOIN	All FDA-approved indications not	Renova (Tretinoin) will not be covered since the only	Diagnosis.Avita, Retin-A, Retin-A Micro, and all generic versions (Tretinoin) of this agent will require a prior authorization for use. Approval will be given to all members using this agent for a		Licensed Practitioner	Plan year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.	indicated use is cosmetic.	medically necessary, FDA approved, non-cosmetic indication.				
TRIHEXYPHENIDYL	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
TRIMETHOBENZAMIDE	All FDA approved indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Plan year duration.	
TRIMIPRAMINE	All FDA approved		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the	Automatic approval if		Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.		specific benefit established with the medication, and how that benefit outweighs the potential risk. AND The physician must document the ongoing monitoring plan for the agent. AND The physician must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.	member is less than 65 years of age.Prior Auth required for age 65 or older.			
TYKERB	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors.Members that have experienced significant disease progressionwhile on Tykerb (lapatinib).	Breast Cancer. The member has a diagnosis of HER2 positive advanced or metastatic breast cancer AND The member had prior therapy, contraindication, or intolerance with an anthracycline and a taxane OR The member has a diagnosis of HER2 positive metastatic breast cancer AND Used as first line treatment in combination with an aromatase inhibitor (Femara/letrozole, Arimidex/anastrozole or Aromasin/exemestane) for hormone receptor positive disease.		Licensed Practitioner	6 month duration	
TYSABRI	All FDA-approved indications not otherwise excluded from Part D.	Concurrent use with immunosuppressants or inhibitors of TNF-a	Natalizumab may be considered medically necessary when the following criteria are met for their respective indication(s):Multiple Sclerosis. Diagnosis of a relapsing form of multiple sclerosis such as Relapsing-Remitting MS (RRMS), Secondary-Progressive MS (SPMS), Progressive-Relapsing MS (PRMS). Monotherapy with natalizumab. At least one of the following: Have had an inadequate response to, or are unable		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			to tolerate alternate MS therapies, inadequate response defined as patient having at least one clinical relapse during the prior year OR The member has never tested positive for anti-JCV antibodies. Crohn's Disease.Diagnosis of moderately to severely active Crohn's disease. Have had an inadequate response to, or are unable to tolerate, conventional CD therapies and inhibitors of TNF-a.				
UNITUXIN	All FDA approved indications not otherwise excluded from Part D.	Members receiving Unituxin (dinutuximab)as monotherapy.Members that have experienced disease progression while on Unituxin (dinutuximab). Members who have experienced unacceptable toxicity while receiving treatment with Unituxin (dinutuximab).	High-risk neuroblastoma:The member has a diagnosis of high-risk neuroblastoma ANDUnituxin (dinutuximab) will be used in combination with isotretinoin AND Unituxin (dinutuximab) will be used in alternating cycles of Leukine (sargramostim) and Proleukin (aldesleukin) AND The member has achieved at least a partial response to the following: Induction combination chemotherapy AND Maximum feasible surgical resection The member has had the previous procedure/therapy: Myeloablative consolidation chemotherapy followed by autologous stem cell transplantation AND Radiation therapy to residual soft tissue disease.	Memebr must be 18 years of age or younger.	Licensed Practitioner	Six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
VALCHLOR	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced disease progression while on Valchlor (mechlorethamine)	Cutaneous T-Cell Lymphoma: The member has a diagnosis of Stage IA or IB fungoides-type cutaneous T-cell lymphoma AND The member has had prior therapy with skin-directed therapy.		Licensed Practitioner	Plan year duration	
VALSTAR	All FDA approved indications not otherwise excluded from Part D.	The member must not have an active urinary tract infection (UTI).	This agent may be considered medically necessary when the following criteria are met:Bladder Cancer.The member has recurrent or persistent carcinoma in situ of the urinary bladder(Cis).The member has experienced disease progression, intolerance or has a contraindication to BCG therapy.The member is not a candidate for immediate cystectomy.		Licensed Practitioner.	Plan Year Duration.	
VARIZIG	All FDA approved indications not otherwise excluded from Part D.		Varicella Zoster: The member is using Varizig (varicella zoster immune globulin)for post-exposure prophylaxis of varicella zoster. The member is at high risk for the development of varicella zoster infection. High risk individuals include: Immunocompromised children and adults. Newborns of mothers with varicella shortly before or after delivery. Premature infants. Neonates and infants less than one year of age. Adults without evidence of immunity. Pregnant women.		Licensed Practitioner	Plan Year Duration	
VECTIBIX	All FDA approved indications not	Metastatic colorectal cancer members with KRAS	Metastatic Colorectal Cancer. Diagnosis of Metastatic (stage IV) Colorectal Cancer. The member has mCRC that expresses verified wild-type (normal) KRAS. KRAS testing should be		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.	mutations should not receive Vectibix (panitumumab) due to known lack of response and possible worse outcomes in this population. Vectibix (panitumumab) and Erbitux (cetuximab) are only indicated for patients with tumors that express the wild type (normal) KRAS gene.Member has had disease progression on Vectibix (panitumumab) or Erbitux (cetuximab).Vectibix (panitumumab) may	performed for all mCRC members that are potential candidates for panitumumab or cetuximab therapy. Applies to new starts only. And one of the following applies .The member had disease progression on or following fluoropyrimidine (generally Xeloda/capecitabine/5-FU/fluorouracil), oxaliplatin, and irinotecan containing chemotherapy regimens. OR Using Vectibix (panitumumab) in combination with FOLFOX or FOLFIRI as first-line treatment OR using Vectibix (panitumumab) concurrently with irinotecan-based therapy in mCRC members that are initially refractory to irinotecan alone.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		not be used in conjunction with Erbitux(cetuximab), Tarceva (erlotinib),or Iressa (gefitinib).Vectibix (panitumumab) may not be used in conjunction with Avastin (bevacizumab) (based on the results from the PACCE trial).					
VELCADE	All FDA approved indications not otherwise excluded from Part D.	The member has experienced significant disease progression while on Velcade (bortezomib).	Non-Hodgkin's Lymphoma. The member has a diagnosis of mycosis fungoides, Sezary syndrome or peripheral T-cell lymphoma. Velcade (bortezomib) is being used as second-line therapy for relapsed, refractory or progressive disease. Mantle Cell Lymphoma (MCL):The member has a diagnosis of Mantle Cell Lymphoma(MCL).Multiple Myeloma. The member has a diagnosis of Multiple Myeloma. Waldenström's Macroglobulinemia. The member has a diagnosis of Waldenström's macroglobulinemia AND Velcade (bortezomib)		Licensed Practitioner	Plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			is being used for primary therapy, progressive or relapsed disease or salvage therapy for disease that does not respond to primary therapy AND Velcade (bortezomib) is being used as monotherapy or in combination with Rituxan (rituximab)				
VELETRI	All FDA approved indications not otherwise excluded from Part D.		Pulmonary Arterial Hypertension (PAH). Higher Risk: Member has a diagnosis of pulmonary arterial hypertension (WHO Group I) AND Member has WHO/NYHA FC IV symptoms or is classified as high risk. Determinants of high risk include: Clinical evidence of RV failure, Rapid progression of symptoms, Shorter 6MW distance (less than300m), Peak VO2 less than 10.4 mL/kg/min for CPET, Pericardial effusion, significant RV enlargement/dysfunction, or right atrial enlargement on echocardiography, RAP greater than 20mmHg, CI less than 2.0 L/min/m2 and/or Significantly elevated BNP. Lower Risk: Member diagnosis of pulmonary arterial hypertension (WHO Group I) with WHO/NYHA Functional Class II or III symptoms. AND member must have had prior therapy, intolerance or contraindication to Adcirca (tadalafil) or Revatio (sildenafil) or Tracleer (bosentan) or Letairis (ambrisentan)or Opsumit (macitentan).		Licensed Practitioner	Plan Year duration	
VFEND	All FDA approved indications not	VFEND/voriconazole therapy is not considered medically	Diagnosis of one of the following fungal infections and has tried and failed generic voriconazole. Antifungal Prophylaxis in members undergoing bone marrow transplants. Antifungal		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.	necessary for members with the following concomitant conditions: Concomitant use of voriconazole and high-dose ritonavir (400 mg every 12 hours), concomitant use with St. John's Wort, rifampin, carbamazepine, or long-acting barbiturates, sirolimus, CYP3A4 substrates such as terfenadine, astemizole, cisapride, pimozide, and quinidine,ergot alkaloids such as ergotamine and	Prophylaxis in members who are intermediate or high risk of developing cancer-related fungal infections. Prophylaxis of Aspergillus species in post-heart transplantation patients should meet one of the following: CMV disease,Isolation of Aspergillus species in respiratory tract cultures,Post-transplant hemodialysis or Reoperation, Existence of an episode of invasive aspergillosis in heart transplant program two months before or after heart transplant.Prophylaxis of both Candida and Aspergillus species in high risk post-liver transplant patients should meet one of the following criteria: Local epidemiology, Renal failure needing hemodialysis or continuous venovenous dialysis pre- or post-transplantation, Reoperation involving thoracic or abdominal cavity (exploratory laparotomy, or intrathoracic surgery), Retransplantation OR Transplantation for fulminant hepatic failure. Prophylaxis of invasive aspergillosis in post-lung transplantation,Treatment of invasive aspergillosis, Treatment of chronic cavitary or necrotizing pulmonary aspergillosis and/or Serious fungal infections cause by Scedosporium apiospermum and Fusarium spp. including Fusarium solani, in patients intolerant of other therapy OR Empiric therapy of suspected invasive Candidiasis or Aspergillosis in high risk patients with febrile neutropenia despite receiving broad-spectrum antibiotic therapy. Diagnosis				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		dihydroergotamine, rifabutin, or azole antifungals.	of one of the following fungal infections and failed to achieve clinical response or has contraindications to fluconazole or itraconazole for sensitive (non-krusei, non-glabrata) candida infections: Esophageal candidiasis, Oropharyngeal candidiasis,Candidemia in nonneutropenic patients and/or The following Candida infections: disseminated infections in skin and infections in abdomen, kidney, bladder wall, and/or wounds.				
VIIBRYD	All FDA approved indications not otherwise excluded from Part D.	Bipolar I disorder,Concurrent use with a MAOI or within 14 days of stopping or starting a MAOI.	Viibryd (vilazodone) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Major depressive disorder. The member must be utilizing it for treatment of major depressive disorder. For new starts only: The member must have a documentation of treatment failure, intolerance, or contraindication to a selective serotonin reuptake inhibitor (SSRI) AND a bupropion product (IR, SR, or XL) or mirtazapine.		Licensed Practitioner	Plan Year	
VIMPAT	All FDA approved indications not otherwise excluded from Part D.		This policy is for New Starts Only. Vimpat® (Lacosamide) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Members who have a seizure diagnosis and have utilized two preferred formulary agents (Depakote, Keppra, Lamictal, Topamax, Tegretol, Trileptal, Dilantin, Zonegran) and have had unsuccessful control of their seizures (ex. break through		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			seizures)as determined by their treating Physician.				
VORICONAZOLE	All FDA approved indications not otherwise excluded from Part D.	VFEND/voriconazole therapy is not considered medically necessary for members with the following concomitant conditions: Concomitant use of voriconazole and high-dose ritonavir (400 mg every 12 hours), concomitant use with St. John's Wort, rifampin, carbamazepine, or long-acting barbiturates, sirolimus, CYP3A4 substrates such as terfenadine, astemizole,	Diagnosis of one of the following fungal infections and has tried and failed generic voriconazole. Antifungal Prophylaxis in members undergoing bone marrow transplants. Antifungal Prophylaxis in members who are intermediate or high risk of developing cancer-related fungal infections. Prophylaxis of Aspergillus species in post-heart transplantation patients should meet one of the following: CMV disease,Isolation of Aspergillus species in respiratory tract cultures,Post-transplant hemodialysis or Reoperation, Existence of an episode of invasive aspergillosis in heart transplant program two months before or after heart transplant.Prophylaxis of both Candida and Aspergillus species in high risk post-liver transplant patients should meet one of the following criteria: Local epidemiology, Renal failure needing hemodialysis or continuous venovenous dialysis pre- or post-transplantation, Reoperation involving thoracic or abdominal cavity (exploratory laparotomy, or intrathoracic surgery), Retransplantation OR Transplantation for fulminant hepatic failure. Prophylaxis of invasive aspergillosis in post-lung transplantation,Treatment of invasive aspergillosis, Treatment of chronic cavitary or necrotizing pulmonary aspergillosis and/or Serious fungal infections cause by Scedosporium apiospermum and Fusarium spp. including		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		cisapride, pimozide, and quinidine,ergot alkaloids such as ergotamine and dihydroergotamine, rifabutin, or azole antifungals.	Fusarium solani, in patients intolerant of other therapy OR Empiric therapy of suspected invasive Candidiasis or Aspergillosis in high risk patients with febrile neutropenia despite receiving broad-spectrum antibiotic therapy. Diagnosis of one of the following fungal infections and failed to achieve clinical response or has contraindications to fluconazole or itraconazole for sensitive (non-krusei, non-glabrata) candida infections: Esophageal candidiasis, Oropharyngeal candidiasis,Candidemia in nonneutropenic patients and/or The following Candida infections: disseminated infections in skin and infections in abdomen, kidney, bladder wall, and/or wounds.				
VOTRIENT	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors. Members that have experienced disease progression while on previous pazopanib therapy.	Advanced Renal Cell Carcinoma RCC).The member has a diagnosis of advanced renal cell carcinoma (stage IV). Soft Tissue Sarcoma. The member has a diagnosis of soft tissue sarcoma AND The member has progressed after first-line chemotherapy.		Licensed Practitioner	6 months	
VPRIV	All FDA-approved		Vpriv velaglucerase alfa will require prior authorization. This agent may be considered medically necessary when the		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.		following criteria are met.Type 1 Gaucher Disease.The member must have a diagnosis of type 1 Gauchers Disease.				
XALKORI	All FDA approved indications not otherwise excluded from Part D.	Xalkori (crizotinib) therapy is not considered medically necessary for members with the following concomitant conditions:Members using Xalkori (crizotinib) for adjuvant therapy, Members taking concomitant TKIs.	Xalkori (crizotinib) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Non-small Cell Lung Cancer (NSCLC).The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC).The member has documented anaplastic lymphoma kinase (ALK)-positive NSCLC disease as detected by an FDA-approved test. The member will be using Xalkori (crizotinib) as monotherapy.		Licensed Practitioner	six month duration	
XENAZINE	All FDA approved indications not otherwise excluded from Part D	concomitant use of an MAOI or reserpine	Tetrabenazine may be considered medically necessary when the following criteria is met: Diagnosis of chorea associated with Huntington’s disease.		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
XGEVA	All FDA approved indications not otherwise excluded from Part D.	Xgeva (denosumab) therapy is not considered medically necessary for members with the following concomitant conditions: Uncorrected Pre-existing hypocalcemia. The member has multiple myeloma.	Xgeva (denosumab) will require prior authorization. This agent may be considered medically necessary when the following criteria are met:Osteolytic Bone Metastases of Solid Tumors. The member has a diagnosis of solid tumor cancer (such as breast cancer, prostate cancer, or other solid tumor). The member must have documented bone metastases.The member has experienced disease progression, intolerance or contraindication following treatment with zoledronic acid or pamidronate (pamidronate applies to breast cancer only). Giant Cell tumor of Bone: Diagnosis of giant cell tumor of bone and must have documented bone metastases.Hypercalcemia of malignancy: The member has hypercalcemia of malignancy, defined as an albumin-corrected calcium of greater than 12.5 mg/dL AND The member has experienced hypersensitivity, intolerance or failed to achieve/maintain appropriate treatment goal(s) with intravenous bisphosphonate therapy (e.g. pamidronate or zoledronic acid).		Licensed Practitioner	Plan Year	
XIFAXAN	All FDA approved indications not otherwise excluded from Part D.	Prevention of traveler’s diarrhea. Treatment of traveler’s diarrhea caused by pathogens other than E.Coli.	Travelers diarrhea. Member must have traveler's diarrhea caused by non-invasive strains of Escherichia Coli. Member must have a trial of at least one of the products listed: ciprofloxacin, levofloxacin, norfloxacin, or azithromycin OR intolerance or contraindication to all these products .Hepatic Encepalopathy. Member must have hepatic encephalpathy.		Licensed Practitioner	Plan year-Hepatic Encepalopathy,3 days of tx. for traveler's diarrhea,3	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Treatement of traveler's diarrha complicated by fever or bloody stools.	Member must have a trial of at least one of the products listed: lactulose or neomycin OR intolerance or contraindication to these products.Irritable bowel syndrome with diarrhea (IBS-D). Diagnosis of Irritable bowel syndrome with diarrhea (IBS-D)and had previous treatment,intolerance,or contrainidication to an antispasmodic agent(dicyclomine)or Alosetron.			month duration for IBS-D.	
XOLAIR	All FDA-approved indications not otherwise excluded from Part D.		Chronic Idiopathic Urticaria. Member has a diagnosis of chronic idiopathic urticaria. Member has remained symptomatic despite at least 2 weeks of H1 antihistamine therapy. Member will continue to receive H1 antihistamine therapy while on Xolair. Diagnosis of moderate or severe persistent asthma, FEV1, allergic sensitivity skin or blood test, baseline serium IgE. Omalizumab may be considered medically necessary when the following criteria are met for the following indication: Moderate or Severe persistent asthma. The patient has a diagnosis of moderate or severe persistent asthma.The patient has evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. RAST) for a specific IgE or in vitro reactivity to a perennial aeroallergen.The patient must have a baseline serum IgE between 30 IU/ml and 700 IU/ml The patient has inadequately controlled asthma despite the use of: Inhaled Corticosteroids.	The patient is 12 years of age or older.	Licensed Practitioner	Plan Year	
XTANDI	All FDA	Concomitant use	The member has metastatic (stage IV) castration-resistant		Licensed	6 month	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D.	with Zytiga(abiraterone acetate),Provenge(sipuleucel-T),Taxotere(docetaxel)or Jevtana(cabazitaxel)is not recommended at this time due to lack of evidence supporting safety and efficacy. Members that have experienced disease progression while on Xtandi (enzalutamide).	prostate cancer (CRPC) AND The member has progressive disease following treatment with with Abiraterone Acetate (rising prostate-specific antigen should not be used as the sole criteria for progression).		Practitioner	duration	
XYREM	All FDA approved indications not otherwise excluded from Part D.	Succinic semialdehyde dehydrogenase deficiency. Concomitant use with sedative	Diagnosis of Narcolepsy with cataplexy: Enrollment in the Xyrem Success Program. Diagnosis of Narcolepsy with excessive daytime sleepiness. Enrollment in the Xyrem Success Program. Previous treatment, intolerance, or contraindication to at least one CNS stimulant.		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		hypnotic drugs.					
YERVOY	All FDA approved indications not otherwise excluded from Part D.	Yervoy (ipilimumab) therapy is not considered medically necessary for members with the following concomitant conditions. Concomitant Zelboraf (vemurafenib), Tafinlar, or Mekinist therapy.	Melanoma.The member has a diagnosis of unresectable or metastatic melanoma. The member is naïve to Yervoy (ipilimumab).The member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-1.Melanoma - Reauthorization Criteria.The member had stable disease, partial response or complete response for greater than 3 months following the completion of initial induction (completion of four cycles within a 16 week period – members who were unable to tolerate or receive the complete induction regimen within 16 weeks of initiation will not receive approval). AND The member has progressive disease, necessitating reinduction therapy with Yervoy (ipilimumab). AND The member has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-1.		Licensed Practitioner	4 month durations	
ZALTRAP	All FDA approved indications not otherwise excluded from Part D.	Members receiving concomitant therapy with Avastin (bevacizumab). The member has experience disease progression while on Zaltrap (ziv-aflibercept).	Metastatic Colorectal Cancer:The member has a diagnosis of metastatic colorectal cancer AND The member is using Zaltrap (ziv-aflibercept) in combination with FOLFIRI (leucovorin, irinotecan, 5-fluorouracil) chemotherapy AND at least one of the following applies: Zaltrap is being used as second line therapy AND The member experienced disease progression or resistance with an Oxaliplatin containing regimen OR The member has unresectable metachronous metastases and has received previous adjuvant FOLFOX (fluorouracil, leucovorin,		Licensed Practitioner.	6 month Duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			and oxaliplatin) or CapeOX(capecitabine and oxaliplatin).				
ZELBORAF	All FDA approved indications not otherwise excluded from Part D.	Zelboraf (vemurafenib) therapy is not considered medically necessary for members with the following concomitant conditions:Members on concomitant Yervoy (ipilimumab)therapy. Members that have experienced significant disease progression while on Zelboraf (vemurafenib).	Zelboraf (vemurafenib) will require prior authorization. This agent may be considered medically necessary when the following criteria are met:Melanoma.The member has a diagnosis of Stage IIIC Unresectable or Stage IV Metastatic melanoma.The member has a documented BRAF V600E mutation as detected by an FDA-approved test.The member will be using Zelboraf (vemurafenib) as monotherapy.		Licensed Practitioner	180-day duration for Melanoma	
ZEMAIRA	All FDA approved indications not otherwise	IgA deficient members or presence of antibodies against	Congenital Alpha1-antitrypsin Deficiency: The member has a diagnosis of congenital alpha1-antitrypsin deficiency with clinically evident emphysema and chronic replacement therapy is needed. The member has an alpha1-antitrypsin phenotype of		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.	IgA.	PiZZ, PiZ(null), or Pi (null, null) or phenotypes associated with serum alpha 1-antitrypsin concentrations of less than 50mg/dL if/when measured by laboratories using nephelometry instead of radial immunodiffusion. Otherwise, a deficiency is shown at 80mg/dL. (These products should not be used in individuals with the PiMZ or PiMS phenotypes of alpha1-antitrypsin deficiency because these individuals appear to be at small risk of developing clinically evident emphysema.)				
ZOLADEX	All FDA-approved indications not otherwise excluded from Part D.	Zoladex (goserelin) is not considered medically necessary for members with the following concomitant conditions: Zoladex should not be continued or restarted after malignant disease progression constituting treatment failure (Exception is	Prostate Cancer. The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. Advanced Breast Cancer. The patient must be pre- or perimenopausal. The patient must have a diagnosis of hormone receptor (ER and/or PR +) positive breast cancer. Endometriosis. The patient must have a diagnosis of endometriosis. The patient has had an inadequate pain control response or intolerance to: Danazol,Combination Oral Contraceptives, Progesterone Only Products.Endometrial Thinning. The patient is scheduled for endometrial ablation.	18 years or older	Licensed Practitioner	2 months for endometrial hyperplasia	Approval Durations. Advanced Prostate Cancer or Invasive Breast Cancer is plan year duration. Endometriosis is six months. Endometrial Hyperplasia is two months

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Prostate Cancer). Concomitant use with other LHRH agents. Abnormal vaginal bleeding of unknown etiology.					
ZOLEDRONIC ACID	All FDA approved indications not otherwise excluded from Part D.Hormone-Receptor-Positive Breast Cancer.	Concurrent use of Reclast (also zoledronic acid) or other bisphosphonate.	Bone Metastasis Associated with Solid Tumors:The member has a solid tumor cancer diagnosis (such as breast cancer, prostate cancer, or other solid tumor) with documented bone metastasis. Hypercalcemia of Malignancy: The member has a cancer diagnosis with tumor related hypercalcemia (albumin-corrected calcium (cCa) of greater than or equal 12 mg/dL) using the corrected calcium formula= (((4 g/dL – patient albumin g/dL) x0.8) +observed calcium in mg/dL). Multiple Myeloma (MM) with documented bone involvement: The member has a MM diagnosis with documented bone involvement. Bone involvement may include: bone metastases, osteolytic lesions, osteopenia, etc. Hormone-Receptor-Positive Breast Cancer: The member has hormone-receptor-positive breast cancer AND The member is receiving an aromatase inhibitor as adjuvant therapy AND The member is at high risk for fracture. Brand Zometa request only: Members must have previous treatment with generic Zoledronic acid (generic		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Zometa) or who have had contraindications or intolerance with generic Zoledronic acid (generic Zometa).Prostate Cancer: The member has a diagnosis of prostate cancer AND The member is receiving androgen deprivation therapy AND The member is at high risk for fracture.				
ZOLEDRONIC ACID-MANNITOL-WATER	All FDA approved indications not otherwise excluded from Part D.	Severe renal impairment (creatinine clearance less than 35 mL/min). Evidence of acute renal failure.Patients with Hypocalcemia.	Osteoporosis in men and postmenopausal women: The member is a postmenopausal female or male with a diagnosis of osteoporosis. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance with an oral bisphosphonate. Osteoporosis Prophylaxis in postmenopausal women: The member is a postmenopausal female. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance with an oral bisphosphonate. Glucocorticoid induced Osteoporosis in men and women taking systemic glucocorticoids: Diagnosis of glucocorticoid induced osteoporosis or is either initiating or continuing systemic glucocorticoids with a daily dosage equivalent of 7.5 mg or greater of prednisone and is expected to remain on glucocorticoids for at least 12 months AND has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance with an oral bisphosphonate. Paget's Disease: Diagnosis of Paget's disease.		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			The member has continued elevation(s) in serum alkaline phosphatase (SAP) of two times or higher than the upper limit of normal despite previous treatment, contraindication, or intolerance with an oral bisphosphonate. And the member: Is symptomatic OR is at risk for complications from their disease, to induce remission, or to normalize serum alkaline phosphatase. Brand Reclast request only: Members must have previous treatment with generic Zoledronic acid (generic Reclast) or who have had contraindications or intolerance with generic Zoledronic acid (generic Reclast).				
ZOLEDRONIC ACID-MANNITOL-WATER	All FDA approved indications not otherwise excluded from Part D.Hormone-Receptor-Positive Breast Cancer.	Concurrent use of Reclast (also zoledronic acid) or other bisphosphonate.	Bone Metastasis Associated with Solid Tumors:The member has a solid tumor cancer diagnosis (such as breast cancer, prostate cancer, or other solid tumor) with documented bone metastasis. Hypercalcemia of Malignancy: The member has a cancer diagnosis with tumor related hypercalcemia (albumin-corrected calcium (cCa) of greater than or equal 12 mg/dL) using the corrected calcium formula= (((4 g/dL – patient albumin g/dL) x0.8) +observed calcium in mg/dL). Multiple Myeloma (MM) with documented bone involvement: The member has a MM diagnosis with documented bone involvement. Bone involvement may include: bone metastases, osteolytic lesions, osteopenia, etc. Hormone-Receptor-Positive Breast Cancer: The member has hormone-receptor-positive		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
			breast cancer AND The member is receiving an aromatase inhibitor as adjuvant therapy AND The member is at high risk for fracture. Brand Zometa request only: Members must have previous treatment with generic Zoledronic acid (generic Zometa) or who have had contraindications or intolerance with generic Zoledronic acid (generic Zometa).Prostate Cancer: The member has a diagnosis of prostate cancer AND The member is receiving androgen deprivation therapy AND The member is at high risk for fracture.				
ZOLINZA	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced significant disease progression constituting treatment failure while on Zolinza (vorinostat).	Cutaneous T-Cell Lymphoma (CTCL).The member has a diagnosis of progressive, persistent, or recurrent disease. The member has not achieved treatment goals, has a contraindication, or intolerance to two of the following: oral retinoids such as Targretin(bexarotene), interferon, or other systemic chemotherapy (not topicals).		Licensed Practitioner	Plan year duration	
ZONTIVITY	All FDA approved indications not otherwise excluded from Part D.	History or occurrence of stroke or transient ischemic attack (TIA). History of intracranial hemorrhage(ICH).	Prophylaxis of MI, stroke, or thrombosis for the reduction of thrombotic cardiovascular events. Zontivity will be used prophylactically AND The member must have a history of myocardial infarction or a diagnosis of peripheral arterial disease AND The member is using Zontivity (vorapaxar) with either aspirin and/or clopidogrel according to their indications		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
		Active pathological bleeding including gastrointestinal bleeding(e.g. peptic ulcer),intracranial hemorrhage.	or standard of care.				
ZOVIRAX	All FDA approved indications not otherwise excluded from Part D.		Diagnosis of genital herpes and previous treatment, contraindication, or intolerance to oral acyclovir and one of the following: valacyclovir or famciclovir. OR member has diagnosis of non-life-threatening mucocutaneous HSV infection and is immunocompromised AND member has had previous treatment with generic acyclovir ointment (applies to brand requests only)		Licensed Practitioner	Plan year duration	
ZOVIRAX	All FDA approved indications not otherwise excluded from Part D.		Diagnosis of recurrent herpes labialis and previous treatment, contraindication, or intolerance to at least two of the following: valacyclovir, famciclovir, or oral acyclovir.	12 years or older	Licensed Practitioner	Plan year duration	
ZYDELIG	All FDA approved indications not otherwise	Members that have experienced significant disease progression while on	Chronic Lymphocytic Leukemia (CLL): The member must have a diagnosis of relapsed or refractory chronic lymphocytic leukemia (CLL). Follicular Lymphoma (FL): The member must have a diagnosis of relapsed follicular lymphoma (FL) AND The		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.	Zydelig (idelalisib).	member must have received at least one prior systemic therapy AND The member will be using Zydelig (idelalisib) as monotherapy. Small Lymphocytic Lymphoma (SLL): The member must have a diagnosis of relapsed small lymphocytic lymphoma (SLL) AND The member must have received at least one prior systemic therapy AND the member will be using Zydelig (idelalisib) as monotherapy.				
ZYKADIA	All FDA approved indications not otherwise excluded from Part D.		Non-small Cell Lung Cancer (NSCLC): The member has a diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND The member has documented anaplastic lymphoma kinase (ALK)-positive NSCLC disease as detected by an FDA-approved test AND The member has progressive disease or intolerance following treatment with Xalkori (crizotinib) AND The member will be using Zykadia (ceritinib) as monotherapy.		Licensed Practitioner	six month duration	
ZYPREXA RELPREVV	All FDA approved indications not otherwise excluded from Part D.		This agent may be considered medically necessary when the following criteria are met:Schizophrenia.Established therapy with oral Zyprexa (olanzapine).	18 years of age.	Licensed Practitioner.	Plan Year.	
ZYTIGA	All FDA approved	Zytiga (abiraterone acetate) therapy is	Zytiga (abiraterone acetate) will require prior authorization. This agent may be considered medically necessary when the		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.	not considered medically necessary for members with the following concomitant conditions: Members with severe hepatic impairment (Child-Pugh Class C). Members that have experienced disease progression while on Zytiga (abiraterone acetate).	following criteria are met: Prostate Cancer. The member has metastatic (stage IV) castration-resistant prostate cancer (CRPC). The member will be using Zytiga (abiraterone acetate) in combination with prednisone.				

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
ACETYLCYSTEINE 10% VIAL	Clolar 20 mg/20 mL intravenous solution	EPIRUBICIN 200 MG/100 ML VIAL	Lipodox 50 2 mg/mL intravenous solution	Recombivax HB (PF) 5 mcg/0.5 mL intramuscular suspension
ACETYLCYSTEINE 20% VIAL	Compazine 10 mg tablet	EPIRUBICIN 50 MG/25 ML VIAL	Liposyn II 20 % intravenous emulsion	Recombivax HB (PF) 5 mcg/0.5 mL intramuscular syringe
ADRIAMYCIN 10 MG VIAL	Compazine 5 mg tablet	EPIRUBICIN HCL 200 MG VIAL	Liposyn III 10 % intravenous emulsion	Sandimmune 100 mg capsule
ADRIAMYCIN 2 MG/ML VIAL	Cosmegen 0.5 mg intravenous solution	EPIRUBICIN HCL 50 MG VIAL	Liposyn III 20 % intravenous emulsion	Sandimmune 100 mg/mL oral solution
ADRIAMYCIN 20 MG VIAL	CROMOLYN 20 MG/2 ML NEB SOLN	Etopophos 100 mg intravenous solution	Marinol 2.5 mg capsule	Sandimmune 25 mg capsule
ADRIAMYCIN 200 MG/100 ML VIAL	CYCLOPHOSPHAMIDE 1 GM VIAL	Faslodex 250 mg/5 mL intramuscular syringe	Marinol 5 mg capsule	Sandimmune 250 mg/5 mL intravenous solution
ADRIAMYCIN 50 MG VIAL	CYCLOPHOSPHAMIDE 2 GM VIAL	FLOXURIDINE 500 MG VIAL	Medrol (Pak) 4 mg tablets in a dose pack	Simulect 10 mg intravenous solution
ALBUTEROL 0.083% INHAL SOLN	CYCLOPHOSPHAMIDE 25 MG TAB	FLUDARABINE 50 MG VIAL	MELPHALAN HCL 50 MG VIAL	Simulect 20 mg intravenous solution
ALBUTEROL 2.5 MG/0.5 ML SOL	CYCLOPHOSPHAMIDE 50 MG TABLET	FLUDARABINE 50 MG/2 ML VIAL	MESNA 100 MG/ML VIAL	SIROLIMUS 0.5 MG TABLET SIROLIMUS 1 MG TABLET SIROLIMUS 2 MG TABLET
ALBUTEROL 5 MG/ML SOLUTION	CYCLOPHOSPHAMIDE 500 MG VIAL	FLUOROURACIL 1,000 MG/20 ML VL	Mesnex 100 mg/mL intravenous solution	SODIUM CHLORIDE 0.9% INHAL VL
ALBUTEROL SUL 0.63 MG/3 ML SOL	CYCLOSPORINE 100 MG CAPSULE	FLUOROURACIL 2,500 MG/50 ML VL	METHYLPREDNISOLONE 16 MG TAB	SODIUM CHLORIDE 10% VIAL

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
ALBUTEROL SUL 1.25 MG/3 ML SOL	CYCLOSPORINE 100 MG/ML SOLN	FLUOROURACIL 5,000 MG/100 ML	METHYLPREDNISOLONE 32 MG TAB	SODIUM CHLORIDE 3% VIAL
Alkeran 2 mg tablet	CYCLOSPORINE 25 MG CAPSULE	FLUOROURACIL 500 MG/10 ML VIAL	METHYLPREDNISOLONE 4 MG DOSEPK	TACROLIMUS 0.5 MG CAPSULE
Alkeran 50 mg intravenous solution	CYCLOSPORINE 50 MG/ML AMPUL	FOSCARNET 24 MG/ML INFUS BTTL	METHYLPREDNISOLONE 4 MG TABLET	TACROLIMUS 1 MG CAPSULE
AMIFOSTINE 500 MG VIAL	CYCLOSPORINE MODIFIED 100 MG	Freamine HBC 6.9 % intravenous solution	METHYLPREDNISOLONE 8 MG TAB	TACROLIMUS 5 MG CAPSULE
amino acids 15 % intravenous solution	CYCLOSPORINE MODIFIED 25 MG	Freamine III 10 % intravenous solution	MITOMYCIN 20 MG VIAL	Taxotere 20 mg/mL (1 mL) intravenous solution
Aminosyn 10 % intravenous solution	CYCLOSPORINE MODIFIED 50 MG	GEMCITABINE 1 GRAM/26.3 ML VL	MITOMYCIN 40 MG VIAL	Taxotere 80 mg/4 mL (20 mg/mL) intravenous solution
Aminosyn 7 % with electrolytes intravenous solution	CYTARABINE 1 GM VIAL	GEMCITABINE 2 GRAM/52.6 ML VL	MITOMYCIN 5 MG VIAL	TENIPOSIDE 50 MG/5 ML AMPULE
Aminosyn 8.5 % intravenous solution	CYTARABINE 100 MG VIAL	GEMCITABINE 200 MG/5.26 ML VL	Mustargen 10 mg solution for injection	TETANUS TOXOID ADSORBED VIAL
Aminosyn 8.5 % with electrolytes intravenous solution	CYTARABINE 100 MG/5 ML VIAL	GEMCITABINE HCL 1 GRAM VIAL	MYCOPHENOLATE 250 MG CAPSULE	Theracys 81 mg intravesical suspension
Aminosyn II 10 % intravenous solution	CYTARABINE 2 G/20 ML VIAL	GEMCITABINE HCL 2 GRAM VIAL	MYCOPHENOLATE 500 MG TABLET	THIOTEPA 15 MG VIAL
Aminosyn II 15 % intravenous solution	CYTARABINE 20 MG/ML VIAL	GEMCITABINE HCL 200 MG VIAL	MYCOPHENOLIC ACID DR 180 MG TB	Thymoglobulin 25 mg intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Aminosyn II 8.5 % with electrolytes intravenous solution	CYTARABINE 500 MG VIAL	Gengraf 100 mg capsule	MYCOPHENOLIC ACID DR 360 MG TB	TOPOTECAN HCL 4 MG VIAL
Aminosyn M 3.5 % intravenous solution	CYTARABINE 500 MG/25 ML VIAL	Gengraf 100 mg/mL oral solution	Nebupent 300 mg solution for inhalation	TOPOTECAN HCL 4 MG/4 ML VIAL
Aminosyn-HBC 7% intravenous solution	DACARBAZINE 100 MG VIAL	Gengraf 25 mg capsule	Neoral 100 mg capsule	Travasol 10 % intravenous solution
Aminosyn-PF 10 % intravenous solution	DACARBAZINE 200 MG VIAL	GRANISETRON HCL 1 MG TABLET	Neoral 100 mg/mL oral solution	Trisenox 10 mg/10 mL intravenous solution
Aminosyn-PF 7 % (sulfite-free) intravenous solution	DAUNORUBICIN 20 MG/4 ML VIAL	Granisol 1 mg/5 mL oral solution	Neoral 25 mg capsule	TrophAmine 10 % intravenous solution
Azasan 100 mg tablet	DaunoXome 2 mg/mL intravenous solution	Hecoria 0.5 mg capsule	Nephramine 5.4 % intravenous solution	Trophamine 6% intravenous solution
Azasan 75 mg tablet	DepoCyt (PF) 50 mg/5 mL (10 mg/mL) intrathecal suspension	Hecoria 1 mg capsule	Nipent 10 mg intravenous solution	Uvadex 20 mcg/mL injection solution
AZATHIOPRINE 50 MG TABLET	DEXRAZOXANE 250 MG VIAL	Hecoria 5 mg capsule	Oncaspar 750 unit/mL injection solution	VINBLASTINE 1 MG/ML VIAL
BiCNU 100 mg intravenous solution	DEXRAZOXANE 500 MG VIAL	Hepatamine 8% intravenous solution	ONDANSETRON 4 MG/5 ML SOLUTION	VINBLASTINE SULF 10 MG VIAL
BLEOMYCIN SULFATE 15 UNIT VIAL	Docefrez 20 mg intravenous solution	Hepatasol 8 % intravenous solution	ONDANSETRON HCL 24 MG TABLET	Vincasar PFS 1 mg/mL intravenous solution
BLEOMYCIN SULFATE 30 UNIT VIAL	Docefrez 80 mg intravenous solution	Hycamtin 4 mg intravenous solution	ONDANSETRON HCL 4 MG TABLET	Vincasar PFS 2 mg/2 mL intravenous solution

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
BUDESONIDE 0.25 MG/2 ML SUSP	DOCETAXEL 140 MG/7 ML VIAL	Idamycin PFS 1 mg/mL intravenous solution	ONDANSETRON HCL 8 MG TABLET	VINCRISTINE 1 MG/ML VIAL
BUDESONIDE 0.5 MG/2 ML SUSP	DOCETAXEL 160 MG/16 ML VIAL	IDARUBICIN PFS 10 MG/10 ML VL	ONDANSETRON ODT 4 MG TABLET	VINCRISTINE 2 MG/2 ML VIAL
Busulfex 60 mg/10 mL intravenous solution	DOCETAXEL 160 MG/8 ML VIAL	IFOSFAMIDE 1 GM VIAL	ONDANSETRON ODT 8 MG TABLET	VINORELBINE 10 MG/ML VIAL
Camptosar 100 mg/5 mL intravenous solution	DOCETAXEL 20 MG/0.5 ML VIAL	IFOSFAMIDE 1 GM/20 ML VIAL	PACLITAXEL 150 MG/25 ML VIAL	Virazole 6 gram solution for inhalation
Camptosar 300 mg/15 mL intravenous solution	DOCETAXEL 20 MG/2 ML VIAL	IFOSFAMIDE 3 GM VIAL	PENTOSTATIN 10 MG VIAL	VUMON 50 MG/5 ML AMPULE
Camptosar 40 mg/2 mL intravenous solution	DOCETAXEL 20 MG/ML VIAL	IFOSFAMIDE 3 GM/ 60 ML VIAL	Perikabiven 2.36 %-6.8 %-3.5 % intravenous emulsion	WinRho SDF 1,500 unit/1.3 mL injection solution
CellCept 200 mg/mL oral suspension	DOCETAXEL 80 MG/2 ML VIAL	IFOSFAMIDE-MESNA KIT	Photofrin 75 mg intravenous solution	WinRho SDF 15,000 unit/13 mL injection solution
CellCept 250 mg capsule	DOCETAXEL 80 MG/4 ML VIAL	Imovax Rabies Vaccine (PF) 2.5 unit intramuscular solution	PREDNISONE 1 MG TABLET	WinRho SDF 2,500 unit/2.2 mL injection solution
CellCept 500 mg tablet	DOCETAXEL 80 MG/8 ML VIAL	Imuran 50 mg tablet	PREDNISONE 10 MG TABLET	WinRho SDF 5,000 unit/4.4 mL injection solution
CellCept Intravenous 500 mg intravenous solution	DOXORUBICIN 10 MG VIAL	Intralipid 20 % intravenous emulsion	PREDNISONE 2.5 MG TABLET	Xopenex 0.31 mg/3 mL solution for nebulization
CHLORPROMAZINE 10 MG TABLET	DOXORUBICIN 10 MG/5 ML VIAL	Intralipid 30 % intravenous emulsion	PREDNISONE 20 MG TABLET	Xopenex 0.63 mg/3 mL solution for nebulization

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
CHLORPROMAZINE 25 MG TABLET	DOXORUBICIN 150 MG/75 ML VIAL	IPRAT-ALBUT 0.5-3(2.5) MG/3 ML	PREDNISONE 5 MG TABLET	Xopenex 1.25 mg/3 mL solution for nebulization
CISPLATIN 100 MG/100 ML VIAL	DOXORUBICIN 20 MG/10 ML VIAL	IPRATROPIUM BR 0.02% SOLN	PREDNISONE 5 MG/5 ML SOLUTION	Xopenex Concentrate 1.25 mg/0.5 mL solution for nebulization
Clinimix 2.75 % in 5 % dextrose Sulfite Free intravenous solution	DOXORUBICIN 50 MG VIAL	IRINOTECAN HCL 100 MG/5 ML VL	PREDNISONE 50 MG TABLET	Zanosar 1 gram intravenous solution
Clinimix 4.25 % in 10 % dextrose Sulfite Free intravenous solution	DOXORUBICIN 50 MG/25 ML VIAL	IRINOTECAN HCL 40 MG/2 ML VIAL	Prednisone Intensol 5 mg/mL oral concentrate	Zinecard 250 mg intravenous solution
Clinimix 4.25 % in 20 % dextrose (sulfite-free) intravenous solution	DOXORUBICIN LIPOSOME 20MG/10ML	IRINOTECAN HCL 500 MG/25 ML VL	Premasol 10 % intravenous solution	Zinecard 500 mg intravenous solution
Clinimix 4.25 % in 25 % dextrose (sulfite-free) intravenous solution	DRONABINOL 10 MG CAPSULE	Kabiven 3.31 %-9.8 %-3.9 % intravenous emulsion	Premasol 6 % intravenous solution	Zortress 0.25 mg tablet
Clinimix 4.25 % in 5 % dextrose Sulfite Free intravenous solution	DRONABINOL 2.5 MG CAPSULE	LEUCOVORIN CAL 500 MG/50 ML VL	Procalamine 3% intravenous solution	Zortress 0.5 mg tablet
Clinimix 5 % in 15 % dextrose Sulfite Free intravenous solution	DRONABINOL 5 MG CAPSULE	LEUCOVORIN CALCIUM 100 MG VIAL	PROCHLORPERAZINE 10 MG TAB	Zortress 0.75 mg tablet
Clinimix 5 % in 20 % dextrose (sulfite-free) intravenous solution	DUONEB 0.5 MG-3 MG/3 ML SOLN	LEUCOVORIN CALCIUM 200 MG VIAL	PROCHLORPERAZINE 5 MG TABLET	
Clinimix 5 % in 25 % dextrose sulfite-free intravenous solution	Ellence 200 mg/100 mL intravenous solution	LEUCOVORIN CALCIUM 350 MG VIAL	Prograf 0.5 mg capsule	
Clinimix E 2.75 % in 10 % dextrose Sulfite Free intravenous solution	Ellence 50 mg/25 mL intravenous solution	LEUCOVORIN CALCIUM 50 MG VIAL	Prograf 1 mg capsule	

The following drugs are subject to a Medicare Part B or D authorization depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.				
Clinimix E 2.75 % in 5 % dextrose Sulfite Free intravenous solution	Emend 125 mg (1)-80 mg (2) capsules in a dose pack	LEUCOVORIN CALCIUM 500 MG VL	Prograf 5 mg capsule	
Clinimix E 4.25 % in 10 % dextrose Sulfite Free intravenous solution	Emend 125 mg capsule	LEVALBUTEROL 0.31 MG/3 ML SOL	Prograf 5 mg/mL intravenous solution	
Clinimix E 4.25 % in 25 % dextrose Sulfite Free intravenous solution	Emend 40 mg capsule	LEVALBUTEROL 0.63 MG/3 ML SOL	Prosol 20 % intravenous solution	
Clinimix E 4.25 % in 5 % dextrose Sulfite Free intravenous solution	Emend 80 mg capsule	LEVALBUTEROL 1.25 MG/3 ML SOL	Pulmozyme 1 mg/mL solution for inhalation	
Clinimix E 5 % in 15 % dextrose Sulfite Free intravenous solution	Engerix-B (PF) 20 mcg/mL intramuscular suspension	Lioresal 2,000 mcg/mL intrathecal solution	RabAvert (PF) 2.5 unit intramuscular suspension	
Clinimix E 5 % in 20 % dextrose Sulfite Free intravenous solution	Engerix-B (PF) 20 mcg/mL intramuscular syringe	Lioresal 50 mcg/mL intrathecal solution	Recombivax HB (PF) 10 mcg/mL intramuscular suspension	
Clinimix E 5 % in 25 % dextrose Sulfite Free intravenous solution	Engerix-B Pediatric (PF) 10 mcg/0.5 mL intramuscular suspension	Lioresal 500 mcg/mL intrathecal solution	Recombivax HB (PF) 10 mcg/mL intramuscular syringe	
Clinisol SF 15 % intravenous solution	Engerix-B Pediatric (PF) 10 mcg/0.5 mL intramuscular syringe	Lipodox 2 mg/mL intravenous solution	Recombivax HB (PF) 40 mcg/mL intramuscular suspension	