You can contact CarePlus for the most recent list of drugs by calling 1-800-794-5907; from 8 a.m. to 8 p.m., 7 days a week. From February 15th to September 30th, we are open Monday – Friday from 8 a.m. to 8 p.m. TTY users should call 711; or visit www.careplushealthplans.com.

This document applies to the following CarePlus Plans:

Plan	Market	Formulary ID	Version
H1019001	South Florida	17228	17
H1019006	South Florida	17228	17
H1019023	South Florida	17226	17
H1019024	South Florida	17226	17
H1019026	Tampa	17226	17
H1019028	Orlando	17226	17
H1019054	Tampa	17228	17
H1019057	Orlando	17228	17
H1019060	Tampa	17226	17
H1019076	South Florida	17226	17
H1019077	Orlando	17226	17
H1019079	Tampa	17226	17
H1019081	South Florida	17226	17

Plan	Market	Formulary ID	Version
H1019083	South Florida	17226	17

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ABRAXANE	All medically accepted 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, recurrent 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. AND The member will be using Abraxane (nab, paclitaxel) as monotherapy or in combination with carboplatin AND One of the following apply:The member will be using for first line therapy OR The member		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			will be using as subsequent therapy for EGFR mutation-positive tumors after prior therapy with erlotinib, afatinib, or gefitinib OR The member will be using as subsequent therapy for ALK-positive tumors after prior therapy with crizotinib or ceritinib or alectinib or brigatinib OR The member will be using as subsequent therapy for ROS-1 positive disease after prior therapy with crizotinib OR the member will be using as subsequent therapy after pembrolizumab (with PDL1 expression greater than 50%) and EGFR, ALK, and ROS-1 negative disease.				
ACIPHEX	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ACTHAR H.P.	All FDA approved indications not otherwise excluded from Part D.		Diagnostic testing of adrenocortical function: Contraindication or intolerance to cosyntropin. West syndrome (infantile spasms). Acute exacerbations of multiple sclerosis (MS): Member must be experiencing an acute exacerbation of multiple sclerosis. Member has contraindications or intolerance to corticosteroids that are not expected to also occur with repository corticotropin injection. Acute Exacerbations of MS Reauthorization Criteria: Member continues to meet all criteria required for initial authorization. There is documented evidence of disease response to treatment as indicated by improvement in symptoms. Other Steroid-Responsive Conditions:Member has contraindications or intolerance to corticosteroids that are not expected to also occur with repository corticotropin injection.		Licensed Practitioner	MS Initial Auth 6 months, MS Reauth 6 months, All Other Indications 6 months.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 OR member has diagnosis of non-life-threatening mucocutaneous HSV infection and is immunocompromised. The member has had previous treatment, contraindication, or intolerance to oral acyclovir and one of the following: valacyclovir or famciclovir.		Licensed Practitioner	Plan year duration	
ADCIRCA	All FDA approved indications not otherwise excluded from Part D.	Concurrent use of nitrates (e.g., nitroglycerin).Concurrent use of another PDE5 inhibitor, sildenafil (Revatio).	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 or contraindication to sildenafil (generic Revatio) for the treatment of PAH (WHO Group I).		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ADEMPAS	All FDA-approved indications not otherwise excluded from Part D.	Use with nitrates or nitric oxide donors in any form. Use with specific PDE5 inhibitors such as sildenafil, tadalafil, vardenafil and non-specific PDE inhibitors such as dipyridamole or theophylline.	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).		Licensed Practitioner	Plan Year Duration	
AFINITOR	All medically accepted indications not otherwise excluded from Part D.	Members that have experienced disease progression while on everolimus.	Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced /metastatic renal cell carcinoma (stage IV)AND the member experienced disease progression following therapy with Inlyta (axitinib). 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		Licensed Practitioner	6 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			resection.Neuroendocrine Tumors: The member has disease that is unresectable, locally advanced or metastatic and one of the following applies: The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) OR The member has a diagnosis of progressive, well differentiated, non-functional neuroendocrine tumors of gastrointestestinal or lung. Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma. The member has a diagnosis of recurrent or not responsive to primary treatment or relapsed Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma AND Afinitor (everolimus) will be used as monotherapy.				
AFINITOR DISPERZ	All medically accepted indications not otherwise excluded from Part D.	Members that have experienced disease progression while on everolimus.	Advanced Renal Cell Carcinoma (RCC). The member has a diagnosis of advanced /metastatic renal cell carcinoma (stage IV)AND the member experienced disease progression following therapy with Inlyta (axitinib). The member has a diagnosis of Subependymal Giant Cell Astrocytoma		Licensed Practitioner	6 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(SEGA) associated with tuberous sclerosis AND The member requires therapeutic intervention but is not a candidate for curative surgical resection.Neuroendocrine Tumors: The member has disease that is unresectable, locally advanced or metastatic and one of the following applies: The member has a diagnosis of progressive neuroendocrine tumors of pancreatic origin (PNET) OR The member has a diagnosis of progressive, well differentiated, non-functional neuroendocrine tumors of gastrointestestinal or lung. Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma. The member has a diagnosis of recurrent or not responsive to primary treatment or relapsed Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma AND Afinitor (everolimus) will be used as monotherapy.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ALECENSA	All FDA approved indications not otherwise excluded from Part D.	The member has experienced disease progression while on Alecensa (alectinib).	Non-small Cell Lung Cancer:The member has recurrent or metastatic non-small cell lung cancer AND The member has anaplastic lymphoma kinase (ALK)-positive disease ANDThe member has progressive disease or intolerance following treatment with Xalkori (crizotinib) AND The member will be using Alecensa (alectinib) as monotherapy.		Licensed Practitioner	Six month duration	
ALIMTA	All FDA approved indications not otherwise excluded from Part D. Bladder cancer, cervical cancer, ovarian cancer, and thymic cancer.	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 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 as second-line as a single		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			agent if not administered first-line. OR Alimta is being used in combination with bevacizumab and cisplatin for treatment of one of the following: unresectable clinical stage I-III with epithelial or mixed histology or clinical stage IV disease with sarcomatoid histology. 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 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 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 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 chemotherapy				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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 or in combination with cisplatin used as neoadjuvant or adjuvant chemotherapy. Concurrent chemoradiation in combination with carboplatin or cisplatin.				
ALIQOPA	All FDA-approved indications not otherwise excluded from Part D				Licensed Practitioner	Plan year duration	
ALUNBRIG	All FDA-approved indications not otherwise	Members on concomitant ALK inhibitors (e.g., Zykadia [certinib], Alecensa	Non-Small cell lung cancer: The member has a diagnosis of advanced or metastatic NSCLC with documented anaplastic lymphoma kinase (ALK) positivity AND Disease progression or intolerance to first		Licensed Practitioner	Six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D	[alectinib]). Members experience disease progression on Alunbrig (brigatinib).	line ALK inhibitors (e.g., crizotinib) AND Alunbrig will be given as monotherapy as subsequent therapy AND The member has intolerance to Zykadia (certinib) which may include the following: Severe or intolerable nausea, vomiting or diarrhea despite optimal antiemetic or antidiarrheal therapy or ALT or AST elevation greater than 3 times upper limit of normal (ULN) with total bilirubin elevation greater than 2 times ULN in the absence of cholestasis or hemolysis or Life-threatening bradycardia AND The member has intolerance to Alecensa (alectinib) which may include the following: Any grade treatment related interstitial lung disease/pneumonitis or Life-threatening bradycardia or ALT or AST elevation greater than 3 times ULN with total bilirubin elevation greater than 2 times ULN in the absence of cholestasis or hemolysis or CPK elevation greater than 10 times ULN or second occurrence of CPK elevation of greater than 5 times ULN				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
AMBIEN CR	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	
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 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.		Licensed Practitioner	6 month duration and then reauthorization at six months for plan year duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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.Monotherapy for the treatment of adults with partial-onset seizures.Diagnosis of partial-onset seizures. Previous treatment with, contraindication or intolerance to at least two other drugs for controlling partial-onset seizures. Unsuccessful conrtol of seizures as determined by treating neurologist.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ARCALYST	All FDA approved indications not otherwise excluded from Part D.		Rilonacept may be considered medically necessary when the following criteria are met- Diagnosis of Familial Cold Autoinflammatory Syndrome or Muckle-Wells Syndrome.		Licensed Practitioner	Plan year	
ARMODAFINIL	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	
ARTHROTEC 50	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ARTHROTEC 75	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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).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. CLL: Chronic Lymphocytic Leukemia, Extended Treatment:The member has a diagnosis of recurrent or progressive chronic lymphocytic leukemia AND The member is in complete or partial response after at least two lines of therapy.		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ATGAM	All FDA approved indications not otherwise excluded from Part D.	Members with aplastic anemia secondary to neoplastic disease, storage disease, myelofibrosis, or Fanconi's syndrome.Members known to have been exposed to myelotoxic agents or radiation.	Aplastic Anemia:The member must have a diagnosis of moderate or severe aplastic anemia.The member is not a suitable candidate for bone marrow transplantation.Renal transplant rejection:The member must have received a renal transplant.The member must utilize Atgam (antithymocyte immune globulin, equine) for the management of allograft rejection.The member must receive conventional therapy for transplant rejection concurrently.Renal transplant rejection, prophylaxis:The member must have received a renal transplant.The member must utilize Atgam (antithymocyte immune globulin, equine) for the prevention of allograft rejection.The member must receive conventional therapy for transplant rejection concurrently.		Licensed Practitioner	28 day duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ATOMOXETINE	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	
AUGMENTIN	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	
AVASTIN	All medically accepted indications not otherwise excluded by 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 fluoropyrimidine (e.g., 5-fluorouracil or capecitabine) based chemotherapy for neoadjuvant or perioperative or first or		Licensed Practitioner	six month duration.	Cervical Cancer: The member has recurrent, or metastatic cervical cancer AND Bevacizumab will be used in combination with paclitaxel and cisplatin or carboplatin and paclitaxel or paclitaxel

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	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 initiated in	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-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 has metastatic				and topotecan. Endometrial Cancer: The member has progressive endometrial cancer AND Bevacizumab will be used as a single-agent. Malignant Pleural Mesothelioma. The member has a diagnosis of unresectable malignant pleural mesothelioma and bevacizumab will be used in combination with cisplatin and pemetrexed.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		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 in members	HER-2 negative breast cancer AND member is using bevacizumab in combination with paclitaxel. 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 systemic therapy for non-clear cell histology OR member is using bevacizumab as subsequent therapy for relapsed or unresectable stage IV disease with predominant clear cell histology following progression with cytokine therapy.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		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.Bevacizumab may not be used in conjunction with Erbitux.Bevacizumab may not be used in the adjuvant or neoadjuvant setting (will not apply to criteria for					

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		metastatic colorectal cancer). Bevacizumab should not be continued or restarted after disease progression 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					

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		are to be used in different eyes.					
AVELOX	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	
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	
AVODART	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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	
AZACITIDINE	All FDA approved indications not otherwise excluded from Part D.AML. Myeloprolife rative	Vidaza (azacitidine) may not be used in conjunction with Dacogen (decitabine)-(both are DNA hypomethylators. The member must not have a diagnosis of	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. And one of the following apply: With deletion 5q chromosomal abnormality. The member		Licensed Practitioner	6 month duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Neoplasms.	advanced malignant hepatic tumors.	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 had an inadequate response with Revlimid (lenalidomide) or the member has an intolerance to 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 than 500 mU/mL and a low probability of response to immunosuppressive therapy (e.g. cyclosporine) OR The member has symptomatic anemia and has failed initial treatment with erythropoietins (e.g. Procrit (epoetin alfa)) or inadequate response or intolerance to immunosuppressive therapy (e.g. cyclosporine) OR The member has				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			thrombocytopenia or neutropenia OR The member has increased marrow blasts .The member has a diagnosis of high risk MDS (according to the International Prognostic Scoring System-IPSS) and one of the following applies: Member is not a candidate for stem cell transplant or is a candidate for stem cell transplant and is waiting donor availability or member will be using Vidaza (azacitidine) as maintenance therapy or has had no response or relapsed after prior stem cell transplant. Myeloproliferative Neoplasms: The member has a diagnosis of myelofibrosis (MF)-accelerated phase or MF-blast phase/acute myeloid leukemia.				
AZOR	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
BANZEL	All FDA approved indications not otherwise excluded from Part D.	Patients with familial short QT syndrome.	Patient has diagnosis of seizures associated with Lennox-Gastaut Syndrome.	Member is one year of age or older.	Licensed Practitioner	plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
BAVENCIO	All FDA approved indications not otherwise excluded from Part D	The member has experienced disease progression on Bavencio (avelumab). The member has experienced disease progression while on or following PD-1/PD-L1 therapy (e.g Keytruda, Opdivo, Tecentriq, Imfinzi). The member has experienced disease progression while on or following Yervoy.	Merkel Cell Carcinoma (Adults). The member has a diagnosis of metastatic Merkel cell carcinoma AND the member has disease progression after at least one previous line of chemotherapy for metastatic disease. Merkel Cell Carcinoma (Pediatrics). The member has a diagnosis of metastatic Merkel cell carcinoma. Urothelial Cancer. The member has a diagnosis of locally advanced or metastatic urothelial cancer AND the member will be using Bavencio (avelumab) as monotherapy AND One of the following apply: The member will be using Bavencio (avelumab) as second or subsequent line therapy OR the member has had disease progression within 12 months of neoadjuvant or adjuvant treatment.	Pediatric Merkel Cell Carcinoma – member must be 12 years of age or older.	Licensed Practitioner.	6 months duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
BELEODAQ	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced disease progression while on Beleodaq (belinostat). Members on concomitant Istodax (romidepsin), Zolinza (vorinostat), or Folotyn (pralatrexate) therapy.	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	
BENDEKA	All FDA approved indications not otherwise excluded from Part D.	Members who experience disease progression on bendamustine containing regimens	Chronic Lymphocytic Leukemia-CLL:The member has a diagnosis of Chronic lymphocytic Leukemia (CLL) without del 17p/TP53 mutation and with or without del(11q)Bendeka (bendamustine) is given with or without Rituxan (rituximab) as first line Therapy. Non-Hodgkin's Lymphoma: The member has a diagnosis of follicular lymphoma, stage IIIE-IV gastric MALT		Licensed Practitioner	Six month durations	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			lymphoma, or Stage IV or recurrent Stage I-II nongastric MALT lymphoma AND Bendeka (bendamustine) in combination with Rituxan (rituximab) is being used as first-line therapy OR The member has a diagnosis of splenic marginal zone lymphoma and Bendeka. (bendamustine) is being used as first line therapy for disease progression following initial treatment for splenomegaly OR The member has a diagnosis of primary B-cell lymphoma (primary cutaneous marginal zone or follicle center lymphoma) and Bendeka (bendamustine) in combination with Rituxan (rituximab) is being used as first line therapy in one of the following situations:Generalized extracutaneous disease. Very extensive or refractory generalized T3 cutaneous disease.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
BENICAR	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	
BENICAR HCT	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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, Actemra), combination with cyclophosphamide	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 Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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BESPONSA	All FDA approved indications not otherwise excluded from Part D.	Member has experienced disease progression while on or following Besponsa (inotuzumab ozogamicin)	Acute Lymphoblastic Leukemia: The member has a diagnosis of B-cell precursor acute lymphoblastic leukemia (ALL)AND The member has relapsed or refractory disease AND The member will be using Besponsa (inotuzumab ozogamicin) as monotherapy.		Licensed Practitioner.	Six month durations (up to a maximum of 6 cycles)	
BETASERON	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with similar interferon products such as Avonex 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 Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
BEXAROTENE	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	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
BOSULIF	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors.Members that have experienced 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 imatinib, dasatinib or nilotinib therapy.		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
BRIVIACT	All FDA approved indications not otherwise excluded from Part D.		Adjunctive treatment of partial-onset seizures:Member must have a diagnosis of partial-onset seizures. Briviact will be used as adjunctive therapy with at least one anti-epileptic medication (e.g. gabapentin, topiramate, lamotrigine). Member has had prior therapy with levetiracetam AND one of the following: topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine. Adjunctive treatment of partial-onset seizures:Member must have a diagnosis of partial-onset seizures. Briviact will be used as adjunctive therapy with at least one anti-epileptic medication(e.g. gabapentin, topiramate, lamotrigine).Member has had prior therapy with levetiracetam AND one of the following:topiramate, carbamazepine, gabapentin, divalproex, or lamotrigine.	Must be 16 years of age or older	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
BROVANA	All FDA-approved indications not otherwise excluded from Part D.	The member has acutely deteriorating COPD.Concurrent use with other medications containing Long acting beta 2 (LABA). Asthma, in the absence of concurrent medication containing inhaled corticosteroid and cormorbid COPD diagnosis.	Maintenance treatment of bronchoconstriction in chronic obstructive pulmonary disease (COPD),including chronic bronchitis and emphysema. The member has a diagnosis of COPD.		Licensed Practitioner	Plan Year duration	
BUPRENEX	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: For induction, members should be exhibiting early symptoms of withdrawal. Buprenorphine injectable Must have diagnosis of Moderate to Severe Pain.		Licensed Practitioner	6 month duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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: For induction, members should be exhibiting early symptoms of withdrawal. Buprenorphine injectable Must have diagnosis of Moderate to Severe Pain.		Licensed Practitioner	6 month duration.	
CABOMETYX	All FDA approved indications not otherwise excluded from Part D.	Member experiences disease progression on cabozantinib.	Renal cell carcinoma:The member has advanced renal cell carcinoma and has experienced disease progression on prior anti-angiogenic therapy.The member will be using Cabometyx (cabozantinib)as monotherapy.		Licensed Practitioner	Six month duration	
CADUET	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
CALQUENCE	All FDA-approved indications not otherwise excluded from Part D.				Licensed Practitioner.	6 months duration.	
CAPRELSA	All FDA approved indications not otherwise excluded from Part D. Follicular carcinoma or Hurthle cell carcinoma or Papillary carcinoma.	Members on concomitant tyrosine kinase inhibitors. Members that have experienced disease progression while on Vandetanib.	Thyroid Cancer. The member has a diagnosis of locally advanced or metastatic medullary thyroid cancer AND The member has symptomatic or progressive disease OR the member has a diagnosis of symptomatic iodine refractory follicular carcinoma or Hurthle cell carcinoma or papillary carcinoma AND unresectable recurrent or persistent locoregional disease or metastatic disease.		Licensed Practitioner	three month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
CARAC	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	
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
CAYSTON	All FDA-approved indications not otherwise excluded from Part D.		Cystic Fibrosis. The member must have a diagnosis of cystic fibrosis (CF). The member is colonized with Pseudomonas aeruginosa. The member must have a short or long-acting beta-agonist bronchodilator (e.g. albuterol or formoterol), and will be utilized prior to Cayston.		Licensed Practitioner	Plan Year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
CEREZYME	All FDA-approved indications not otherwise excluded from Part D.		Cerezyme (imiglucerase) will require prior authorization. These 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.		Licensed Practitioner	Plan Year	
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
CHOLBAM	All FDA approved indications not otherwise excluded from Part D.		For the treatment of bile acid synthesis disorders due to single enzyme defects.The member must have a diagnosis of bile acid synthesis disorders due to single enzyme defects (e.g. 3ß-hydroxy- ? 5-C27-steroid oxidoreductase (3ß-HSD)deficiency, ?4-3-oxosteroid 5ß-reductase (AKR1D1) deficiency, cerebrotendinous xanthomatosis (CTX), or 2-[or a-] methylacyl-CoA racemase (AMACR) deficiency).For adjunctive treatment of peroxisomal disorders.The member must have a diagnosis of a peroxisomal disorder (e.g. ZellwegerSyndrome, Neonatal Adrenoleukodystrophy, Generalized Peroxisomal Disorder,Refsum Disease, or peroxisomal disorder of unknown type) AND The member must have signs and symptoms of liver disease (e.g. jaundice,hepatomegaly, dark urine, discolored stools), steatorrhea or complications from decreased fat soluble vitamin absorption.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
CHORIONIC GONADOTROPIN, HUMAN	All medically accepted indications not otherwise excluded from Part D.	Obesity, Female or male infertility, Erectile Dysfunction, Precocious puberty, Prostatic carcinoma or other androgen-dependent neoplasm.			Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
CINRYZE	All FDA approved indications not otherwise excluded from Part D.		Hereditary Angioedema: The member must have a diagnosis of hereditary angioedema (HAE) by documentation of: Low evidence of C4 level (less than 14 mg/dL) AND Low C1 inhibitor (C1INH) antigenic level (C1INH less than 19 mg/dL) OR Low C1INH functional level (functional C1INH less than 50%) OR Known HAE-causing C1INH mutation.The member is using Cinryze for prophylaxis and has no signs of current acute angioedema attack .The member has previous treatment, contraindication, or intolerance with danazol or other appropriately dosed anabolic steroid/androgen for HAE prophylaxis.	Member must be 9 years of age or older.	Licensed Practitioner	Plan Year duration	
CLARINEX	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
CLOZAPINE	All FDA approved indications not otherwise excluded from Part D.	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	The member must be using clozapine orally disintegrating tablet for treatment-resistant schizophrenia.The member must have had previous treatment or intolerance to generic clozapine.		Licensed Practitioner	Plan year duration	
COMETRIQ	All medically accepted indications not otherwise excluded from Part D.	The member has experienced disease progression while on Cometriq (cabozantinib). Members on concomitant tyrosine kinase inhibitors.	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 Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
COMTAN	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	
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
CORLANOR	All FDA approved indications not otherwise excluded from Part D.	Acute decompensated heart failure, Sick sinus syndrome, sinoatrial block or 3rd degree atrioventricular block unless a functioning demand pacemaker is present, Severe hepatic impairment, Heart rate maintained exclusively by pacemaker,Strong CYP3A4 inhibitors.	Heart Failure:The member must have a diagnosis of NYHA Class II, III, or IV heart failure AND Documentation of left ventricular ejection fraction less than or equal to 35% AND The member must be in sinus rhythm with a resting heart rate greater than or equal to 70 beats per minute AND Documentation of blood pressure greater than or equal to 90/50 mmHg AND Documentation of previous treatment, intolerance, or contraindication to maximally tolerated doses of at least one beta-blocker (e.g., carvedilol 50 mg daily, metoprolol 200 mg daily, or bisoprolol 10 mg daily).		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 Remicade.	Moderate to Severe Chronic Plaque Psoriasis: The member has a diagnosis of moderate to severe plaque psoriasis. The member has prior therapy, contraindication, or intolerance to Humira AND Enbrel. Psoriatic Arthritis:The member have a diagnosis of psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance to Humira AND Enbrel. Ankylosing Spondylitis: The member must have a diagnosis of active ankylosing spondylitis. The member has had prior therapy, contraindication, or intolerance to Humira AND Enbrel.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 prior therapy, contraindication, or intolerance to Humira AND Enbrel. Psoriatic Arthritis:The member have a diagnosis of psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance to Humira AND Enbrel. Ankylosing Spondylitis: The member must have a diagnosis of active ankylosing spondylitis. The member has had prior therapy, contraindication, or intolerance to Humira AND Enbrel.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 prior therapy, contraindication, or intolerance to Humira AND Enbrel. Psoriatic Arthritis:The member have a diagnosis of psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance to Humira AND Enbrel. Ankylosing Spondylitis: The member must have a diagnosis of active ankylosing spondylitis. The member has had prior therapy, contraindication, or intolerance to Humira AND Enbrel.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
COSENTYX PEN (2 PENS)	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 prior therapy, contraindication, or intolerance to Humira AND Enbrel. Psoriatic Arthritis:The member have a diagnosis of psoriatic arthritis. The member has had prior therapy, contraindication, or intolerance to Humira AND Enbrel. Ankylosing Spondylitis: The member must have a diagnosis of active ankylosing spondylitis. The member has had prior therapy, contraindication, or intolerance to Humira AND Enbrel.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
COTELLIC	All FDA approved indications not otherwise excluded from Part D.	Members on Cotellic as a single agent.Members on concomitant Yervoy (ipilimumab), Opdivo (nivolumab), Keytruda(pembrolizumab), Tafinlar (dabrafenib), or Mekinist (trametinib).Members that have experienced disease progression while on Cotellic.	Melanoma:The member has a diagnosis of unresectable or stage IV metastatic melanoma AND The member has a BRAF V600E or BRAF V600K mutation as detected by an FDA approved test AND The member will be using Cotellic (cobimetinib) in combination with Zelboraf(vemurafenib).		Licensed Practitioner	Six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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.	The member must be 18 years or older.	Licensed Practitioner	plan year duration	
CRESTOR	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
CYCLOSET	All FDA-approved indications not otherwise excluded from Part D.		Diabetes mellitus: Diagnosis of Type 2 diabetes mellitus AND Previous treatment with, contraindication, or intolerance to the following therapies:A metformin containing medicine.		Licensed Practitioner	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 clotting.	Hemophilia–Hemorrhage.Prophylaxis for Tooth extraction.Members with Hemophilia undergoing dental extraction.		Licensed Practitioner	30 day duration	
CYRAMZA	All medically accepted	Members that have experienced	Gastric Cancer: The member has a diagnosis of advanced or metastatic		Licensed Practitioner	six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.	disease progression while on Cyramza (ramuciruma).	gastric cancer or gastro-esophageal adenocarcinoma AND The member has disease progression or intolerance on or after prior therapy 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 disease progression 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.Cyramza will be used in combination with Docetaxel. Colorectal Cancer:The member has a diagnosis of unresectable or metastatic colorectal cancer AND Primary treatment in combination with irinotecan or FOLFIRI (fluorouracil, leucovorin calcium, and irinotecan) for unresectable metachronuous metastatses and previous treatment with FOLFOX (fluorouracil, leucovorin calcium, and oxaliplatin) or				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			CapeOX (capecitabine, oxaliplatin) as adjuvant therapy has been given OR The member has disease progression on or after prior therapy with bevacizumab, oxaliplatin, and a fluoropyrimidine (e.g. 5-fluorouracil, capecitabine) AND Cyramza (ramucirumab) given in combination with FOLFIRI (irinotecan, folinic acid,and 5-fluorouracil) or irinotecan. Esophageal Cancer: The member has a diagnosis of unresectable locally advanced or metastatic or recurrent esophageal adenocarcinoma with an Eastern Cooperative Oncology Group (ECOG) performance status 0-2 AND Cyramza (ramucirumab) will be used as second line therapy with or without paclitaxel.				
CYSTARAN	All FDA approved indications not otherwise excluded from Part D.		Cystinosis: The member has a diagnosis of cystinosis AND The member is using Cystaran (cysteamine ophthalmic solution) in the treatment of corneal cystine crystal accumulation.		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
CYTOGAM	All FDA approved indications not otherwise excluded from Part D.	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	
DAKLINZA	All FDA approved indications not otherwise excluded from Part D.	Monotherapy with Daklinza (daclatasvir).Coad ministration with strong inducers of CYP3A (e.g. phenytoin, carbamazepine,rifampin, and St. John's wort).	Chronic Hepatitis C Virus HCV):The member must have a diagnosis of chronic hepatitis C virus(HCV)infection. The member must have documented genotype (GT)1a, 1b, 2, 3 infection.Baseline HCV RNA must be documented. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HbsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. GT1 only: must have failed to achieve SVR after completing a full course of Harvoni or has a contraindication to Harvoni therapy. In all genotypes, Daklinza must be used in	The member must be 18 years or older.	Licensed Practitioner	12 to 24 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			combination with sofosbuvir with or without ribavirin.Post liver transplant: The member must have received a liver transplant. The member must have experienced recurrent HCV infection post-transplant in the allograft liver.The member must have GT 1 or 3 infection. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HbsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. For GT 1 only: must have failed to achieve SVR after completing a full course of Harvoni or has a contraindication to Harvoni therapy.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
DARZALEX	All FDA approved indications not otherwise excluded from Part D.	Disease progression while taking Darzalex (daratumumab).	Multiple Myeloma:The member has a diagnosis of multiple myeloma AND one of the following applies: The member will be using Darzalex (daratumumab) in combination with Velcade (bortezomib) and dexamethasone or Revlimid (lenalidomide) and dexamethasone for relapsed, progressive, or refractory disease OR The member will be using Darzalex (daratumumab) as monotherapy and one of the following applies: the member has received at least three prior lines of therapy, which must have included a proteasome inhibitor (e.g. bortezomib or carflizomib) and an immunomodulatory drug (e.g. thalidomide, lenalidomide, or pomalidomide) OR The member is double-refractory to a proteasome inhibitor (e.g. bortezomib or carflizomib) and an immunomodulatory drug (e.g. thalidomide, lenalidomide, or pomalidomide).		Licensed Practitioner	six month duration	
DECITABINE	All FDA	In conjunction	Myelodysplastic Syndromes.The member		Licensed	6 month	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D.AML. Myeloprolife rative Neoplasms.	with Vidaza (azacitidine)-both are DNA hypomethylators).	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 and on e of the following apply: 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 International Prognostic Scoring System—IPSS, lower risk members include IPSS Low and Intermediate-1 categories) AND The member has had an inadequate response or intolerane to 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		Practitioner	duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			member has symptomatic anemia and serum erythropoietin levels greater the 500 mU/mL and a low probability of response to immunosuppressive therapy (e.g. cyclosporine) OR The member has symptomatic anemia and has had no response to erythropoietins or inadequate response or intolerance to immunosuppressive therapy OR The member has thrombocytopenia, neutropenia or increased marrow blasts. Acute Myelogenous Leukemia (AML). The member has a diagnosis of AML. Myeloproliferative Neoplasms: The member has a diagnosis of myelofibrosis (MF)-accelerated phase or MF-blast phase/acute myeloid leukemia.				
DENAVIR	All FDA approved indications not otherwise excluded from Part D.		Penciclovir cream is being utilized for the treatment of recurrent herpes labialis (cold sores). Member has had previous treatment, contraindication, or intolerance with at least two of the following: oral acyclovir, valacyclovir, or famciclovir.	Member is 12 years or older	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
DICLOFENAC SODIUM	All FDA approved indications not otherwise excluded from Part D.		Actinic Keratosis:The member has a diagnosis of actinic keratosis.The member has trial,intolerance, or contraindication to generic imiquimod 5% cream AND topical fluorouracil.		Licensed Practitioner	Plan year duration	
DOXORUBICIN, PEG-LIPOSOMAL	All medically accepted indications not otherwise excluded from Part D.		Ovarian Cancer: The member has a diagnosis of persistent or recurrent ovarian cancer. Breast Cancer: The member has a diagnosis of recurrent or metastatic HER-2-negative breast cancer AND The member has disease progression after treatment with or intolerance to conventional doxorubicin (For Medicare and Puerto Rico, this criteria applies to pharmacy benefits only.) Hodgkin Lymphoma: The member has a diagnosis of relapsed or refractory Hodgkin's Lymphoma AND The member will be using liposomal doxorubicin as second-line or subsequent therapy AND The member has disease progression after treatment with or intolerance to conventional		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			doxorubicin (For Medicare and Puerto Rico, this criteria applies to pharmacy benefits only.)Kaposi's Sarcoma: The member has a diagnosis of AIDS-related Kaposi's sarcoma AND One of the following criteria applies: The member has had prior treatment, intolerance, or contraindication to prior systemic chemotherapy. Multiple Myeloma: The member has a diagnosis of relapsed or refractory multiple myeloma AND The member will be using liposomal doxorubicin in combination with Velcade.				
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-	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 a member who is		Licensed practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		dependent neoplasia. Active or past history of arterial thromboembolism (e.g. stroke and myocardial infarction). Duavee should not be used in members who are pregnant or lactating. 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	postmenopausal AND the member must have had previous treatment, intolerance, or contraindication to either alendronate or Evista (raloxifene).				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		agonists/antagonists.					
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ELIGARD	All FDA approved indications not otherwise excluded from Part D. Breast and ovarian cancer.	Concomitant use with other LHRH agents.Should not be used in pregnancy.	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. 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. Diagnosis of recurrent ovarian cancer (epithelial cell or ovarian stromal tumor).		Licensed Practitioner	12 months	
ELIGARD (3 MONTH)	All FDA approved indications not otherwise excluded from Part D. Breast and ovarian cancer.	Concomitant use with other LHRH agents.Should not be used in pregnancy.	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. 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. Diagnosis of recurrent ovarian cancer (epithelial cell or ovarian stromal tumor).		Licensed Practitioner	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ELIGARD (4 MONTH)	All FDA approved indications not otherwise excluded from Part D. Breast and ovarian cancer.	Concomitant use with other LHRH agents.Should not be used in pregnancy.	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. 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. Diagnosis of recurrent ovarian cancer (epithelial cell or ovarian stromal tumor).		Licensed Practitioner	12 months	
ELIGARD (6 MONTH)	All FDA approved indications not otherwise excluded from Part D. Breast and ovarian cancer.	Concomitant use with other LHRH agents.Should not be used in pregnancy.	The patient must have a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. 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. Diagnosis of recurrent ovarian cancer (epithelial cell or ovarian stromal tumor).		Licensed Practitioner	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ELITEK	All FDA approved indications not otherwise excluded from Part D.	Members deficient in glucose-6-phosphate dehydrogenase (G6PD).Members who have developed hemolytic reactions or methemoglobinemia related to the use of rasburicase.	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.	
EMEND (FOSAPREPITANT)	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	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 highly emetogenic cancer chemotherapy (HEC) or moderately emetogenic cancer chemotherapy (MEC).		Licensed Practitioner	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		time.Concurrent use with oral Emend (aprepitant) capsules if taking the150mg dose.Emend IV (fosaprepitant) monotherapy (Emend should be used in conjunction with a 5HT3 antagonist and dexamethasone).					
EMPLICITI	All medically accepted indications not otherwise excluded from Part D.	Members with disease progression while on Empliciti (elotuzumab)	Multiple Myeloma:The member has a diagnosis of multiple myeloma AND The member has disease progression after receiving one to three prior lines of therapy ANDEmpliciti (elotuzumab) will be given in combination with lenalidomide (Revlimid) and dexamethasone OR in combination with bortezomib (Velcade) and dexamethasone.		Licensed Practitioner	Six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Plaque Psoriasis. Diagnosis of chronic moderate to severe, chronic plaque psoriasis. Member has had prior therapy, 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 prior therapy, contraindication, or intolerance with a: NSAID (e.g. meloxicam, ibuprofen, naproxen) AND a DMARD: (e.g.Hydroxychloroquine, Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide).Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy, contraindication, or intolerance with a		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			DMARD(e.g.methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of with moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, sulfasalazine, cyclosporine, leflunomide).				
ENBREL MINI	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 prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Plaque Psoriasis. Diagnosis of chronic moderate to severe, chronic plaque psoriasis. Member has had prior therapy, 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 prior therapy,		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			contraindication, or intolerance with a: NSAID (e.g. meloxicam, ibuprofen, naproxen) AND a DMARD: (e.g.Hydroxychloroquine, Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide).Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD(e.g.methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of with moderately to severely active polyarticular juvenile idiopathic arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, sulfasalazine, cyclosporine, leflunomide).				
ENBREL SURECLICK	All FDA approved indications not otherwise	Combination therapy with other biologicals such as Humira, Remicade, Orencia, or	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drugs (NSAIDs) (e.g.		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.	Kineret.	ibuprofen, meloxicam, naproxen). Plaque Psoriasis. Diagnosis of chronic moderate to severe, chronic plaque psoriasis. Member has had prior therapy, 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 prior therapy, contraindication, or intolerance with a: NSAID (e.g. meloxicam, ibuprofen, naproxen) AND a DMARD: (e.g.Hydroxychloroquine, Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide).Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD(e.g.methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis: Diagnosis of with moderately to severely active polyarticular juvenile idiopathic arthritis.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, sulfasalazine, cyclosporine, leflunomide).				
ENTRESTO	All FDA approved indications not otherwise excluded from Part D.	History of angioedema related to previous angiotensin-converting enzyme (ACE)inhibitor or ARB therapy.Concomitant use with ACE inhibitors.Concomitant use with aliskiren in patients with diabetes.	Heart Failure: The member must have a diagnosis of NYHA Class II, III, or IV systolic heart failure AND Documentation of left ventricular ejection fraction less than or equal to 40%.	The member must be 18 years or older.	Must be prescribed by or in consultation with a cardiologist.	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
EPCLUSA	All FDA approved indications not otherwise excluded from Part D.		Chronic Hepatitis C Virus Genotypes 1, 4, 5, and 6: The member must have a diagnosis of chronic hepatitis C (HCV).The member must have documented genotype 1, 4, 5, or 6 infection. Baseline HCV RNA must be documented. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HbsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. The member must have failed to achieve SVR after completing a full course of Harvoni or has a contraindication to Harvoni therapy. Chronic Hepatitis C Virus Genotype 2 and 3: The member must have a diagnosis of chronic hepatitis C (HCV). The member must have documented genotype 2 or 3 infection. Baseline HCV RNA must be documented. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HbsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy.	18 years of age or older	Licensed Practitioner	12 week duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	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 10 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				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			continued after completion of myelosuppressive chemotherapy.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 Tracleer (bosentan) or Letairis (ambrisentan)or Opsumit (macitentan) or Adempas (riociguat).		Licensed Practitioner	Plan Year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 Erbutux.Erbitux may not be used in	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		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		conjunction with Vectibix, Tarceva or Iressa (all are EGFR inhibitors). Erbitux may not be used in conjunction with Avastin.	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 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.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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). Members that are using Erivedge (vismodegib) as neoadjuvant therapy.	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 OR the member is not a candidate for surgery AND radiation.		Licensed Practitioner	6 month duration	
ERWINAZE	All FDA approved indications	Erwinaze (asparaginase Erwinia	Erwinaze (asparaginase Erwinia chrysanthemi) will require prior authorization. This agent may be		Licensed Practitioner	Six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	not otherwise excluded from Part D.	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 with prior asparaginase based therapy,Members with a history of serious hemorrhagic events with prior	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.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		asparaginase based therapy,Members that have experienced disease progression while on asparaginase based therapy.					
ESBRIET	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 radiation,	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) ORA surgical lung biopsy.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		sarcoidosis, hypersensitivity pneumonitis, bronchiolitis, obliterans organizing pneumonia, human immunodeficiency virus (HIV), viral hepatitis, and cancer.					
EVOMELA	All FDA approved indications not otherwise excluded from Part D.		Multiple Myeloma:The member has a diagnosis of mutliply myeloma. The member is utilizing Evomela as:High-dose conditioning treatment prior to stem cell transplantation OR Palliative treatment in members for whom oral therapy is not appropriate. Systemic Light Chain Amyloidosis: The member has a diagnosis of systemic light chain amyloidosis.The member will receive Evomela as:Primary treatment AND High-dose single-agent therapy with stem cell transplant.		Licensed Practitioner	six month durations	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
EVOXAC	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.	Patients on concomitant deferoxamine or deferipone. The member has platelet counts less 50,000.	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 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		Licensed Practitioner.	Plan Year Duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
EXONDYS 51	All FDA approved indications not otherwise excluded from Part D.		Duchenne Muscular Dystrophy. Initiation of therapy: The member must have a diagnosis of Duchenne Muscular Dystrophy with a confirmed mutation of DMD gene that is amenable to exon 51 skipping documented by: Multiplex ligation-dependent probe amplification (MLPA) OR array comparative genomic hybridization (array CGH) OR DMD gene sequencing. The member must be ambulatory (e.g. able to walk with assistance, not wheelchair dependent). Continuation of therapy: The member remains ambulatory (e.g. able to walk with assistance, not wheelchair dependent).		Licensed Practitioner	Initial approval for 6 months. Continuation of care approved for one year.	
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
FANAPT	All FDA approved indications not otherwise excluded from Part D.	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Schizophrenia. The member must be utilizing it for acute treatment of schizophrenia.The member must have previous treatment or intolerance or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.	The member must be 18 years or older.	Licensed Practitioner	Plan Year duration.	
FARYDAK	All medically accepted indications not otherwise excluded by 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 one of the following applies: The member will be using Farydak(panobinostat)in combination with bortezomib and dexamethasone OR the member will be using Farydak (panobinostat) in combination with Kyprolis (carfilzomib).		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 indications not otherwise excluded from Part D.	Concurrent use with a MAOI or within 14 days of stopping or 7 days of starting a MAOI.	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 serotonin and norepinephrine reuptake inhibitor (SNRI) AND a bupropion product (IR, SR, or XL) or mirtazapine.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
FIORICET WITH CODEINE	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	
FIRAZYR	All FDA approved indications not otherwise excluded from Part D.		Hereditary Angioedema: The member must have a diagnosis of hereditary angioedema (HAE) by documentation of: Low evidence of C4 level (less than 14 mg/dL) AND Low C1 inhibitor (C1INH) antigenic level (C1INH less than 19 mg/dL) OR Low C1INH functional level (functional C1INH less than 50%) OR Known HAE-causing C1INH mutation.The member is using Firazyr for treatment of acute attacks of HAE.	The member must be 18 years or older.	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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	12 months	
FIRMAGON KIT W DILUENT SYRINGE	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	12 months	
FLECTOR	All FDA approved indications not otherwise excluded from Part D.		Topical treatment of acute pain due to minor strains, sprains, and contusions. The patient has a documented symptomatic acute pain condition.		Licensed Practitioner	1 Month	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
FOLOTYN	All FDA-approved indications not otherwise excluded from Part D.	Members that have experienced disease progression while on pralatrexate.	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.		Licensed Practitioner	6 months	
FROVA	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	
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		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		conditions:Members with pernicious anemia or megaloblastic anemia secondary to the lack of vitamin B12"	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 has advanced metastatic colorectal cancer.The member is receiving palliative treatment with combination chemotherapy with 5-fluorouracil.The member has been treated				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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 excluded from Part D.		Adjunctive treatment for members with partial-onset seizures: Inadequately controlled partial-onset seizures. Concomitant use of at least one antiepileptic medication. Adjunctive treatment for members with generalized tonic-clonic seizures: Inadequately controlled partial-onset seizures and concomitant use of at least one antiepileptic medication.	Age 12 years and older	Licensed Practitioner	Plan year duration	
GAMUNEX-C	All medically accepted indications not otherwise excluded from Part D.		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		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

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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				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. 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

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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).				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 bone marrow suppression. Chronic Inflammatory Demyelinating Polyneuropathies. Not responded to corticosteroid treatment. One of the

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
							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 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 Instructions	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/ thrombocytopenia. Prevention of Bacterial / Viral Infections in Non-primary Immunodeficiency Members.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
							Experiencing iatrogenically induced or disease associated immunosuppression. Or diagnosed with hematologic malignancy.
GATTEX 30-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	
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
GAZYVA	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced disease progression while on Gazyva (obinutuzumab).	Chronic Lymphocytic Leukemia: The member must have a diagnosis of chronic lymphocytic leukemia AND The member is using Gazyva (obinutuzumab) in combination with Chlorambucil OR the member is using Gazyva (obinutuzumab) as monotherapy for relapsed or refractory disease. Follicular Lymphoma: The member has a diagnosis of follicular lymphoma AND One of the following sets of criteria apply: The member will be using Gazyva (obinutuzumab) for first lint therapy OR The member has relapsed after, or is refractory to, a rituximab-containing regimen AND The member will initially be using Gazyva (obinutuzumab) in combination with bendamustine (after 6 cycles Gazyva (obinutuzumab) may be continued as monotherapy per reauthorization criteria below). Follicular Lymphoma--Reauthorization Criteria: The member has achieved stable disease, complete response, or partial response after therapy with Gazyva (obinutuzumab) in combination with bendamustine.		Licensed Practitioner.	CLL: 6 months duration. Follicular Lymphoma: Initial auth: 6 months duration, Reauth: 12 months.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
GILOTRIF	All FDA approved indications not otherwise excluded from Part D.		Non-small cell lung cancer (NSCLC): The member has a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND the following apply: 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 Gilotrif (afatinib) as monotherapy (without concomitant chemotherapy) OR squamous cell histology after disease progression on platinum containing chemotherapy and is using Gilotrif (afatinib) as monotherapy.		Licensed Practitioner	Six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 medically accepted indications not otherwise	Patients on concomitant tyrosine kinase inhibitors. Patients that have	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. Acute lymphoid leukemia	The patient is at least one year of age.	Licensed Practitioner	12 months	Pediatric indications: The patient has a diagnosis of Philadelphia chromosome positive (Ph+) CML that is newly diagnosed in chronic

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.	experienced disease progression while on imatinib.	(ALL).The member has a diagnosis of Ph+ ALL that is relapsed, refractory, or newly diagnosed and imatinib is being added to consolidation or induction therapy OR the member has a diagnosis of PH+ALL and receiving maintenance therapy. The member has a diagnosis of Kit (CD117)-positive GIST. The member has a diagnosis of Dermatofibrosacrome protuberans (DFSP) that is adjuvant (positive surgical margins following excision) unresectable, recurrent, and/or metastatic. The member has a diagnosis of chronic eosinophilic leukemia or hypereosinophilic syndrome. 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).The member has a diagnosis of aggressive systemic mastocytosis. The member must not harbor the D816v mutation of C-kit. Melanoma. The member has a diagnosis				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 Ph+ ALL AND the member will be using Gleevec in combination with chemotherapy.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			of unresectable melanoma with activating mutation of C-kit. Gleevec (imatinib) will be used as single agent in subsequent therapy.				
GRANIX	All medically accepted indications not otherwise excluded by 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 therapeutic 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 fever 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		Licensed Practitioner	120 day duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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 receiving a dose-dense chemotherapy regimen. Neutropenia in Myelodysplastic Syndromes. The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Treatment of Febrile Neutropenia. The member must have a diagnosis of febrile neutropenia AND Granix (tbo-filgrastim) must be used in adjunct with appropriate antibiotics in high risk members.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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.Liposarcoma: The member has a diagnosis of unresectable or metastatic liposarcoma and has received a prior anthracycline containing regimen.		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
HARVONI	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with other Direct Acting Antivirals (e.g. HCV protease inhibitors, polymerase inhibitors, NS5A inhibitors).	Chronic Hepatitis C:Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotypes 1a,1b,4,5 and 6 infection. HCV RNA level must be documented prior to therapy. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HbsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. Chronic Hepatitis C - Pediatrics: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 1, 4, 5 or 6 infection. HCV RNA level must be documented prior to therapy. Member must be 12 years of age or older or weigh at least 35kg. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy.	The member must be 18 years or older. Pediatric indications: The member must be 12 years or older.	Licensed Practitioner	12 to 24 weeks depending on disease state and genotype based on AASLD treatment guidelines for HCV.	
HERCEPTIN	All FDA approved		Breast Cancer: The member has a diagnosis of breast cancer and HER2		Licensed Practitioner	Six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.		(human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or ISH positive [single-probe average HER2 copy number greater than or equal to 6.0 signals/cell: dual-probe HER2/CEP17 ratio greater than or equal to 2.0 with an average HER2 copy number greater than or equal to 4.0 signals per cell: dual-probe HER2/CEP17 ratio greater than or equal to 2.0 with an average HER2 copy number less than 4.0 signals/cell: dual-probe HER2/CEP17 ratio less than 2.0 with an average HER2 copy number greater than or equal to 6.0 signals/cell]).Gastric Cancer:The member has a diagnosis of advanced, gastric cancer or gastroesophageal adenocarcinoma and HER2 (human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or ISH positive [single-probe average HER2 copy number greater than or equal to 6.0 signals/cell: dual-probe HER2/CEP17 ratio greater than or equal to 2.0 with an average HER2 copy number greater than				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			or equal to 4.0 signals per cell: dual-probe HER2/CEP17 ratio greater than or equal to 2.0 with an average HER2 copy number less than 4.0 signals/cell: dual-probe HER2/CEP17 ratio less than 2.0 with an average HER2 copy number greater than or equal to 6.0 signals/cell]) AND Herceptin (trastuzumab) is being used in combination with cisplatin and fluorouracil or capecitabine.				
HETLIOZ	All FDA approved indications not otherwise excluded from Part D.		Non-24-Hour Sleep-Wake Disorder. The member must utilize Hetlioz for the treatment of Non-24-Hour Sleep-Wake Disorder.		Licensed Practitioner	plan year duration	
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 prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis,Moderate to severe Chronic Plaque	Licensed Practitioner	Plan Year Duration	Uveitis. The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis.The member has had prior therapy, contraindication, or intolerance with one of the

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAIDs (e.g. meloxicam, ibuprofen, naproxen) AND a DMARDs: (e.g. Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide).Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis. Member has had prior therapy,contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. Member has had prior therapy, contraindication, or intolerance with conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, cyclosporine).	Psoriasis, Uveitis .The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis.Must be six years or older for Crohns Disease.			following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
HUMIRA PEDIATRIC CROHN'S START	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 prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAIDs (e.g. meloxicam, ibuprofen, naproxen) AND a DMARDs: (e.g. Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide).Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis. Member has had prior therapy,contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis,Moderate to severe Chronic Plaque Psoriasis, Uveitis .The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis.Must be six years or older for Crohns Disease.	Licensed Practitioner	Plan Year Duration	Uveitis. The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis.The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			chronic plaque psoriasis. Member has had prior therapy, contraindication, or intolerance with conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, cyclosporine).				
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 prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAIDs (e.g. meloxicam, ibuprofen, naproxen) AND a DMARDs: (e.g. Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide).Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, sulfasalazine,	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis,Moderate to severe Chronic Plaque Psoriasis, Uveitis .The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis.Must be six years or older for Crohns Disease.	Licensed Practitioner	Plan Year Duration	Uveitis. The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis.The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis. Member has had prior therapy,contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. Member has had prior therapy, contraindication, or intolerance with conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, cyclosporine).				
HUMIRA PEN CROHN'S-UC-HS START	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 prior therapy, contraindication, or intolerance with a non-steroidal anti-inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAIDs (e.g. meloxicam, ibuprofen, naproxen) AND a DMARDs:	The member must be at least 18 years of age for the following indications: Rheumatoid Arthritis,Moderate to severe Chronic Plaque Psoriasis, Uveitis .The member must be two years of age or older and have a diagnosis	Licensed Practitioner	Plan Year Duration	Uveitis. The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis.The member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(e.g. Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide).Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis. Member has had prior therapy,contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. Member has had prior therapy, contraindication, or intolerance with conventional therapy including one or more oral systemic treatments (e.g., acitretin, methotrexate, cyclosporine).	of moderately to severely active polyarticular juvenile idiopathic arthritis.Must be six years or older for Crohns Disease.			prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).
HUMIRA PEN PSORIASIS-UVEITIS	All FDA approved indications not	Combination therapy with other biologics such as Enbrel, Remicade,	Ankylosing Spondylitis. Diagnosis of active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with a non-steroidal anti-	The member must be at least 18 years of age for the following indications:	Licensed Practitioner	Plan Year Duration	Uveitis. The member must have a diagnosis of non-infectious, intermediate, posterior, or pan-uveitis.The

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.	Orencia, or Kineret.	inflammatory drug (NSAIDs) (e.g. ibuprofen, meloxicam, naproxen). Psoriatic Arthritis. Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAIDs (e.g. meloxicam, ibuprofen, naproxen) AND a DMARDs: (e.g. Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide).Rheumatoid Arthritis. Diagnosis of moderately to severely active rheumatoid arthritis. Member has had prior therapy, contraindication, or intolerance with a DMARD (e.g. methotrexate, sulfasalazine, cyclosporine, leflunomide). Polyarticular Juvenile Idiopathic Arthritis. Member has had prior therapy,contraindication, or intolerance with a DMARD (e.g. methotrexate, cyclosporine, leflunomide). Moderate to severe Chronic Plaque Psoriasis. Diagnosis of moderate to severe chronic plaque psoriasis. Member has had prior therapy, contraindication, or intolerance with conventional therapy including one or more oral systemic	Rheumatoid Arthritis,Moderate to severe Chronic Plaque Psoriasis, Uveitis .The member must be two years of age or older and have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis.Must be six years or older for Crohns Disease.			member has had prior therapy, contraindication, or intolerance with one of the following: an intravitreal steroid (e.g. triamcinolone, dexamethasone) OR a systemic corticosteroid (e.g. prednisone, methylprednisolone) OR an anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate) OR a calcineurin inhibitor (e.g. cyclosporine, tacrolimus).

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			treatments (e.g., acitretin, methotrexate, cyclosporine).				
IBANDRONATE	All FDA approved indications not otherwise excluded from Part D.	In patients with severe renal impairment (patients with serum creatinine greater than 200uMol/L [2.3 mg/dL] or creatinine clearance less than 30mL/min.	Postmenopausal Osteoporosis: The member is a postmenopausal with a diagnosis of osteoporosis or at high risk for osteoporosis.The member has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance with an oral bisphosphonate.		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
IBRANCE	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced disease progression while on Ibrance (palbociclib).	Breast Cancer:The member has a diagnosis of estrogen receptor-positive and human epidermal growth factor receptor 2-negative breast cancer AND Tone of the following applies: The member will be using Ibrance in combination with aromatase inhibitor (e.g. letrozole) as initial endocrine-based therapy for their recurrent disease OR The member will be taking Ibrance (palbociclib) in combination with aromatase inhibitor (e.g. letrozole) as initial endocrine based therapy for their metastatic disease or the member will be using Ibrance in combination with Faslodex as subsequent therapy after disease progression on or following endocrine based therapy (e.g. anastrazole) for their recurrent disease or the member will be using Ibrance in combination with Faslodex as subsequent therapy after disease progression on or following endocrine based therapy (e.g. anastrazole) for their metastatic disease.		Licensed Practitioner	Six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ICLUSIG	All FDA approved indications not otherwise excluded from Part D.	The member has experienced disease progression 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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
IDHIFA	All FDA-approved indications not otherwise excluded from Part D	Member has experienced disease progression while on or following Idhifa(enasidenib)	Acute Myeloid Leukemia: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has relapsed or refractory disease AND The member has a documented IDH2 mutation as detected by an FDA-approved test AND The member will be using Idhifa (enasidenib) as monotherapy		Licensed Practitioner	Six month durations.	
IMBRUVICA	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced 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 as monotherapy. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL).The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL). Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL) with deletion (17p).The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic		Licensed Practitioner	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Lymphoma (SLL) with del (17p) AND The member is using Imbruvica as monotherapy. Waldenstrom's Macroglobulinemia:The member has a diagnosis of Waldenstrom's macroglobulinemia AND The member is using Imbruvica (ibrutinib) as monotherapy. Marginal Zone Lymphoma: The member has a diagnosis of marginal zone lymphoma AND The member is using Imbruvica (ibrutinib) as second line or subsequent for refractory or progressive disease AND The member is using Imbruvica (ibrutinib) as monotherapy. Chronic Graft Versus Host Disease: The member has a diagnosis of chronic graft versus host disease (cGVHD) AND The member has been unable to achieve treatment goals with at least one prior line of systemic therapy (e.g. corticosteroids)				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
IMFINZI	All FDA approved indications not otherwise excluded from Part D.	Disease progression while on anti-PD-1/PD-L1 therapy [e.g., Opdivo (nivolumab), Keytruda (pembrolizumab), Tecentriq (atezolizumab), Imfinzi (durvalumab)]	Urothelial Cancer: The member has a diagnosis of locally advanced or metastatic urothelial cancer AND The member will be using Imfinzi (durvalumab) as a single agent AND One of the following apply:The member will be using as a second or subsequent line-therapy OR the member has had disease progression within 12 months of neoadjuvant or adjuvant treatment		Licensed Practitioner.	6 Months Duration.	
IMLYGIC	All FDA approved indications not otherwise excluded from Part D.	Members who are immunocompromised. Members who are pregnant. Members that have experienced disease progression while on Imlygic (talimogene laherparepvec).	Unresectable Melanoma: The member must have one of the following melanoma diagnoses:unresectable Stage III with in-transit metastases, unresectable local/satellite recurrence (may also have in-transit metastases), unresectable or distant metastatic disease. The member will receive Imlygic as an intralesional therapy into cutaneous, subcutaneous, or nodal lesions that are visible on the skin, palpable, or detectable by ultrasound guidance.	The member must be 18 years or older.	Licensed Practitioner	six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
INCRELEX	All FDA approved indications not otherwise excluded from Part D.	The bone epiphyses are closed.	Member has a diagnosis of GH gene deletion with development of neutralizing antibodies to GH OR The patient has a diagnosis of severe primary IGF-1 deficiency 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.	The patient is 2 years or older	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
INGREZZA	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with other VMAT2 Inihibitors (e.g. tetrabenazine). Members at significant risk for suidicial or violet behavior. Members with unstable psychiatric conditions.	Tardive Dyskinesia – Initial therapy. The member is utilizing Ingrezza (valbenazine) for the treatment of tardive dyskinesia as seen by the following: the member has involuntary athetoid or choreiform movements AND the member has a history of treatment with dopamine receptor blocking agent AND the member has experienced symptoms for longer than 8 weeks. The member has a moderate to severe tardive dyskinesia demonstrated by a score of 3 or 4 on item 8 (severity of abnormal movements overall) on the Abnormal Involuntary Movement Scale (AIMS). Tardive Dyskinesia -Reauthorization. The member must show a documented overall reduction in their Abnormal Involuntary Movement Scale (AIMS) score (items 1 through 7) from baseline while on Ingrezza (valbenazine) therapy.	The member is 18 years of age or older.	Licensed Practitioner.	Initial authorization: 3 months. Reauthorization: 12 months.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
INLYTA	All FDA approved indications not otherwise excluded from Part D. Advanced Thyroid Carcinoma	Members on concomitant tyrosine kinase inhibitors. Members on concomitant mTOR inhibitors.Members that have experienced disease progression while on Inlyta /axitinib.	Renal Cell Carcinoma.The member has a diagnosis of advanced renal cell carcinoma. Advanced Thyroid Carcinoma:The member has a diagnosis of advanced/metastatic follicular carcinoma, Hürthle cell carcinoma, or papillary carcinoma and clinical trials are not available or appropriate AND The member has disease that is not responsive to radio-iodine treatment.		Licensed Practitioner	6 month duration	
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	Chronic Hep C must 3 years or older. Must be 18 years or older for Hairy Cell Leukemia, Malignant Melanoma, Follicular Non-Hodkins Lymphoma, Condylomata Acuminata, AIDS-related Kaposi¿s	Licensed Practitioner	HepC,Melanoma,lymphoma Plan year,Leukemia 6months, HepB 16 week,Condylomata 3	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			or other clinical circumstance preventing them from using before the member will be eligible to receive Intron A. For members 3 – 17 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.	Sacroma. 1 year or older for Chronic Hep B.		weeks,Kaposis 4 months.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
INVEGA	All medically accepted indications not otherwise excluded from Part D.	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Bipolar Disorder, Acute Manic and Mixed Episodes:The member must have a diagnosis of bipolar disorder (acute manic and mixed episodes). 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 or aripiprazole. Schizophrenia: The member must have a diagnosis of schizophrenia. 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 or aripiprazole. Schizoaffective Disorder: The member must have a diagnosis of schizoaffective disorder. 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 or aripiprazole.	Age 18 or older for Bipolar Disorder, Acute Manic and Mixed Episodes and for Schizoaffective Disorder and age 12 or older for Schizophrenia.	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 metastatic or recurrent non-small cell lung cancer (NSCLC) AND the following 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 Iressa (gefitinib) as monotherapy (without concomitant chemotherapy).		Licensed Practitioner	Six month duration	
ISORDIL	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ISORDIL TITRADOSE	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	
ISTODAX	All medically accepted indications not otherwise excluded from Part D.	Members that have experienced disease progression, while on Istodax (romidepsin).Members on concomitant Zolinza (vorinostat) therapy.	Cutaneous T-cell Lymphoma (CTCL). Istodax (romidepsin) is being used to treat cutaneous T-cell lymphoma AND one of the following applies: the member will be using Istodax (romidepsin) as primary biologic systemic therapy OR the member will be using Istodax (romidepsin) as adjuvant systemic biologic therapy OR the member has received at least one prior therapy. Peripheral T-cell Lymphoma (PTCL).Istodax (romidepsin) is being used to treat relapsed or refractory peripheral T-cell lymphoma. The member has received at least one prior therapy.		Licensed Practitioner.	6 month duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 (ixabepilone) should be discontinued after disease progression constituting treatment failure.	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 (e.g. Doxorubicin),a taxane(e.g.paclitaxel) 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 (e.g. Doxorubicin),and a taxane (e.g.paclitaxel)(or further anthracycline therapy is contraindicated and disease is refractory to a taxane).		Licensed Practitioner	six months	
JAKAFI	All FDA approved indications not otherwise excluded from Part D.	Jakafi (ruxolitinib) therapy is not considered medically necessary for members with the following	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		Licensed Practitioner	6 months for Myelofibrosis and 8 months Polycythemia Vera	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		concomitant conditions:Members that have experienced disease progression while on Jakafi (ruxolitinib).Members on concomitant tyrosine kinase inhibitors or immunomodulatory medications (example: Revlimid/lenalidomide)	myelofibrosis or post-essential thrombocythemia myelofibrosis AND The member has one of the following risk categories, as defined by International Prognostic Scoring System (IPSS): Symptomatic low risk disease OR Symptomatic intermediate-1 risk disease OR Intermediate-2 risk disease OR High risk disease. 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 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				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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%.				
JALYN	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 equal togreater than or equal to 3 x ULN. Concomitant use with Zytiga or Xtandi.	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 duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
KADCYLA	All FDA approved indications not otherwise excluded from Part D.	The member has experienced disease progression while on Kadcyla (ado-trastuzumab emtansine. Use in the adjuvant setting.Members on concomitant Herceptin (trastuzumab), Tykerb (lapatinib), or Perjeta (pertuzumab).	Metastatic Breast Cancer. The member has a diagnosis of metastatic breast cancer and HER2 (human epidermal growth factor receptor2) positive disease (e.g., defined as IHC 3+ or ISH positive [single-probe average HER2 copy number greater than or equal to 6.0 signals/cell: dual-probe HER2/CEP17 ratio greater than or equal to 2.0 with an average HER2 copy number greater than or equal to 4.0 signals per cell: dual-probe HER2/CEP17 ratio greater than or equal to 2.0 with an average HER2 copy number less than 4.0 signals/cell: dual-probe HER2/CEP17 ratio less than 2.0 with an average HER2 copy number greater than or equal to 6.0 signals/cell]) AND The member is using Kadcyla (ado-trastuzumab emtansine) as monotherapy AND The member has received prior therapy with trastuzumab and a taxanee(eg. paclitaxel, docetaxel), separately or in combination and one of the following applies: Received prior treatment for metastatic disease. Recurrence occurred during or within six		Licensed Practitioner	Six month Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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: A1067T, A455E, D110E, D110H, D1152H, D1270N, D579G, E193K, E56K, F1052V, F1074L, G1069R, G551D, G1244E, G1349D, G178R, G551S, K1060T, L206W, P67L, R117C, R117H, R347H, R352Q, R74W, R1070W, R1070Q, S1251N, S1255P, S549N, S945L, S977F, S549R, 711+3A-G, E831X, 2789+5G-A, 3272-26A-G, or 3849+10kbC-T.		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. Non-small cell lung cancer (NSCLC) - First Line Therapy: The member must have a diagnosis of metastatic NSCLC AND disease with high PD-L1 expression [(Tumor Proportion Score (TPS) greater than or equal to 50%)] with no EGFR or ALK genomic tumor aberrations and given as first line therapy		Licensed Practitioner	six months	MSI-High/d-MMR Solid tumors: The member has a diagnosis of unresectable or metastatic documented microsatellite instability-high (MSI-High) or mismatch repair deficient (d-MMR) solid tumors (excluding pediatric patients with MSI-H central nervous system cancers) AND

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			AND tumor expresses PD-L1 as determined by an FDA-approved test AND will be used as monotherapy OR Nonsquamous histology where pembrolizumab is given in combination with pemetrexed and carboplatin as first line therapy.Non-small cell lung cancer (NSCLS) - Subsequent therapy: The member must have a diagnosis of metastatic NSCLC AND Disease progression on or following chemotherapy and EGFR inhibitor (e.g.,Tarceva[erlotinib], Iressa [gefitinib], Gilotrif [afatinib]), if EGFR mutation positive or ALK inhibitor (e.g., Xalkori (crizotinib)), if ALK positive AND Tumor expresses PD-L1 as determined by an FDA-approved test (e.g., in the subsequent line disease expressing Tumor Proportion Score (TPS) of greater than or equal to 1%) AND will be used as monotherapy. Head and Neck Cancer: The member has a diagnosis of recurrent or metastatic head and neck squamous cell carcinoma AND disease progression on platinum containing				one of the following applies: The member has disease that has progressed on prior therapy with no alternative treatments and Keytruda is being given as monotherapy OR The member has a diagnosis of colorectal cancer AND one of the following applies: Keytruda is being given as a monotherapy and as subsequent therapy after progression on treatment with fluoropyrimidine, oxaliplatin, and irinotecan or First line therapy as monotherapy in unresectable or metastatic colorectal cancer with previous treatment with adjuvant FOLFOX (fluorouracil, leucovorin, and oxaliplatin) or CapeOX (capecitabine and oxaliplatin) within the past 12 months. Urothelial Cancer:

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			chemotherapy. Hodgkin's Lymphoma (Adult). The member has classical Hodgkin’s lymphoma AND Keytruda is being used as monotherapy and one of the following applies: Refractory disease if Deauville score 4-5 OR Relapsed after 3 or more lines of prior therapy (including, where applicable, autologous or allogenic stem cell transplant) or previously treated with brentuximab vedotin OR Palliative therapy for relapsed or refractory disease in adults (greater than 60 years of age).Hodgkin's Lymphoma (Pediatric): The member has classical Hodgkin’s lymphoma AND Keytruda is being used as monotherapy and one of the following applies: Refractory disease OR Relapsed after 3 or more lines of prior therapy				The member has a diagnosis of locally advanced or metastatic urothelial cancer AND The member will be using Keytruda (pembrolizumab) as monotherapy AND one of the following applies: Keytruda (pembrolizumab) is being used as initial therapy in members who are ineligible to receive cisplatin containing chemotherapy defined as one of the following: ECOG Performance Status 2, Creatinine clearance (calculated or measured) less than 60, Grade greater than or equal to 2 audiometric hearing loss or peripheral neuropathy (per NCI-CTCAE v4), NYHA class III heart failure. OR Keytruda (pembrolizumab) is being used as subsequent therapy

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
							after disease progression within 12 months of neoadjuvant or adjuvant chemotherapy.
KISQALI	All FDA approved indications not otherwise excluded from Part D.	Concomitant use of another CDK4/6 inhibitor (e.g., palbociclib).	Breast Cancer. The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (Her2neu)-negative breast cancer AND the member is post-menopausal AND the member will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine therapy AND the member has a medical reason as to why Ibrance (palbociclib) cannot be started or continued as initial endocrine based therapy.		Licensed Practitioner.	6 months duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
KISQALI FEMARA CO-PACK	All FDA approved indications not otherwise excluded from Part D.	Concomitant use of another CDK4/6 inhibitor (e.g., palbociclib).	Breast Cancer. The member has a diagnosis of advanced or metastatic hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (Her2neu)-negative breast cancer AND the member is post-menopausal AND the member will be using Kisqali (ribociclib) in combination with an aromatase inhibitor (e.g., letrozole) as first line endocrine therapy AND the member has a medical reason as to why Ibrance (palbociclib) cannot be started or continued as initial endocrine based therapy.		Licensed Practitioner.	6 months duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
KORLYM	All FDA approved indications not otherwise excluded from Part D.	Pregnancy. Members with a history of unexplained vaginal bleeding. Members with endometrial hyperplasia with atypia or endometrial carcinoma. Concurrent long-term corticosteroid use.	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	
KUVAN	All FDA approved indications not otherwise excluded from Part D.		BH4 (Sapropterin) responsive PKU. Diagnosis of PKU that is responsive to BH4. Response is defined as a 20% 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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
KYNAMRO	All FDA approved indications not otherwise excluded from Part D.	Moderate or severe hepatic impairment (based on Child-Pugh category B or C)or active liver disease including unexplained persistent abnormal liver function tests. Concomitant use with a MTP inhibitor or a PCSK9 inhibitor.	Homozygous Familial Hypercholesteremia. Diagnosis of definite homozygous familial hypercholesteremia as defined by at least one of the following: Genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or ARH adaptor protein gene locus OR An untreated LDL-C greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) or treated non-HDL cholesterol greater than or equal to 330 mg/dL (8.5 mmol/L) with at least one of the following: Cutaneous or tendonous xanthoma before age 10 years OR Elevated LDL cholesterol levels before lipid-lowering therapy consistent with heterozygous familial hypercholesteremia in both parents (untreated total cholesterol greater than 290 mg/dL (7.5 mmol/L) or untreated LDL-C greater than 190 mg/dL (4.0 mmol/L)) AND Member must meet one of the following criteria: Must have had previous treatment, intolerance or contraindication to a high-intensity statin at the maximum approved		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			or tolerated dose per the package insert (high-intensity statins include atorvastatin 80 mg and Crestor 40 mg) and Zetia.				
KYPROLIS	All medically accepted indications not otherwise excluded by Part D.	Members receiving concomitant therapy with a proteasome inhibitor.The member has experienced disease progression while on Kyprolis(carfilzomib).	Multiple Myeloma:The member has a diagnosis of Multiple Myeloma AND The member is using Kyprolis (carfilzomib) as a single agent or in combination with dexamethasone for disease relapse or progressive disease OR the member will be using Kyprolis (carfilzomi) in combination with Farydak (panobinostat) and the member has received at least two prior regimens, including both bortezomib and an immunomodulatory drug (e.g. thalidomide, lenalidomide, pomalidomide) OR The member will be using Kyprolis (carfilzomib) in combination with Revlimid (lenalidomide) and dexamethasone and one of the following applies: Is using as primary therapy OR Using for treatment of disease relapse (for transplant candidates, disease relapse must be after 6 months following primary chemotherapy with the same regimen) or progressive		Licensed Practitioner	6 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			disease.Waldenstrom's Macroglobulinemia: The member has a diagnosis of Waldenstrom's macroglobulinemia AND Kyprolis (carfilzomib) will be used as a component of CaRD regimen (carfilzomib, rituximab, and dexamethasone) as primary therapy OR for relapsed disease (if CaRD previously used as primary therapy relapse must occur after 24 months).				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
LARTRUVO	All FDA approved indications not otherwise excluded from Part D.	Member has disease progression on Lartruvo (olaratumab).	Soft Tissue Sarcoma. The member has a diagnosis of soft tissue sarcoma (which includes angiosarcoma, retroperitoneal or intraabdominal or extremity/superficial trunk, head/neck soft tissue sarcoma, and rhabdomyosarcoma) that is not curable by radiation or surgery AND the member has had no prior exposure to anthracycline (e.g., doxorubicin) AND Lartruvo (olaratumab) will be given in combination with doxorubicin (excluding liposomal doxorubicin). Soft Tissue Sarcoma - Reauthorization Criteria. The member has evidence of response AND the member has not experienced grade 3 or 4 infusion related reaction with previous Lartruvo (olaratumab) and doxorubicin therapy AND combination therapy of doxorubicin and Lartruvo (olaratumab) will be given for a total of eight cycles.		Licensed Practitioner.	Approved for 4 months.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
LATUDA	All FDA approved indications not otherwise excluded from Part D.	Concurrent use with strong CYP3A4 inhibitors (ketoconazole).Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Diagnosis of Schizophrenia or Schizoaffective Disorder:The member must have previous treatment,intolerance or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole. Diagnosis of Bipolar Depression:The member must have documentation of previous treatment, intolerance, or contraindication to quetiapine.	For diagnosis of Schizophrenia or schizoaffective disorder, the member must be 13 years of age or older. For diagnosis of Bipolar disorder, the member must be 18 years of age or older.	Licensed Practitioner	Plan Year Duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	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.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
LENVIMA	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors.Members that have experienced 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. Renal Cell Carcinoma. The member has a diagnosis of advanced renal cell carcinoma AND using in combination with Afinitor (everolimus) for disease progression following anti-angiogenic therapy with Inlyta (axitinib).		Licensed Practitioner	six months	
LETAIRIS	All FDA-approved indications not otherwise excluded from Part D.	The patient is concomitantly taking endothelin receptor antagonist (e.g., Tracleer®). Member has a diagnosis of idiopathic pulmonary fibrosis.	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I).		Licensed Practitioner	Plan year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
LEUKINE	All FDA approved indications not otherwise excluded from Part D. Febrile neutropenia prophylaxis in non-myeloid malignancies, treatment of severe febrile neutropenia, Neutropenia in MDS, Malignant Melanoma,Agranulocytosis,Aplastic Anemia,Neutropenia in	Routine use as prophylaxis in patients/chemotherapy regimens without significant risk of febrile 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	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 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-		Licensed Practitioner	4 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	HIV or AIDS members.	with myelosuppressive chemotherapy or therapeutic radiation.	blood stem cell (PBSC) transplantation, storing celss for a possible future autologous transplant,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.				
LEVOLEUCOVORIN	All FDA approved indications not otherwise excluded from Part D.	"Fusilev (levoleucovorin) is considered not medically necessary for members with the following concomitant conditions:Membe	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		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		rs with pernicious anemia or megaloblastic anemia secondary to the lack of vitamin B12"	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 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				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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 medically accepted 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. Neuropathic cancer pain. The member must have a diagnosis of neuropathic cancer pain.		Licensed Practitioner	6 month duration	
LIPODOX	All medically accepted indications not otherwise excluded from Part D.		Ovarian Cancer: The member has a diagnosis of persistent or recurrent ovarian cancer. Breast Cancer: The member has a diagnosis of recurrent or metastatic HER-2-negative breast cancer AND The member has disease progression after treatment with or intolerance to conventional doxorubicin (For Medicare and Puerto Rico, this criteria applies to pharmacy benefits only.) Hodgkin Lymphoma: The member has a diagnosis of relapsed or refractory Hodgkin's		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Lymphoma AND The member will be using liposomal doxorubicin as second-line or subsequent therapy AND The member has disease progression after treatment with or intolerance to conventional doxorubicin (For Medicare and Puerto Rico, this criteria applies to pharmacy benefits only.)Kaposi's Sarcoma: The member has a diagnosis of AIDS-related Kaposi's sarcoma AND One of the following criteria applies: The member has had prior treatment, intolerance, or contraindication to prior systemic chemotherapy. Multiple Myeloma: The member has a diagnosis of relapsed or refractory multiple myeloma AND The member will be using liposomal doxorubicin in combination with Velcade.				
LIPODOX 50	All medically accepted indications not otherwise excluded		Ovarian Cancer: The member has a diagnosis of persistent or recurrent ovarian cancer. Breast Cancer: The member has a diagnosis of recurrent or metastatic HER-2-negative breast cancer AND The member has disease progression		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	from Part D.		after treatment with or intolerance to conventional doxorubicin (For Medicare and Puerto Rico, this criteria applies to pharmacy benefits only.) Hodgkin Lymphoma: The member has a diagnosis of relapsed or refractory Hodgkin's Lymphoma AND The member will be using liposomal doxorubicin as second-line or subsequent therapy AND The member has disease progression after treatment with or intolerance to conventional doxorubicin (For Medicare and Puerto Rico, this criteria applies to pharmacy benefits only.)Kaposi's Sarcoma: The member has a diagnosis of AIDS-related Kaposi's sarcoma AND One of the following criteria applies: The member has had prior treatment, intolerance, or contraindication to prior systemic chemotherapy. Multiple Myeloma: The member has a diagnosis of relapsed or refractory multiple myeloma AND The member will be using liposomal doxorubicin in combination with Velcade.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
LODOSYN	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
LONSURF	All FDA approved indications not otherwise excluded from Part D.	The member has experienced disease progression while on Lonsurf.	Metastatic Colorectal Cancer:The member has a diagnosis of metastatic colorectal cancer AND The member is using Lonsurf as monotherapy AND The member has experienced disease progression, intolerance, or contraindication with ALL of the following therapies: fluoropyrimidine-based chemotherapy (e.g., 5-fluorouracil, capecitabine),oxaliplatin-based chemotherapy, irinotecan-based chemotherapy, and anti-VEGF therapy (e.g. bevacizumab, ziv-aflibercept) AND If the member is KRAS wild-type: the member has experienced disease progression,intolerance, or contraindication with anti-EGFR therapy (e.g. cetuximab or panitumumab).		Licensed Practitioner	Six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
LUMIZYME	All FDA-approved indications not otherwise excluded from Part D.		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 Pompe disease.		Licensed Practitioner.	Plan Year	
LUNESTA	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	
LUPRON DEPOT	All medically accepted 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: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. Central Precocious Puberty: The patient must have a diagnosis of central precocious puberty (idiopathic or neurogenic) with onset of secondary		Licensed Practitioner	12 months for all except for Endometriosis: 6 months and Uterine Leiomyom	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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).			a 3 month	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
LUPRON DEPOT (3 MONTH)	All medically accepted 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: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. 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		Licensed Practitioner	12 months for all except for Endometriosis: 6 months and Uterine Leiomyoma 3 month	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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 medically accepted 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: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. 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		Licensed Practitioner	12 months for all except for Endometriosis: 6 months and Uterine Leiomyoma 3 month	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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 medically accepted indications	Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of		Licensed Practitioner	12 months for all	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	not otherwise excluded from Part D.		endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. 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.			except for Endometriosis: 6 months and Uterine Leiomyoma 3 month	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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 medically accepted 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: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine leiomymoma. 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		Licensed Practitioner	12 months for all except for Endometriosis: 6 months and Uterine Leiomyoma 3 month	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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 (3 MONTH)	All medically accepted indications not otherwise excluded	Concomitant use with other LHRH agents.	Diagnosis of advanced prostate cancer or at risk for disease recurrence. Endometriosis: Diagnosis of endometriosis. Fibroids (Uterine leiomyomata). The patient must have a diagnosis of anemia due to uterine		Licensed Practitioner	12 months for all except for Endometriosis: 6	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	from Part D.		leiomymoma. 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 Ovarian Cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal			months and Uterine Leiomyoma 3 month	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			tumor. Patient has recurrent ovarian cancer (epithelial cell cancer, fallopian tube cancer, primary peritoneal cancer or ovarian stromal tumor).				
LYNPARZA	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced 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 chemotherapy AND The member will be using Lynparza as monotherapy.		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
LYNPARZA	All FDA-approved indications not otherwise excluded from Part D	Members that have experienced disease progression while on Lynparza (olaparib).	Ovarian Cancer Maintenance Therapy:The member has a diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND The member has been treated with at least two prior lines of platinum based chemotherapy AND The member is in complete or partial response to their last platinum regimen AND The member will utilize Lynparza (olaparib) tablets as monotherapy (capsules not indicated for maintenance therapy). Ovarian Cancer Fourth Line Treatment: 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 chemotherapy AND The member will be using Lynparza (olaparib) as monotherapy (capsules or tablets).		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
MARQIBO	All FDA approved indications not otherwise excluded from Part D.	Members who have experienced disease progression on Marqibo (vincristine sulfate liposome injection).	Acute Lymphoblastic Leukemia: The member has a diagnosis of relapsed/refractory Philadelphia chromosome-negative (Ph-) acute lymphoblastic leukemia (ALL) or member has a diagnosis of Philadelphia chromosome (Ph+) disease that is refractory to tyrosine kinase inhibitor therapy AND Marqibo will be used as a single-agent salvage therapy AND The member has had disease progression following vincristine sulfate AND One of the following applies: The member is beyond second relapse. The member has had disease progression following two or more therapies.		Licensed Practitioner	6 month duration	
MEGACE ES	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
MEKINIST	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant Yervoy (ipilimumab),or Zelboraf, Opdivo, Keytruda or Cotellic. Members that have experienced disease progression while on Mekinist (trametinib).	Melanoma: The member has a diagnosis of 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). Non-small cell lung cancer: The member has a diagnosis of recurrent or metastatic non-small cell lung cancer(NSCLC) AND The member has a BRAF V600E mutation as detected by an FDA-approved test AND The member will be using Mekinist (trametinib) in combination with Tafinlar (dabrafenib).		Licensed Practitioner	six months	
MEMANTINE	All FDA approved indications not otherwise excluded from Part D.	Diagnosis of Autism or Atypical Autism (PDD)		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.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
MODAFINIL	All medically accepted indications not otherwise excluded from Part D.		Excessive Daytime Sleepiness.For the treatment of excessive daytime sleepiness or hypersomnolence associated with Narcolepsy,obstructive sleep apnea,or due to sleep problems resulting from circadian rhythm disruption (i.e., shift-work sleep disorder). Steinert myotonic dystrophy syndrome.Member must have hypersomnia due to Steinert myotonic dystrophy syndrome.		Licensed Practitioner	Plan Year Duration	
MOLINDONE	All FDA approved indications not otherwise excluded from Part D.	Drug or alcohol induced severe central nervous system depression.	Schizophrenia:The member must utilize molindone hydrochloride for the management of clinically diagnosed schizophrenia.The member must have documentation of previous treatment, intolerance, or contraindication to two (2) of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.		Licensed Practitioner	Plan year duration	
MOZOBIL	All FDA approved indications not otherwise	Treatment or prophylaxis of neutropenia or febrile neutropenia.	Diagnosis of Non-Hodgkin's Lymphoma and/or Multiple Myeloma. Mozobil must be used in combination with Zarxio (filgrastim-sndz), Neupogen/filgrastim, or Granix (tbo-filgrastim). Mozobil must be a		Licensed Practitioner	30 days. Mozobil will be approved for a 30-	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	excluded from Part D.	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 with leukemia.	component of an autologous stem cell transplant mobilization protocol.			day interval once per transplant	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 generalized lipodystrophy.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
MYLOTARG	All FDA-approved indications not otherwise excluded from Part D	Member has experienced disease progression on Mylotarg (gemtuzumab ozogamicin)	Acute Myelogenous Leukemia: The member has a diagnosis of acute myeloid leukemia (AML) AND The member has documented CD33-positive disease AND One of the following applies: The member has newly-diagnosed disease and is an adult OR The member has relapsed/refractory disease and is an adult or pediatric patient 2 years and older		Licensed Practitioner	Approved in six month durations (maximum of 1 cycle of induction and 8 cycles of consolidation)	
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
NAMENDA	All FDA approved indications not otherwise excluded from Part D.	Diagnosis of Autism or Atypical Autism (PDD)		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 Part D.	Diagnosis of Autism or Atypical Autism (PDD)		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 XR	All FDA approved indications not otherwise excluded from Part D.	Diagnosis of Autism or Atypical Autism (PDD)		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.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
NATPARA	All FDA approved indications not otherwise excluded from Part D.	Patients with hypoparathyroidism caused by calcium-sensing receptor mutations.Patients with acute post-surgical hypoparathyroidism.	Hypocalcemia in patients with hypoparathyroidism:Member must have a diagnosis of hypocalcemia secondary to hypoparathyroidism AND Hypocalcemia is not corrected by calcium supplements and active forms of vitamin D alone AND Member is concurrently taking a calcium supplement and an active form of vitamin D.		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
NERLYNX	All FDA-approved indications not otherwise excluded from Part D	Member has disease progression on Nerlynx (neratinib). Member is not using Nerlynx (neratinib) for treatment of metastatic breast cancer. Member is taking Nerlynx (neratinib) total treatment for more than one year	Breast Cancer: Initial Therapy. The member has early stage (i.e. Stage I, II, III) documented HER2 + positive disease AND The member has completed adjuvant therapy with trastuzumab (Herceptin)containing treatment AND Nerlynx (neratinib) is being used for the treatment in extended adjuvant setting AND The member is taking antidiarrheal prophylaxis (loperamide) concomitantly during the first two cycles. Continuation of therapy. The member is not experiencing any of the following situations: Grade 4 any adverse event [e.g., diarrhea, ALT (greater than 20 times ULN), bilirubin (greater than 10 times ULN)], Greater than or equal to grade 2 diarrhea with Nerlynx (neratinib) dosing of 120mg per day AND If any of the above severe adverse reactions have been experienced, then provider has given a rationale for benefit of continued use that outweighs risk		Licensed Practitioner	Initial therapy- 3 months. Continuation therapy- 9 months	
NEULASTA	All FDA	Concomitant use	Febrile Neutropenia Prophylaxis:The		Licensed	4 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D.	(within seven days of pegfilgrastim dose) with filgrastim, tbo-filgrstim or sargramostim.Same day administration with myelosuppressive chemotherapy or therapeutic 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	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 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.		Practitioner		

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		frequently than every two weeks).					
NEUPOGEN	All FDA approved indications not otherwise excluded from Part D. Agranulocytosis, AIDS induced neutropenia, aplastic anemia, MDS.	Treatment of neutropenic patients who are afebrile unless chronic symptomatic neutropenic disorder. Same day administration with myelosuppressive chemotherapy or therapeutic radiation.Concomitant use with tbo-filgratim, sargramostim (unless part of stem cell mobilization protocol) or pegfilgrastim	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 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		Licensed Practitioner	4 months	Harvesting of peripheral blood stem cells.The member must be scheduled for autologous peripheral-blood stem cell (PBSC) transplantation, storing cells for a possible future autologous transplant, or donating stem cells for an allogeneic or syngeneic PBSC transplant. Neutropenic 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

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(within seven days of pegfilgrastim dose)	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.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).				syndrome.Treatment of Febrile Neutropenia.The member must have a diagnosis of 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 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. Hematopoietic Syndrome of Acute radiation syndrome. The member has been acutely exposed to myelosuppressive doses of radiation.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
NEXAVAR	All FDA approved indications not otherwise excluded from Part D.Gastrointestinal stromal tumor (GIST),Thyroid Carcinoma.	Members on concomitant tyrosine kinase inhibitors. Members that have experienced disease progression while on Nexavar (sorafenib).	Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma (stage IV) AND the member has experienced disease progression with Inlyta (axitinib). 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 progression with Gleevec (imatinib) or Sutent (sunitinib)or Stivarga.		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
NINLARO	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with proteasome inhibitors. Members with disease progression on Ninlaro (ixazomib).	Multiple Myeloma: The member has a diagnosis of relapsed or refractory multiple myeloma AND Ninlaro (ixazomib) will be used after disease progression on at least one prior therapy AND Ninlaro (ixazomib) will be used in combination with lenalidomide and dexamethasone and members must not be refractory to lenalidomide and proteasome inhibitors(disease progression within last 60 days of treatment).		Licensed Practitioner	six month duration	
NORTHERA	All FDA approved indications not otherwise excluded from Part D.		Neurogenic Orthostatic Hypotension: The member has symptomatic, neurogenic orthostatic hypotension (NOH) caused by:Primary autonomic failure- Parkinson's disease (PD), multiple system atrophy or pure autonomic failure OR Dopamine beta-hydroxylase deficiency OR Non-diabetic neuropathy. Reauthorization Criteria: The member has experienced a positive clinical response with Northera use (e.g.,sustained decrease in dizziness).		Licensed Practitioner	will be approved in 3 months duration. reauthorization will be approved in plan year duration.	
NOXAFIL	All FDA	Coadministration	Noxafil/posaconazole oral suspension will	Must be 13 years of	Licensed	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	approved indications not otherwise excluded from Part D.	with sirolimus,ergot alkaloids (ergotamine and dihydroergotamine), with CYP3A4 substrates terfenadine, astemizole, cisapride, pimozide, halofantrine, or quinidine can lead to QT prolongation and simvastatin.	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	age or older	Practitioner		

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			can not receive other antifungal agents due to potential toxicities, intolerance, or 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.	Members who are Epstein-Barr virus (EBV) seronegative, or have unknown EBV serostatus.	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.Member must be using belatacept in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids.		Licensed Practitioner	Plan Year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
NUPLAZID	All FDA approved indications not otherwise excluded from Part D.	Dementia related psychosis(in the absence of an approvable diagnosis)for members 65 years of age or older.	Parkinson's Disease Psychosis:The member is using Nuplazid for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis.		Licensed Practitioner	Plan Year duration	
OCTREOTIDE ACETATE	All FDA approved indications not otherwise excluded from Part D. AIDS-diarrhea, non-infective diarrhea (caused by chemotherapy), and for the acute management of potentially		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		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	life-threatening hypotension associated with carcinoid crisis.		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 Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ODOMZO	All FDA approved indications not otherwise excluded from Part D.	The member has experienced disease progression while on Odomzo.	Basal Cell Carcinoma:The member has a diagnosis of locally advanced or metastatic basal cell carcinoma AND The member has experienced recurrence or disease progression following surgery or radiation OR has a contraindication to surgery or radiation.		Licensed Practitioner	Six month duration	
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 radiation, sarcoidosis, hypersensitivity	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 Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		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,	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		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Noonan 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	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 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				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		bifida. 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,	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.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		and inflammatory bowel disease. Down syndrome and other syndromes associated with short stature and increased susceptibility to neoplasms (Bloom syndrome, Fanconi syndrome).					
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ONIVYDE	All FDA approved indications not otherwise excluded from Part D.		Pancreatic Cancer: The member has a diagnosis of metastatic adenocarcinoma of the pancreas.The member has previously received gemcitabine based therapy and experienced disease progression. The member will be using Onivyde (liposomal irinotecan) in combination with fluorouracil and leucovorin.		Licensed Practitioner.	6 months duration.	
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) in combination with Yervoy (ipilimumab) OR The member will be using Opdivo (nivolumab) as monotherapy AND One of the following criteria applies: As first-line therapy OR As subsequent therapy for disease progression, if Opdivo (nivolumab) has not been previously used. Non-Small Cell Lung Cancer:The member must have a diagnosis of metastatic squamous or non-squamous nonsmall cell lung cancer AND The member has experienced disease		Licensed Practitioner	six months	Squamous Cell Carcinoma of the Head and Neck (SCCHN): The member has a diagnosis of recurrent or metastatic squamous cell carcinoma of the head and neck AND the member will be using Opdivo (nivolumab) as monotherapy AND the member has disease progression on or after platinum based therapy. Small Cell Lung Cancer: The member has a diagnosis of small cell lung cancer (SCLC) AND the member will be

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			progression on or after chemotherapy AND The member will be using Opdivo (nivolumab) as monotherapy. Renal Cell Carcinoma: The member has a diagnosis of advanced renal cell carcinoma (RCC) AND The member will be using Opdivo (nivolumab) as monotherapy AND one of the following applies: the member has predominant clear cell histology and will be using Opdivo (nivolumab) as subsequent thearpy OR the member has non-clear cell histology. Classical Hodgkin Lymphoma: The member has a diagnosis of classical Hodgkin Lymphoma AND The member will be using Opdivo (nivolumab) as monotherapy AND One of the following criteria applies: The member has relapsed or refractory disease OR The member has relapsed or progressed, following autologous stem cell transplant and maintenance Adcetris (brentuximab vedotin) OR The member will be using Opdivo (nivolumab) as palliative therapy.				using Opdivo (nivolumab) for subsequent therapy AND the member will be using Opdivo (nivolumab) as monotherapy or in combination with Yervoy (ipilimumab) for one of the following: Disease relapse within 6 months following complete response, partial response, or stable disease with initial treatment OR Progressive disease. Urothelial Cancer: The member has a diagnosis of locally advanced or metastatic urothelial cancer AND the member will be using Opdivo (nivolumab) as a monotherapy AND One of the following apply: the member will be using Opdivo (nivolumab) as a second or subsequent line therapy OR the member has had disease progression within 12 months

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
							of neoadjuvant or adjuvant treatment.
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).		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 6 years or older.	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
OXANDROLONE	All medically accepted indications not otherwise excluded from Part D.	Enhancement of athletic performance.	Oxandrolone will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Cachexia associated with AIDS wasting syndrome: weight loss from cancer chemotherapy, severe burns, spinal cord injury, Corticosteroid-induced protein catabolism, Symptomatic treatment of bone pain accompanying osteoporosis, Alcoholic hepatitis, Turner Syndrome, Constitutional delay in growth and puberty, Duchenne muscular dystrophy.		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
PALIPERIDONE	All medically accepted indications not otherwise excluded from Part D.	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Bipolar Disorder, Acute Manic and Mixed Episodes:The member must have a diagnosis of bipolar disorder (acute manic and mixed episodes). 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 or aripiprazole. Schizophrenia: The member must have a diagnosis of schizophrenia. 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 or aripiprazole. Schizoaffective Disorder: The member must have a diagnosis of schizoaffective disorder. 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 or aripiprazole.	Age 18 or older for Bipolar Disorder, Acute Manic and Mixed Episodes and for Schizoaffective Disorder and age 12 or older for Schizophrenia.	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
PEGASYS	All FDA approved indications not otherwise excluded from Part D.		Chronic Hepatitis C (CHC): Diagnosis of chronic hepatitis C with compensated liver disease. HCV RNA level must be documented prior to therapy.The member must have a diagnosis of chronic HBeAG-positive or HBeAG-negative hepatitis B.	Member must age 5 or above	Licensed Practitioner	12 to 120 week treatment course depending on the disease state and/or genotype	
PEGASYS PROCLICK	All FDA approved indications not otherwise excluded from Part D.		Chronic Hepatitis C (CHC): Diagnosis of chronic hepatitis C with compensated liver disease. HCV RNA level must be documented prior to therapy.The member must have a diagnosis of chronic HBeAG-positive or HBeAG-negative hepatitis B.	Member must age 5 or above	Licensed Practitioner	12 to 120 week treatment course depending on the disease state and/or genotype	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
PEGINTRON	All FDA approved indications not otherwise excluded from Part D.	PegIntron monotherapy in a pegylated interferon-experienced member.	The member must have a diagnosis of chronic hepatitis C with compensated liver disease:Viral genotype and baseline HCV RNA level must be documented prior to therapy.	must be age 3 or older	Licensed Practitioner	total of 12 to 120 weeks depending on disease state and genotype, one year for monotherapy	
PEGINTRON REDIPEN	All FDA approved indications not otherwise excluded from Part D.	PegIntron monotherapy in a pegylated interferon-experienced member.	The member must have a diagnosis of chronic hepatitis C with compensated liver disease:Viral genotype and baseline HCV RNA level must be documented prior to therapy.	must be age 3 or older	Licensed Practitioner	total of 12 to 120 weeks depending on disease state and genotype, one year for monotherapy	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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	
PERJETA	All FDA approved indications not otherwise excluded from Part D.		Breast Cancer. Diagnosis of metastatic breast cancer. The member has a diagnosis of metastatic breast cancer and HER2 (human epidermal growth factor receptor2) positive disease (e.g.defined as IHC 3+ or ISH positive [single-probe average HER2 copy number greater than or equal to 6.0 signals/cell: dual-probe		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			HER2/CEP17 ratio greater than or equal to 2.0 with an average HER2 copy number greater than or equal to 4.0 signals per cell: dual-probe HER2/CEP17 ratio greater than or equal to 2.0 with an average HER2 copy number less than 4.0 signals/cell: dual-probe HER2/CEP17 ratio less than 2.0 with an average HER2 copy number greater than or equal to 6.0 signals/cell]) AND will be receiving Perjeta (pertuzumab) in combination with trastuzumab and docetaxel or paclitaxel AND has not received prior anti-HER2 therapy or chemotherapy for metastatic disease OR the member has received prior cytotoxic therapy with or without Herceptin for second or subsequent line of therapy 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 HER2 positive disease (e.g., defined as IHC 3+ or ISH positive [single-probe average HER2 copy number greater than or equal to 6.0 signals/cell:				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			dual-probe HER2/CEP17 ratio greater than or equal to 2.0 with an average HER2 copy number greater than or equal to 4.0 signals per cell: dual-probe HER2/CEP17 ratio greater than or equal to 2.0 with an average HER2 copy number less than 4.0 signals/cell: dual-probe HER2/CEP17 ratio less than 2.0 with an average HER2 copy number greater than or equal to 6.0 signals/cell]) AND (one of the following applies):Perjeta (pertuzumab) will be used in combination with trastuzumab and docetaxel or paclitaxel as neoadjuvant treatment OR Perjeta (pertuzumab) will be used as adjuvant treatment in conjunction with chemotherapy if a pertuzumab containing regimen was not use as neoadjuvant therapy.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
POMALYST	All FDA approved indications not otherwise excluded from Part D.	Members receiving concomitant therapy with an immunomodulator. The member has experienced disease progression while on Pomalyst (pomalidomide).	Multiple Myeloma: The member has a diagnosis of Multiple Myeloma AND The member has received at least two previous regimens AND The member has demonstrated disease progression while on Revlimid (lenalidomide) OR Thalomid (thalidomide) AND The member demonstrated disease progression while on a protease inhibitor (e.g. bortezomib, carflizomib) AND The member demonstrated disease progression on or within 60 days of completion of the last therapy regimen.		Licensed Practitioner	Six month duration	
PORTRAZZA	All FDA approved indications not otherwise excluded from Part D.	The member has experienced disease progression while on Portrazza (necitumumab).	Non-Small Cell Lung Cancer:The member has a diagnosis of metastatic squamous non-small cell lung cancer AND The member will be initially using Portrazza (necitumumab) in combination with gemcitabine and cisplatin AND The member will be using Portrazza (necitumumab) as first-line treatment.		Licensed Practitioner	six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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	
PRALUENT PEN	All FDA approved indications not otherwise excluded from Part D.		Heterozygous Familial Hypercholesterolemia:The member must have a diagnosis of definite heterozygous familial hypercholesterolemia (HeFH) as defined by at least one of the following: Total cholesterol greater than 7.5 mmol/L (290 mg/dL) or LDL cholesterol above 4.9 mmol/L (190 mg/dL) in an adult with tendon xanthomas in member, or in a 1st degree relative (parent, sibling, child), or in a 2nd degree relative(grandparent, uncle, aunt) OR Genetic confirmation of only 1 mutant allele at the LDL receptor or Apo B: Praluent (alirocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g., atorvastatin or rosuvastatin) in members	The member must be 18 years or older.	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			that have failed to achieve goal LDL-C reduction OR The member is determined to be intolerant to statin therapy. Intolerance to statin therapy may include: Skeletal-muscle related symptoms with both rosuvastatin and atorvastatin (at least one initiated at the lowest starting daily dose),Statin-associated rhabdomyolysis to one statin OR Provider attestation of intolerance to statin therapy.				
PRALUENT SYRINGE	All FDA approved indications not otherwise excluded from Part D.		Heterozygous Familial Hypercholesterolemia:The member must have a diagnosis of definite heterozygous familial hypercholesterolemia (HeFH) as defined by at least one of the following: Total cholesterol greater than 7.5 mmol/L (290 mg/dL) or LDL cholesterol above 4.9 mmol/L (190 mg/dL) in an adult with tendon xanthomas in member, or in a 1st degree relative (parent, sibling, child), or in a 2nd degree relative(grandparent, uncle, aunt) OR Genetic confirmation of only 1 mutant allele at the LDL receptor or	The member must be 18 years or older.	Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Apo B: Praluent (alirocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g., atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to be intolerant to statin therapy. Intolerance to statin therapy may include: Skeletal-muscle related symptoms with both rosuvastatin and atorvastatin (at least one initiated at the lowest starting daily dose),Statin-associated rhabdomyolysis to one statin OR Provider attestation of intolerance to statin therapy.				
PROCRIT	All FDA approved indications not otherwise excluded from Part D. Myelodysplastic	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		Licensed Practitioner	3 months for chemo induced anemia,HIV,HCV,MDS,RA,surgery and 6 months for CKD	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Syndrome, Hepatitis C, Rheumatoid Arthritis.		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				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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 10 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.				
PROMACTA	All FDA approved indications not otherwise excluded	Concomitant use with other platelet stimulating factors such as Nplate (romiplostim) or Neumega	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		Licensed Practitioner	6 month duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	from Part D.	(oprelvekin). ITP members with previous documented failure of eltrombopag.	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 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				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
QUETIAPINE	All FDA approved indications not otherwise excluded from Part D.	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Schizophrenia or bipolar I disorder (manic or mixed episodes):Must have one of the following clinically diagnosed conditions: Schizophrenia or bipolar I disorder, manic or mixed episodes 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 or aripiprazole.Bipolar Depression:The member must have a diagnosis of bipolar depression and the member must have documentation of previous treatment with queitapine.Major depressive disorder:The member must have a diagnosis of Major Depressive Disorder and The member must have documentation of previous treatment, intolerance, or contraindication to at least 2 other antidepressant therapies (ADT).		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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	
REBIF (WITH ALBUMIN)	All FDA approved indications not otherwise excluded from Part D.	Concurrent therapy with Avonex, Betaseron, Extavia.	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	
REBIF REBIDOSE	All FDA approved indications not otherwise excluded from Part D.	Concurrent therapy with Avonex, Betaseron, Extavia.	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 Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
REBIF TITRATION PACK	All FDA approved indications not otherwise excluded from Part D.	Concurrent therapy with Avonex, Betaseron, Extavia.	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	
REMICADE	All FDA approved indications not otherwise excluded from Part D.	Combination therapy with other biologicals such as Enbrel, Humira, Cimzia, Simponi, Orencia, or Kineret.	Psoriatic arthritis: Diagnosis of active psoriatic arthritis. Member has had prior therapy, contraindication, or intolerance with an NSAIDs (e.g. meloxicam, ibuprofen, naproxen) AND Member has had prior therapy, contraindication, or intolerance with ONE of the following DMARDs: Sulfasalazine, Methotrexate, Cyclosporine, Leflunomide. Ulcerative colitis: Diagnosis of moderately to severely active ulcerative colitis. Member has had prior therapy, contraindication, or intolerance with a conventional therapy including: 5-aminosalicylic acids (e.g. mesalamine, olsalazine) or corticosteroids (e.g.prednisone, hydrocortisone, methylprednisolone) or	Must be 18 years of age for Plaque Psoriasis and Rheumatoid Arthritis.	Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			immunomodulators (e.g. azathioprine, 6-mercaptopurine). Ankylosing Spondylitis: Diagnosis of highly persistent, active ankylosing spondylitis. Member has had prior therapy, contraindication, or intolerance with at least one non-steroidal anti-inflammatory drugs (NSAIDs) (e.g.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 prior therapy, contraindication, or intolerance with a corticosteroid (e.g.prednisone, hydrocortisone) OR immunosuppressive agents (e.g. mesalamine, olsalazine, azathioprine, or 6-mercaptopurine).				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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) or Adempas (riociguat).		Licensed Practitioner	Plan Year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
REPATHA PUSHTRONEX	All FDA approved indications not otherwise excluded from Part D.		Heterozygous Familial Hypercholesterolemia (HeFH):The member must have a diagnosis of definite HeFH as defined by at least one of the following: Total cholesterol greater than 7.5 mmol/L (290 mg/dL) or LDL cholesterol above 4.9 mmol/L (190 mg/dL) in an adult with tendon xanthomas in member or in a 1st degree relative (parent, sibling, child), or in a 2nd degree relative (grandparent, uncle, aunt) OR Genetic confirmation of at least 1 mutant allele at the LDL receptor or Apo – B. Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C recduction OR The member is determined to be intolerant to statin therapy:Intolerance to statin therapy may include:Skeletal-muscle related symptoms with both rosuvastatin and atorvastatin (at least one initiated at the lowest starting daily dose).Statin-associated rhabdomyolysis to one statin OR Provider	Member must be 18 years of age or older for diagnosis of Heterozygous Familial Hypercholesterolemia or Clinical Atherosclerotic Cardiovascular Disease	Licensed Practitioner.	Plan year duration	Clinical Atherosclerotic Cardiovascular Disease (ASCVD):The member must have documentation of a ASCVD (e.g.acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin). Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to be intolerant to statin therapy. Intolerance to statin therapy may

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			attestation of intolerance to statin therapy.				include:Skeletal-muscle related symptoms with both rosuvastatin and atorvastatin (at least one initiated at the lowest starting daily dose).Statin-associated rhabdomyolysis to one statin OR Provider attestation of intolerance to statin therapy. Homozygous Familial Hypercholesterolemia (HoFH):The member must have a diagnosis of definite HoFH as defined by at least one of the following: Genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or ARH adaptor protein gene locus OR An untreated LDL-C greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) or treated non-HDL cholesterol greater than or

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
							equal to 330 mg/dL (8.5 mmol/L) with at least one of the following:Cutaneous or tendon xanthoma before age 10 years OR Elevated LDL cholesterol levels before lipid-lowering consistent with HeFH in both parents [untreated total cholesterol greater than 290 mg/dL (7.5 mmol/L) or untreated LDL-C greater than 190 mg/dL (4.9 mmol/L)]. For HoFH diagnosis only: Repatha (evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.
REPATHA SURECLICK	All FDA approved indications not		Heterozygous Familial Hypercholesterolemia (HeFH):The member must have a diagnosis of definite HeFH as defined by at least one of the	Member must be 18 years of age or older for diagnosis of Heterozygous Familial	Licensed Practitioner.	Plan year duration	Clinical Atherosclerotic Cardiovascular Disease (ASCVD):The member must have documentation of a

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	otherwise excluded from Part D.		following: Total cholesterol greater than 7.5 mmol/L (290 mg/dL) or LDL cholesterol above 4.9 mmol/L (190 mg/dL) in an adult with tendon xanthomas in member or in a 1st degree relative (parent, sibling, child), or in a 2nd degree relative (grandparent, uncle, aunt) OR Genetic confirmation of at least 1 mutant allele at the LDL receptor or Apo – B. Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C recduction OR The member is determined to be intolerant to statin therapy:Intolerance to statin therapy may include:Skeletal-muscle related symptoms with both rosuvastatin and atorvastatin (at least one initiated at the lowest starting daily dose).Statin-associated rhabdomyolysis to one statin OR Provider attestation of intolerance to statin therapy.	Hypercholesterolemia or Clinical Atherosclerotic Cardiovascular Disease			ASCVD (e.g.acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin). Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to be intolerant to statin therapy. Intolerance to statin therapy may include:Skeletal-muscle related symptoms with both rosuvastatin and atorvastatin (at least one initiated at the

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
							lowest starting daily dose).Statin-associated rhabdomyolysis to one statin OR Provider attestation of intolerance to statin therapy. Homozygous Familial Hypercholesterolemia (HoFH):The member must have a diagnosis of definite HoFH as defined by at least one of the following: Genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or ARH adaptor protein gene locus OR An untreated LDL-C greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) or treated non-HDL cholesterol greater than or equal to 330 mg/dL (8.5 mmol/L) with at least one of the following:Cutaneous or tendon xanthoma before age

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
							10 years OR Elevated LDL cholesterol levels before lipid-lowering consistent with HeFH in both parents [untreated total cholesterol greater than 290 mg/dL (7.5 mmol/L) or untreated LDL-C greater than 190 mg/dL (4.9 mmol/L)]. For HoFH diagnosis only: Repatha (evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.
REPATHA SYRINGE	All FDA approved indications not otherwise excluded from Part D.		Heterozygous Familial Hypercholesterolemia (HeFH):The member must have a diagnosis of definite HeFH as defined by at least one of the following: Total cholesterol greater than 7.5 mmol/L (290 mg/dL) or LDL cholesterol above 4.9 mmol/L (190 mg/dL) in an adult with tendon xanthomas in member or in a	Member must be 18 years of age or older for diagnosis of Heterozygous Familial Hypercholesterolemia or Clinical Atherosclerotic Cardiovascular	Licensed Practitioner.	Plan year duration	Clinical Atherosclerotic Cardiovascular Disease (ASCVD):The member must have documentation of a ASCVD (e.g.acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			1st degree relative (parent, sibling, child), or in a 2nd degree relative (grandparent, uncle, aunt) OR Genetic confirmation of at least 1 mutant allele at the LDL receptor or Apo – B. Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C recduction OR The member is determined to be intolerant to statin therapy:Intolerance to statin therapy may include:Skeletal-muscle related symptoms with both rosuvastatin and atorvastatin (at least one initiated at the lowest starting daily dose).Statin-associated rhabdomyolysis to one statin OR Provider attestation of intolerance to statin therapy.	Disease			or other arterial revascularization, stroke, transient ischemic attack or peripheral arterial disease, all of presumed atherosclerotic origin). Repatha (evolocumab) is used as adjunctive therapy to maximally tolerated high-intensity statin therapy (e.g. atorvastatin or rosuvastatin) in members that have failed to achieve goal LDL-C reduction OR The member is determined to be intolerant to statin therapy. Intolerance to statin therapy may include:Skeletal-muscle related symptoms with both rosuvastatin and atorvastatin (at least one initiated at the lowest starting daily dose).Statin-associated rhabdomyolysis to one statin OR Provider attestation of

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
							intolerance to statin therapy. Homozygous Familial Hypercholesterolemia (HoFH):The member must have a diagnosis of definite HoFH as defined by at least one of the following: Genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or ARH adaptor protein gene locus OR An untreated LDL-C greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) or treated non-HDL cholesterol greater than or equal to 330 mg/dL (8.5 mmol/L) with at least one of the following:Cutaneous or tendon xanthoma before age 10 years OR Elevated LDL cholesterol levels before lipid-lowering consistent with HeFH in both parents

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
							[untreated total cholesterol greater than 290 mg/dL (7.5 mmol/L) or untreated LDL-C greater than 190 mg/dL (4.9 mmol/L)]. For HoFH diagnosis only: Repatha (evolocumab) is used as adjunctive therapy to other LDL-lowering therapies (e.g. statins, ezetimibe) in members that have failed to achieve goal LDL-C reduction.
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 FDA approved	Members on concomitant	Myelodysplastic Syndromes (MDS) with 5Q deletion. Diagnosis of MDS with		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D. Hodgkins Lymphoma, Non-Hodgkins Lymphoma,Chronic lymphoid leukemia.	Thalomid (thalidomide).Members that have experienced disease progression while on Revlimid (lenalidomide).	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 failed or has a low probability of response to immunosuppressive therapy (such as ATG or cyclosporine.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				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Leukemia (CLL).For Reauthorizations: The approval duration may be continued for six additional months if benefit is shown via no evidence of disease progression. Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma (MCL) AND the member has relapsed ,refractory or progressive disease.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
REXULTI	All FDA approved indications not otherwise excluded from Part D.	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	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 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.	The member must be 18 years or older.	Licensed Practitioner	Plan year duration	
RITUXAN	All medically accepted indications not otherwise excluded from Part D.	High dose CLL therapies (doses greater than 500mg/m^2).	Chronic Lymphocytic Leukemia.The member has a diagnosis of CLL.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		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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.Hodgkin's Disease (Hodgkin's Lymphoma). The patient has a diagnosis of Hodgkin's Disease. The member will be using Rituxan for primary treatment or for relapsed or progressive disease.Disease has confirmed CD20 positivity. Rheumatoid Arthritis. For moderately- to severely-active rheumatoid arthritis. The member has had previous treatment with one or more tumor-necrosis-factor antagonist				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			therapies including infliximab. The member must be on concomitant treatment with methotrexate during rituximab therapy, unless contraindicated or intolerant to methotrexate.				
RITUXAN HYCELA	All FDA approved indications not otherwise excluded from Part D.	The member will be using Rituxan Hycela (rituximab/hyaluronidase) for the treatment of a non-malignant condition (e.g. rheumatoid arthritis). The member will be using Rituxan Hycela(rituximab/hyaluronidase) as a single agent for chronic lymphocytic leukemia (CLL). The member will	Chronic Lymphocytic Leukemia: The member must have a diagnosis of chronic lymphocytic leukemia AND The member will be using Rituxan Hycela in combination with fludarabine and cyclophosphamide AND The member must receive at least one full dose of rituximab by intravenous infusion without experiencing severe adverse reactions. Follicular lymphoma: The member has a diagnosis of follicular lymphoma AND The member must receive at least one full dose of rituximab by intravenous infusion without experiencing severe adverse reactions AND One of the following applies: Previously untreated disease and will be using Rituxan Hycela in combination with first line chemotherapy and, in patients achieving a complete or		Licensed Practitioner.	12 months duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		be using Rituxan Hycela(rituximab/hyaluronidase) as maintenance therapy for diffuse large B cell lymphoma (DLBCL). The member will be using Rituxan Hycela (rituximab/hyaluronidase) as a single agent for first-line therapy in follicular lymphoma (FL).	partial response to Rituxan Hycela in combination with chemotherapy, as single-agent maintenance therapy OR Non-progressing (including stable disease) disease, as a single agent after first line cyclophosphamide, vincristine, and prednisone chemotherapy OR Relapsed or refractory disease, as a single agent. Diffuse large B cell lymphoma: The member has a diagnosis of diffuse large B cell lymphoma AND The member has previously untreated disease and will be using Rituxan Hycela in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone or with another anthracycline-based chemotherapy regimen AND The member must receive at least one full dose of rituximab by intravenous infusion without experiencing severe adverse reactions.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
RUBRACA	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced disease progression while on PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib)]	BRCA-Mutated Advanced Ovarian Cancer:The member has a diagnosis of advanced ovarian cancer AND The member has deleterious BRCA mutation (germline and/or somatic) as detected by an FDA-approved test AND The member has been treated with two or more prior lines of chemotherapy AND The member will utilize Rubraca (rucaparib) as a monotherapy.		Licensed Practitioner.	6 month duration	
RYDAPT	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced disease progression while on or following Rydapt (midostaurin), Members with a diagnosis of therapy-related acute myeloid leukemia (defined as acute myeloid leukemia due to	Acute Myeloid Leukemia: The member has newly diagnosed acute myeloid leukemia (AML) AND The member has documented FLT3 mutation-positive disease AND The member will be using Rydapt (midostaurin) in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy. Systemic Mastocytosis: The member has a diagnosis of aggressive systemic mastocytosis (ASM),systemic mastocytosis with associated hematologic neoplasm (SM-AHN), or mast cell leukemia (MCL).		Licensed Practitioner.	6 Months Duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		prior radiation therapy or prior chemotherapy used as therapy for a prior disorder or malignancy), Members with a diagnosis of acute promyelocytic leukemia (APL), Members that are using Rydapt (midostaurin) for post-consolidation therapy, Members that are using Rydapt (midostaurin) as a single agent induction therapy for acute myeloid leukemia					

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 LAR DEPOT	All FDA approved indications not otherwise excluded from Part D. AIDS-		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		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	diarrhea, non-infective diarrhea (caused by chemotherapy), and for the acute management of potentially life-threatening hypotension associated with carcinoid crisis.		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				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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).				
SAPHRIS (BLACK CHERRY)	All FDA approved indications not otherwise excluded from Part D.	Major depressive disorder. Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Schizophrenia/Bipolar I Disorder, manic or mixed episodes. The member must be utilizing it for treatment of schizophrenia,or bipolar I disorder.The member must have previous treatment or intolerance or contraindication to at least 2 of the following: risperidone or olanzapine or quetiapine or ziprasidone or aripiprazole.		Licensed Practitioner	Plan Year Duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
SEROQUEL XR	All FDA approved indications not otherwise excluded from Part D.	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Schizophrenia or bipolar I disorder (manic or mixed episodes):Must have one of the following clinically diagnosed conditions: Schizophrenia or bipolar I disorder, manic or mixed episodes 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 or aripiprazole.Bipolar Depression:The member must have a diagnosis of bipolar depression and the member must have documentation of previous treatment with queitapine.Major depressive disorder:The member must have a diagnosis of Major Depressive Disorder and The member must have documentation of previous treatment, intolerance, or contraindication to at least 2 other antidepressant therapies (ADT).		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 (e.g. 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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
SIGNIFOR	All FDA approved indications not otherwise excluded from Part D.		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.	
SILDENAFIL (ANTIHYPERTENSIVE)	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.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 must be 18 years or older.	Licensed Practitioner	Plan year duration	
SIRTURO	All FDA approved indications not otherwise excluded from Part D.	Concomitant use with a systemic strong CYP3A4 inhibitor for longer than 14 days. Concomitant use with a strong CYP3A4 inducer.	Multidrug-resistant tuberculosis (MDR-TB). The member must have a diagnosis of pulmonary multidrug-resistant tuberculosis (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.		Licensed Practitioner	24 weeks duration	
SKELAXIN	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
SOLARAZE	All FDA approved indications not otherwise excluded from Part D.		Actinic Keratosis:The member has a diagnosis of actinic keratosis.The member has trial,intolerance, or contraindication to generic imiquimod 5% cream AND topical fluorouracil.		Licensed Practitioner	Plan year duration	
SOMA	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 Instructions	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 liver disease.Baseline HCV RNA must be documented. HCV genotype has been documented. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HbsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy. For all genotypes, criteria will be applied consistent with current AASLD-IDSA guidance. Chronic Hepatitis C - Pediatrics: Member must have a diagnosis of chronic hepatitis C infection. Member must have documented Genotype 2 or 3 infection. HCV RNA level must be documented prior to therapy. Member must be 12 years of age or older or weigh at least 35kg. Sovaldi must be used in combination with ribavirin. Member must be tested for the presence of HBV by screening for the surface antigen of HBV (HBsAg) and anti-hepatitis B core total antibodies (anti-HBc) prior to initiation of therapy.	The member must be 18 years or older. Pediatric indications: The member must be 12 years or older.	Licensed Practitioner	GT 1,2,3,4= 12-24 wks.GT 5,6=12 wks. Cirrhosis= 24-48 wks.Post liver transplant = 12-48 wks	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
SPRYCEL	All FDA approved indications not otherwise excluded from Part D.GIST, ALL(induction/consolidation)	Members on concomitant tyrosine kinase inhibitors, Members that have experienced 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 treatment is for maintenance therapy or the treatment of members with resistance or intolerance to prior therapy. 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)or Stivarga.		Licensed Practitioner	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
STALEVO 100	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	
STALEVO 125	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	
STALEVO 150	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
STALEVO 200	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	
STALEVO 50	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	
STALEVO 75	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	
STIVARGA	All FDA approved	The member has experienced	Metastatic Colorectal Cancer.The member has a diagnosis of metastatic colorectal		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	indications not otherwise excluded from Part D.	disease progression while on Stivarga (regorafenib).Members on concomitant tyrosine kinase inhibitors.	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: 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 disease progression, intolerance, or contraindication with imatinib mesylate and sunitinib malate. Hepatobiliary Cancers: The member has a diagnosis of hepatocellular carcinoma AND Stivarga (regorafenib) is being given as				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			monotherapy AND The member has experienced progression on or after sorafenib (Nexavar).				
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
STRENSIQ	All FDA approved indications not otherwise excluded from Part D.		Hypophosphatasia (HPP):The member must have a diagnosis of perinatal-onset, infantile-onset, or juvenile onset hypophosphatasia. Hypophosphatasia (HPP):The member must have a diagnosis of perinatal-onset, infantile-onset, or juvenile-onset hypophosphatasia defined by:Low total serum alkaline phosphatase (ALP) activity determined by the gender- and age-specific reference range, AND Elevated urine concentration of phosphoethanolamine (PEA) determined by age-specific reference range, OR Elevated serum pyridoxal 5'-phosphate (PLP) level (normal range 5 – 50 mcg/L), OR Documented gene mutation of tissue-nonspecific alkaline phosphatase (TNSALP).		Licensed Practitioner	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
SUBOXONE	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: For induction, members should be exhibiting early symptoms of withdrawal. Buprenorphine injectable Must have diagnosis of Moderate to Severe Pain.		Licensed Practitioner	6 month duration.	
SULAR	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	
SUTENT	All medically accepted indications not otherwise excluded by Part D.	Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progression while on Sutent.	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)		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			AND The member has unresectable locally advanced or metastatic disease. Advanced Thyroid Carcinoma. Diagnosis of advanced/metastatic follicular carcinoma, Hurthle cell carcinoma, papillary or medullary carcinoma (types of thyroid carcinoma) and clinical trials are not available or appropriate. Follicular, papillary, or Hurthle 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).Thymomas/thymic carcinoma: The member will be using as monotherapy in the second line. Lung Neuroendocrine				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			Tumors. The member has a diagnosis of Stage III-IV low or intermediate grade neuroendocrine tumors.				
SYLATRON	All medically accepted 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. Myeloproliferative Neoplasms. The member has a diagnosis of symptomatic low risk myelofibrosis.		Licensed Practitioner	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 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.		Licensed Practitioner	6 month duration	
SYNAGIS	All FDA approved indications		Chronic Lung Disease (CLD) or Prematurity: Infants and children younger than one year of age at the beginning of		Licensed Practitioner	Plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	not otherwise excluded from Part D.		RSV season: Diagnosed with CLD of prematurity defined as gestational age less than 32 weeks and a requirement of greater than 21% oxygen for at least 28 days after birth OR Infants and children younger than two years of age at the beginning of RSV season: Diagnosis of CLD of prematurity and continues to require medical intervention (e.g., supplemental oxygen, diuretic therapy, or chronic corticosteroid therapy) during the six month before the start of the RSV season. (Maximum of five monthly doses). Prematurity. Infants born less than 29 weeks gestation AND less than 12 months old (chronologic age) at the start of RSV season (Maximum of five monthly doses). Congenital Abnormalities of the Airway or Neuromuscular. Infants and children who are one year of age or younger at the start of RSV season with neuromuscular disease or congenital pulmonary abnormalities that impairs the ability to clear secretions from upper airway: (Maximum of five monthly doses).				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
SYNRIBO	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors.Members that have experienced 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 One of the following applies: The member has had prior therapy, intolerance, or resistance to at least two of the following tyrosine kinase inhibitors: Bosulif, Gleevec, Sprycel, or Tasigna. OR The member has a documented T315I mutation.		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
TAFINLAR	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant Yervoy (ipilimumab), Zelboraf, Opdivo, Keytruda or Cotellic. Members that have experienced disease progression while on Tafinlar (dabrafenib).Members that have experienced disease progression while on Zelboraf (vemurafenib).	Melanoma: The member has a diagnosis of 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 or in combination with Mekinist (trametinib). Non-small cell lung cancer: The member has a diagnosis of recurrent or metastatic non-small cell lung cancer (NSCLC) AND The member has a BRAF V600E mutation as detected by an FDA-approved test AND The member will be using Tafinlar (dabrafenib) in combination with Mekinist (trametinib).		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
TAGRISSO	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors. Members who have disease progression on Tagrisso (osimertinib).	Non small cell lung cancer NSCLC:The member has a diagnosis of metastatic non small cell lung cancer (NSCLC) and the following criteria applies: The member has a documented epidermal growth factor receptor (EGFR) T790M mutation as detected by an FDA approved test AND Tagrisso (osimertinib) is used as monotherapy after progression of EGFR inhibitors (e.g., erlotinib, gefitinib)		Licensed Practitioner	Six month duration	
TARCEVA	All FDA approved indications not otherwise excluded from Part D.Renal Cell Carcinoma.	Members on concomitant tyrosine kinase inhibitors.	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).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:		Licensed Practitioner	six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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 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.Renal Cell Carcinoma: Diagnosis of relasped or unresectable stage IV renal cell carcinoma with non clear histology and Tarceva will be used as monotherapy and Tarceva will be used as first line therapy.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
TASIGNA	All FDA approved indications not otherwise excluded from Part D.Acute Lymphoblastic Leukemia(ALL).Advanced Gastrointestinal Stromal Tumor (GIST).	Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progression while on Tasigna (nilotinib).	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), Sutent (sunitinib),or Stivarga.Acute Lymphoblastic Leukemia (ALL). The member has diagnosis of Philadelphia positive acute lymphoblastic leukemia.		Licensed Practitioner	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
TAZAROTENE	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	
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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
TECENTRIQ	All FDA approved indications not otherwise excluded from Part D.	Disease progression while on anti-PD-1/PD-L1 therapy (e.g. Opdivo [nivolumab], Keytruda [pembrolizumab], Tecentriq [atezolizumab]	Urothelial cancer:The member has a diagnosis of locally advanced or metastatic urothelial cancer AND The member will be using Tecentriq (atezolizumab) as a single agent AND One of the following apply: The member will be using Tecentriq (atezolizumab) as a second-line therapy OR The member has had disease progression within 12 months of neoadjuvant or adjuvant treatment OR the member is ineligible for cisplatin containing chemotherapy due to one of the following: creatinine clearance great than 30 ml/min but less than 60 ml/min or hearing loss greater than or equal to 25 dB OR greater than or equal to Grade 2 peripheral neuropathy or ECOG status of 2. Non-Small Cell Lung Cancer: The member must have a diagnosis of metastatic squamous or non-squamous nonsmall cell lung cancer AND the member has experienced disease progression on or after chemotherapy AND the member will be using Tecentriq (atezolizumab) as monotherapy.		Licensed Practitioner	Six month durations	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
TEMODAR	All FDA-approved indications not otherwise excluded from Part D.		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 as a single agent or in combination with radiotherapy OR Maintenance therapy for GBM or anaplastic astrocytoma or treatment of recurrent disease as a single agent or in combination with Avastin 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 for recurrent or progressive disease OR The member must use Temodar (temozolomide) as a signle agent as		Licensed Practitioner	six months	Neuroendocrine Tumors of the Lung: The member has stage IIIb OR stage IV low-or intermediate-grade neuroendocrine carcinoma 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

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			adjuvant thearpy. Ewing's Sarcoma: 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 diagnosis of unresectable locoregional and/or distant metastatic neuroendocrine tumors of the pancreas (islet cell tumors) and Temodar is being as single agent or in combo with Xeloda for the management				with bulky lymph nodes or visceral disease. Refractory or progressive stage III MF or SS. Primary Central Nervous System (CNS) Lymphoma: The member has a diagnosis or primary CNS lymphoma and will be using Temodar as part of induction therapy in combination with high-dose methotrexate and Rituxan OR The member has progressive or recurrent primary CNS lymphoma and Temodar (temozolomide) is being used as a single agent or in combination with Rituxan 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

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			of symptomatic disease, clinically significant tumor burden or clinically significant progression.				regimen OR In combination with radiation therapy after short or no response to prior regimen. Soft tissue sarcoma: The member has diagnosis of soft tissue sarcoma.
TETRABENAZINE	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	
THALOMID	All FDA approved indications not otherwise excluded from Part D. Waldenstrom's Macroglobulinemia	Members on concomitant Revlimid (lenalidomide).Members that have experienced 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		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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).				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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.		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
TOLCAPONE	All FDA approved indications not otherwise excluded from Part D.	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.	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 has not achieved adequate symptom control after previous treatment with Comtan or Stalevo.		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
TORISEL	All FDA-approved indications not otherwise excluded from Part D. Relapsed or Refractory Mantle Cell Lymphoma and Endometrial Cancer.	Patients that have experienced significant disease progression while on temsirolimus.	The member has a diagnosis of advanced/metastatic 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). 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 primary treatment. OR The member has a diagnosis of recurrent or metastatic endometrial cancer.		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 antagonist (e.g., Letairis).	Pulmonary Arterial Hypertension (PAH). The member has a diagnosis of pulmonary arterial hypertension (WHO Group I).		Licensed Practitioner	Plan Year Duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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	
TREANDA	All FDA approved indications not otherwise excluded from Part D. Hodgkins Lymphoma,	Members who experience disease progression on bendamustine containing regimens.	Diagnosis of Chronic Lymphocytic Leukemia (CLL). The member has a diagnosis of CLL without del(17p)/TP53 mutation and with or without del(11q).Treanda is being used for relapsed or refractory disease or as first line therapy. Diagnosis of Multiple Myeloma (MM). Treanda is being used for disease relapse or for progressive or		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Mutiple Myeloma,Waldenstroms.		refractory disease. Non-Hodgkin's Lymphoma:The member has a diagnosis of follicular lymphoma, gastric MALT lymphoma or nongastric MALT lymphoma and is using Treanda.Diagnosis of mantle cell lymphoma and Treanda 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 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 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-				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			cell lymphoma and Treanda is being used as second-line therapy or subsequent therapy .The member has a diagnosis of AIDS-related B-cell lymphoma and Treanda is being used as second-line therapy or subsequent.				
TRELSTAR	All FDA-approved indications not otherwise excluded from Part D.	Female members who are pregnant or lacting. Concomitant use with other LHRH agonists.	Prostate Cancer.The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence.		Licensed Practitioner	12 months	
TRETINOIN	All FDA-approved indications not otherwise excluded from Part D.		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 medically necessary, FDA approved, non-cosmetic indication.		Licensed Practitioner	Plan year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
TRIBENZOR	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	
TYKERB	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant tyrosine kinase inhibitors.Members that have experienced disease progressionwhile on Tykerb (lapatinib).	Breast Cancer. The member has a diagnosis of HER2(human epidermal growth factor receptor2) positive advanced or metastatic breast cancer AND The member had prior therapy, contraindication, or intolerance with an anthracycline (e.g. doxorubicin) and a taxane (e.g.paclitaxel)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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 to tolerate at least one alternate MS therapy (e.g. interferon, glatiramer, fingolimod) 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. Crohns Disease.Diagnosis of moderately to severely active Crohns disease. Have had an inadequate response to, or are unable to tolerate, conventional CD therapies and inhibitors of TNF-a.		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 Instructions	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 fungoides-type cutaneous T-cell lymphoma AND The member has had prior therapy with skin-directed therapy or using as primary treatment.		Licensed Practitioner	12 months	
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.	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 members.		Licensed Practitioner	Plan Year Duration	
VECTIBIX	All FDA approved indications not otherwise excluded from Part D.	Metastatic colorectal cancer members with KRAS mutations should not receive Vectibix (panitumumab) due to known lack of response and possible worse outcomes in this	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 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		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		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 not be used in conjunction with Erbitux(cetuximab), Tarceva (erlotinib),or Iressa (gefitinib).Vectibix	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.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		(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. Non-Hodgkin's Lymphoma, Waldenström's Macroglobulinemia.	The member has experienced disease progression while on Velcade (bortezomib).	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) is being used for primary therapy,therapy for previously treated disease that does not respond to primary therapy or progressive or relasped disease AND Velcade (bortezomib) is being used as monotherapy in combination with Dexamethasone or in combination with Rituxan (rituximab)		Licensed Practitioner	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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) or Adempas (riociguat).		Licensed Practitioner	Plan Year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
VELTASSA	All FDA approved indications not otherwise excluded from Part D.		Hyperkalemia:Veltassa is used for hyperkalemia defined as a serum potassium level greater than 5.5 mEq/L.The member has been unable to control hyperkalemia with all of the folllowing interventions if applicable: Discontinuation of NSAID therapy.Dose reduction or discontinuation of ACEI, ARB, or aldosterone antagonist therapy if clinically appropriate. Initiation or adjustment of loop diuretic therapy (e.g., furosemide, bumetanide, and torsemide) if clinically appropriate. The member has had previous treatment, intolerance to, or contraindication to a sodium polystyrene sulfonate containing product.		Licensed Practitioner	Approved for an inital 60 day period. For reauthorizations: will be approved in 6 month durations.	Reauthorization:The member has documentation in the medical recorded of a serum potassium level less than 5.5 mEq/L.

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
VENCLEXTA	All medically accepted indications not otherwise excluded from Part D.		Chronic Lymphocytic Leukemia (CLL):The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL) with or without deletion 17p (as detected by FDA approved test) and has received at least one prior therapy AND the member is using Venclexta (venetoclax) as monotherapy. Mantle Cell Lymphoma: The member has a diagnosis of MCL AND the member is using Venclexta (venetoclax) as monotherapy and one of the following applies: relapsed, refractory, or progressive disease OR used after a partial response to induction therapy (and treatment goal is to achieve complete response).		Licensed Practitioner	Six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
VENCLEXTA STARTING PACK	All medically accepted indications not otherwise excluded from Part D.		Chronic Lymphocytic Leukemia (CLL):The member has a diagnosis of Chronic Lymphocytic Leukemia (CLL) with or without deletion 17p (as detected by FDA approved test) and has received at least one prior therapy AND the member is using Venclexta (venetoclax) as monotherapy. Mantle Cell Lymphoma: The member has a diagnosis of MCL AND the member is using Venclexta (venetoclax) as monotherapy and one of the following applies: relapsed, refractory, or progressive disease OR used after a partial response to induction therapy (and treatment goal is to achieve complete response).		Licensed Practitioner	Six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
VENTAVIS	All FDA-approved indications not otherwise excluded from Part D.		Pulmonary Arterial Hypertension (PAH).The member has a diagnosis of pulmonary arterial hypertension (WHO Group I) with: WHO/NYHA Function Class IV symptoms and 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	
VERSACLOZ	All FDA approved indications not otherwise excluded from Part D.	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	The member must be using clozapine orally disintegrating tablet for treatment-resistant schizophrenia.The member must have had previous treatment or intolerance to generic clozapine.		Licensed Practitioner	Plan year duration	
VERZENIO	All FDA-approved indications not otherwise excluded from Part D				Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
VIBERZI	All FDA approved indications not otherwise excluded from Part D.		Irritable Bowel Syndrome with Diarrhea (IBS-D):The member must have a diagnosis of irritable bowel syndrome with diarrhea.	The member must be 18 years of age or older	Licensed Practitioner	plan year duration	
VIGABATRIN	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	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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.	The member must be utilizing it for treatment of major depressive disorder. For new starts only: The member must have a documentation of previous treatment, 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 seizures)as determined by their treating Physician.		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
VIVITROL	All FDA approved indications not otherwise excluded from Part D.	Concurrent opioid use or dependency, Not opioid free for minimum of seven days prior to Vivitrol treatment.	Treatment of alcohol dependence: The member has failed treatment on oral naltrexone and The member has abstained from drinking prior to Vivitrol therapy. Prevention of relapse to opioid dependence: The member is taking Vivitrol for the prevention of relapse to opioid dependence, following opioid detoxification.		Licensed Practitioner	Plan Year duration	
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	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		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		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 dihydroergotamine, rifabutin, or azole antifungals.	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				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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 medically accepted 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). First-line therapy as a single agent for relapsed or unresectable stage IV disease with predominant clear cell histology OR as subsequent therapy as a single agent for relapsed or unresectable stage IV disease with predominant clear cell histology in members who have progressed on prior first-line therapy.Soft Tissue Sarcoma. The		Licensed Practitioner	6 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			member has a diagnosis of soft tissue sarcoma AND The member has progressed after prior chemotherapy.Thyroid Carcinoma:The member has a diagnosis of advanced/metastatic follicular carcinoma, Hürthlecell carcinoma, papillary or medullary carcinoma (types of thyroid carcinoma) and one of the following applies: Follicular, papillary, or Hürthle cell carcinoma are progressive and radio-iodine treatment refractory OR The member has a diagnosis of advanced medullary carcinoma and has disease progression on or intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib). Non-Melanoma Skin Cancer. The member has a diagnosis of metastatic dermatofibrosarcoma protuberans (DFSP) AND Votrient (pazopanib) will be used as a single agent. Ovarian Cancer. The member has a diagnosis of epithelial ovarian, fallopian tube, or primary peritoneal cancer and the disease is platinum resistant AND Votrient (pazopanib) is to				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			be used in combination with weekly paclitaxel. Uterine Neoplasms. The member has a diagnosis of stage II, III, IV, or advanced metastatic uterine neoplasm sarcoma and disease is not suitable for primary surgery AND Votrient (pazopanib) will be used as a single agent.				
VPRIV	All FDA-approved indications not otherwise excluded from Part D.		Vpriv velaglucerase alfa will require prior authorization. This agent may be considered medically necessary when the following criteria are met.Type 1 Gaucher Disease.The member must have a diagnosis of type 1 Gauchers Disease.		Licensed Practitioner	Plan Year	
VRAYLAR	All FDA approved indications not otherwise excluded from Part D.	Dementia-related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.	Schizophrenia/ Bipolar I Disorder, manic or mixed episode:The member must be utilizing Vraylar for the treatment of schizophrenia or bipolar I disorder AND The member must have documentation of previous treatment, intolerance, or contraindication to at least 2 of the following: risperidone, olanzapine, quetiapine, ziprasidone or aripiprazole.		Licensed Practitioner	plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
VYXEOS	All FDA-approved indications not otherwise excluded from Part D.	Member has experienced disease progression on Vyxeos (daunorubicin and cytarabine). Member has experienced disease progression on conventional daunorubicin and cytarabine regimen (e.g. “7+3”)	Acute Myeloid Leukemia: The member has a diagnosis of therapy-related acute myeloid leukemia (t-AML) or AML with myelodysplasia-related changes (AML-MRC) AND The member has newly diagnosed disease.		Licensed Practitioner.	6 months duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
XALKORI	All FDA approved indications not otherwise excluded from Part D.	Members using Xalkori (crizotinib) for adjuvant therapy. Members taking concomitant TKIs.	Non-small Cell Lung Cancer (NSCLC).The member has a diagnosis of metastatic or recurrent 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 OR the member has disese which is ROS1 positive. The member will be using Xalkori (crizotinib) as monotherapy.		Licensed Practitioner	six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
XATMEP	All FDA approved indications not otherwise excluded from Part D.	Members that are pregnant or nursing. Members with disease progression on Xatmep (methotrexate) (applies to acute lymphoblastic leukemia only).	Acute Lymphoblastic Leukemia (ALL): The member has a diagnosis of acute lymphoblastic leukemia AND The member will be using Xatmep (methotrexate) as part of a multi-phase, combination chemotherapy maintenance regimen AND The member has had previous treatment or intolerance to generic methotrexate. Polyarticular Juvenile Idiopathic Arthritis (pJIA): The member has a diagnosis of active polyarticular juvenile idiopathic arthritis (pJIA) AND The member has had an insufficient therapeutic response to previous treatment, or is intolerant to, an adequate trial of first-line therapy including non-steroidal antiinflammatory agents (NSAIDs) AND The member has had previous treatment or intolerance to generic methotrexate.	The member is less than 18 years of age.	Licensed Practitioner.	6 months duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
XELJANZ	All FDA approved indications not otherwise excluded from Part D.	Combination therapy with biologic DMARDs (such as Humira, Enbrel, Remicade, Cimzia, Simponi, Actemra, Orencia, and Stelara) or potent immunosuppresants (such as azathioprine and cyclosporine).	Diagnosis of moderately to severely active rheumatoid arthritis. The member has had previous treatment, contraindication, or intolerance with two of Humana's three formulary tumor necrosis factor (TNF) alpha inhibitors including Humira, Enbrel, and Remicade.		Licensed Practitioner	plan year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
XELJANZ XR	All FDA approved indications not otherwise excluded from Part D.	Combination therapy with biologic DMARDs (such as Humira, Enbrel, Remicade, Cimzia, Simponi, Actemra, Orencia, and Stelara) or potent immunosuppresants (such as azathioprine and cyclosporine).	Diagnosis of moderately to severely active rheumatoid arthritis. The member has had previous treatment, contraindication, or intolerance with two of Humana's three formulary tumor necrosis factor (TNF) alpha inhibitors including Humira, Enbrel, and Remicade.		Licensed Practitioner	plan year 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 Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
XGEVA	All FDA approved indications not otherwise excluded from Part D.	Uncorrected Pre-existing hypocalcemia. The member has multiple myeloma.	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 (disease progression, intolerance, or contraindication following treatment with pamidronate does not apply for prostate cancer requests). Giant Cell tumor of Bone: Diagnosis of giant cell tumor of bone. 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 had prior therapy with intravenous bisphosphonate therapy (e.g. pamidronate or zoledronic acid).		Licensed Practitioner	Plan Year duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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. Treatement of traveler's diarrha complicated by fever or bloody stools.	Travelers diarrhea. Member must have traveler's diarrhea caused by non-invasive strains of Escherichia Coli. Member has previous treatment, intolerance or contraindication to ciprofloxacin, levofloxacin, or azithromycin. Hepatic Encepalopathy. Member must have hepatic encephalpathy. Member has previous treatment, intolerance or contraindication to lactulose or neomycin. Irritable bowel syndrome with diarrhea (IBS-D). Diagnosis of Irritable bowel syndrome with diarrhea (IBS-D).	Must be age 12 or older for Travelers Diarrhea, Age 18 or older for Hepatic encephalopathy prophylaxis and IBS-D.	Licensed Practitioner	Plan year for Hepatic Encepalopathy,30 days for traveler's diarrhea and 3 months 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, unless contraindicated. Member will continue to receive H1 antihistamine therapy while on Xolair,unless contraindicated. Diagnosis of moderate or severe persistent asthma, FEV1, allergic sensitivity skin or blood test, baseline serium IgE. Omalizumab may be	The patient is 12 years of age or older for diagnosis of chronic idiopathic urticaria. The patient is 6 years of age or older for moderate to severe persistent asthma.	Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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. For ages 12 and older, patient must have a baseline serum IgE between 30 IU/ml and 700 IU/ml. For ages 6 years old to less than 12 years old: must have baseline serum IgE between 30 IU/ml and 1300 IU/ml. The patient has inadequately controlled asthma despite the use of: Inhaled Corticosteroids.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
XTANDI	All FDA approved indications not otherwise excluded from Part D.	Concomitant use 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).	The member has metastatic (stage IV) castration-resistant prostate cancer (CRPC).		Licensed Practitioner	12 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
XYREM	All FDA approved indications not otherwise excluded from Part D.	Succinic semialdehyde dehydrogenase deficiency. Concomitant use with sedative hypnotic drugs.	Narcolepsy with Cataplexy: The member has a diagnosis of narcolepsy with cataplexy. Narcolepsy with excessive daytime sleepiness: The member has a diagnosis of narcolepsy with excessive daytime sleepiness AND previous treatment, intolerance, or contraindication to at least one CNS stimulant (e.g. methylphenidate, amphetamine salt combination immediate release, or dextroamphetamine) and modafinil. Prerequisite therapy required only for diagnosis of narcolepsy with excessive daytime sleepiness.		Licensed Practitioner	Plan Year Duration	
YERVOY	All FDA approved indications not otherwise excluded from Part D.	Concomitant Zelboraf (vemurafenib), Tafinlar, Cotellic or Mekinist therapy.	Melanoma.The member has a diagnosis of unresectable or metastatic melanoma OR Adjuvant treatment of cutaneous melanoma with pathologic involvement of regional lymph nodes of more than 1 millimeter who have undergone complete resection, including total lymphadenectomy. The member is naive to Yervoy (ipilimumab).The member has		Licensed Practitioner	4 month durations	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2.Melanoma - Reauthorization Criteria Melanoma.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 0-2. Reauth adjuvant treatment of cutaneous melanoma. The member has not had disease recurrence or unacceptable toxicity with Yervoy (ipilimumab) AND The total duration of treatment is less than 3 years AND The member has an ECOG performance status of 0-2.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
YONDELIS	All FDA approved indications not otherwise excluded from Part D.	Member experiences disease progression on Yondelis (trabectedin)	Liposarcoma/Leiomyosarcoma:The member has unresectable or metastatic liposarcoma or leiomyosarcoma AND The member has received prior anthracycline (e.g., doxorubicin) containing regimen. Soft Tissue Sarcoma. Yondelis (trabectedin) will be used as monotherapy for palliative treatment and one of the following applies: The member has a diagnosis of unresectable or progressive retroperitoneal or intraabdominal soft tissue sarcoma OR the member has a diagnosis of angiosarcoma or rhabdomyosarcoma OR the member has a diagnosis stage IV soft tissue sarcoma of the extremity/superficial trunk, head/neck, or recurrent disease with disseminated metastases.		Licensed Practitioner	six month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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.	Metastatic Colorectal Cancer: The member has a diagnosis of metastatic colorectal cancer AND The member is using Zaltrap in combination with irinotecan or 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, and oxaliplatin) or CapeOX(capecitabine and oxaliplatin)		Licensed Practitioner	six month duration	
ZARXIO	All medically accepted indications not otherwise excluded by Part D.	Treatment of neutropenic patients who are afebrile unless chronic symptomatic neutropenic disorder. Same day	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-sndz) injections.The		Licensed Practitioner	4 month duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
		administration with myelosuppressive chemotherapy or therapeutic radiation.Concomitant use with Neupogen (filgramstim), tbo-filgratim, sargramostim (unless part of stem cell mobilization protocol) or pegfilgrastim (within seven days of pegfilgrastim dose)	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 fever 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.Febrile Neutropenia Prophylaxis, In non-myeloid malignancies following progenitor-cell transplantation.The member must have had a peripheral-blood progenitor cell				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			(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). Neutropenia in Myelodysplastic Syndromes. The member must have a diagnosis of neutropenia associated with myelodysplastic syndrome. Treatment of Febrile Neutropenia. The member must have a diagnosis of febrile neutropenia AND Zarxio (filgrastim-sndz) must be used in adjunct with appropriate antibiotics in high risk members.				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ZAVESCA	All FDA approved indications not otherwise excluded from Part D.		Type 1 Gaucher Disease: The member must have a diagnoses of type 1 Gaucher disease.The member has had prior therapy, contraindication, or intolerance to Cerezyme OR Cerdelga.		Licensed Practitioner	plan year duration	
ZEJULA	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced disease progression while on or following PARP inhibitor therapy [e.g., Rubraca (rucaparib), Lynparza (olaparib), Zejula (niraparib)].	Epithelial Ovarian Cancer, Fallopian Tube Cancer, or Primary Peritoneal Cancer. The member has a diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer AND the member has been treated with at least two prior lines of platinum based chemotherapy AND the member is in complete or partial response to their last platinum regimen AND the member will utilize Zejula (niraparib) as monotherapy.		Licensed Practitioner.	6 months duration.	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ZELBORAF	All FDA approved indications not otherwise excluded from Part D.	Members on concomitant Yervoy, Tafinlar, Mekinist, Keytruda or Opdivo. Members that have experienced disease progression while on Zelboraf (vemurafenib).	Melanoma.The member has a diagnosis of 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 OR in combination with Cotellic (cobimetnib).		Licensed Practitioner	six months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ZOLADEX	All FDA-approved indications not otherwise excluded from Part D.	Zoladex should not be continued or restarted after malignant disease progression(Exception is Prostate Cancer). Concomitant use with other LHRH agents. Abnormal vaginal bleeding of unknown etiology.	Prostate Cancer. The patient has a diagnosis of advanced prostate cancer or has a high risk of disease recurrence. 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.	The member must be 18 years or older.	Licensed Practitioner	2 months for endometrial hyperplasia	Approval Durations. Advanced Prostate Cancer or Invasive Breast Cancer is 12 months. Endometriosis is six months. Endometrial Hyperplasia is two months
ZOLEDRONIC AC-MANNITOL-0.9NACL	All FDA approved indications not otherwise excluded from Part D.Hormone-Receptor-	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		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
	Positive Breast Cancer.		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 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				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			at high risk for fracture.				
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		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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.				
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: The member has 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 members: The member is postmenopausal. Has new fractures or significant loss of bone mineral density despite previous treatment, contraindication, or intolerance with an		Licensed Practitioner	Plan Year Duration	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			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. 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				

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
			previous treatment with generic Zoledronic acid (generic Reclast) or who have had contraindications or intolerance with generic Zoledronic acid (generic Reclast).				
ZOLINZA	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced 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 or The member hwill be using Zolinza as primary treatment or adjuvant therapy.		Licensed Practitioner	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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). Active pathological bleeding including gastrointestinal bleeding(e.g. peptic ulcer),intracranial hemorrhage.	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 or standard of care.		Licensed Practitioner	Plan year duration	
ZORBTIVE	All FDA approved indications not otherwise excluded from Part D.		For the treatment of short bowel syndrome in patients receiving specialized nutrition support as directed by a health care professional		Licensed Practitioner	Plan Year	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
ZOVIRAX	All FDA approved indications not otherwise excluded from Part D.		Penciclovir cream is being utilized for the treatment of recurrent herpes labialis (cold sores). Member has had previous treatment, contraindication, or intolerance with at least two of the following: oral acyclovir, valacyclovir, or famciclovir.	Member is 12 years or older	Licensed Practitioner	Plan year duration	
ZYDELIG	All FDA approved indications not otherwise excluded from Part D.	Members that have experienced disease progression while on Zydelig (idelalisib).	Chronic Lymphocytic Leukemia (CLL): The member must have a diagnosis of relapsed OR refractory chronic lymphocytic leukemia (CLL) or relapsed OR refractory small lymphocytic lymphoma (SLL). Follicular Lymphoma (FL): The member must have a diagnosis of relapsed follicular lymphoma (FL) AND The member must have received at least one prior systemic therapy AND The member will be using Zydelig (idelalisib) as monotherapy.		Licensed Practitioner	12 months	

Drug Name	Covered Uses	Exclusion Criteria	Required Medical Information	Age Instructions	Prescriber Restrictions	Coverage Duration	Other Criteria
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 and documented anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC) 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	
ZYTIGA	All FDA approved indications not otherwise excluded from Part D.	Members with severe hepatic impairment (Child-Pugh Class C). Members that have experienced disease progression while on Zytiga.Concomitant use with Xtandi, Provenge, Taxotere or Jevtana.	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.		Licensed Practitioner	12 months	

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.				
AA 6%-D10W-CA GLUC 3.75-HEPARN	Clinimix 5 % in 20 % dextrose (sulfite-free) intravenous solution	FLUOROURACIL 5 GM/100 ML VIAL	MELPHALAN HCL 50 MG VIAL	Sandimmune 100 mg/mL oral solution
Abelcet 5 mg/mL intravenous suspension	Clinimix 5 % in 25 % dextrose sulfite-free intravenous solution	FLUOROURACIL 5,000 MG/100 ML	MESNA 1 GRAM/10 ML VIAL	Sandimmune 25 mg capsule
Abraxane 100 mg intravenous suspension	Clinimix E 2.75 % in 10 % dextrose Sulfite Free intravenous solution	FLUOROURACIL 500 MG/10 ML VIAL	MESNA 100 MG/ML VIAL	Sandimmune 250 mg/5 mL intravenous solution
ACETYLCYSTEINE 10% VIAL	Clinimix E 2.75 % in 5 % dextrose Sulfite Free intravenous solution	Folotyn 20 mg/mL (1 mL) intravenous solution	Mesnex 100 mg/mL intravenous solution	Signifor LAR 20 mg intramuscular suspension
ACETYLCYSTEINE 20% VIAL	Clinimix E 4.25 % in 10 % dextrose Sulfite Free intravenous solution	Folotyn 40 mg/2 mL (20 mg/mL) intravenous solution	METHYLPREDNISOLONE 16 MG TAB	Signifor LAR 40 mg intramuscular suspension
ACYCLOVIR 1,000 MG/20 ML VIAL	Clinimix E 4.25 % in 25 % dextrose Sulfite Free intravenous solution	FOSCARNET 24 MG/ML INFUS BTTL	METHYLPREDNISOLONE 32 MG TAB	Signifor LAR 60 mg intramuscular suspension
ACYCLOVIR 500 MG/10 ML VIAL	Clinimix E 4.25 % in 5 % dextrose Sulfite Free intravenous solution	Foscavir 24 mg/mL intravenous solution	METHYLPREDNISOLONE 4 MG TABLET	Simponi ARIA 12.5 mg/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.				
ACYCLOVIR SODIUM 1 GM VIAL	Clinimix E 5 % in 15 % dextrose Sulfite Free intravenous solution	Freamine HBC 6.9 % intravenous solution	METHYLPREDNISOLONE 8 MG TAB	Simulect 10 mg intravenous solution
ACYCLOVIR SODIUM 500 MG VIAL	Clinimix E 5 % in 20 % dextrose Sulfite Free intravenous solution	Freamine III 10 % intravenous solution	Millipred 5 mg tablet	Simulect 20 mg intravenous solution
Adriamycin 10 mg/5 mL intravenous solution	Clinimix E 5 % in 25 % dextrose Sulfite Free intravenous solution	Fusilev 50 mg intravenous solution	Mircera 100 mcg/0.3 mL injection syringe	SIROLIMUS 0.5 MG TABLET
Adriamycin 2 mg/mL intravenous solution	Clinimix N9G20E 2.75 % in 10 % dextrose (sulfite-free) IV solution	GamaSTAN S/D 15 %-18 % range intramuscular solution	Mircera 150 mcg/0.3 mL injection syringe	SIROLIMUS 1 MG TABLET
Adriamycin 20 mg/10 mL intravenous solution	Clinisol SF 15 % intravenous solution	Gammagard Liquid 10 % injection solution	Mircera 200 mcg/0.3 mL injection syringe	SIROLIMUS 2 MG TABLET
Adriamycin 50 mg/25 mL intravenous solution	CLOFARABINE 20 MG/20 ML VIAL	Gammagard S-D (IgA < 1 mcg/mL) 10 gram intravenous solution	Mircera 30 mcg/0.3 mL injection syringe	SMOFlipid 20 % intravenous emulsion
Adrucil 2.5 gram/50 mL intravenous solution	Clolar 20 mg/20 mL intravenous solution	Gammagard S-D (IgA < 1 mcg/mL) 5 gram intravenous solution	Mircera 50 mcg/0.3 mL injection syringe	SODIUM CHLORIDE 0.9% INHAL VL

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.				
Adrucil 5 gram/100 mL intravenous solution	Compazine 10 mg tablet	Gammaked 1 gram/10 mL (10 %) injection solution	Mircera 75 mcg/0.3 mL injection syringe	SODIUM CHLORIDE 10% VIAL
Adrucil 500 mg/10 mL intravenous solution	Compazine 5 mg tablet	Gammaked 10 gram/100 mL (10 %) injection solution	MITOMYCIN 20 MG VIAL	SODIUM CHLORIDE 3% VIAL
Akynzeo 300 mg-0.5 mg capsule	Cosmegen 0.5 mg intravenous solution	Gammaked 2.5 gram/25 mL (10 %) injection solution	MITOMYCIN 40 MG VIAL	Somatuline Depot 120 mg/0.5 mL subcutaneous syringe
ALBUTEROL 15 MG/3 ML SOLUTION	CROMOLYN 20 MG/2 ML NEB SOLN	Gammaked 20 gram/200 mL (10 %) injection solution	MITOMYCIN 5 MG VIAL	Somatuline Depot 60 mg/0.2 mL subcutaneous syringe
ALBUTEROL 2.5 MG/0.5 ML SOL	CYCLOPHOSPHAMIDE 1 GM VIAL	Gammaked 5 gram/50 mL (10 %) injection solution	Mozobil 24 mg/1.2 mL (20 mg/mL) subcutaneous solution	Somatuline Depot 90 mg/0.3 mL subcutaneous syringe
ALBUTEROL 20 MG/4 ML SOLUTION	CYCLOPHOSPHAMIDE 2 GM VIAL	Gammaplex (with sorbitol) 5 % intravenous solution	Mustargen 10 mg solution for injection	Stelara 130 mg/26 mL intravenous solution
ALBUTEROL 5 MG/ML SOLUTION	CYCLOPHOSPHAMIDE 25 MG CAPSULE	Gammaplex 10 % intravenous solution	MYCOPHENOLATE 200 MG/ML SUSP	Stelara 45 mg/0.5 mL subcutaneous solution
ALBUTEROL SUL 0.63 MG/3 ML SOL	CYCLOPHOSPHAMIDE 50 MG CAPSULE	Gamunex-C 1 gram/10 mL (10 %) injection solution	MYCOPHENOLATE 250 MG CAPSULE	Stelara 45 mg/0.5 mL subcutaneous syringe
ALBUTEROL SUL 1.25 MG/3 ML SOL	CYCLOPHOSPHAMIDE 500 MG VIAL	Gamunex-C 10 gram/100 mL (10 %) injection solution	MYCOPHENOLATE 500 MG TABLET	Stelara 90 mg/mL subcutaneous syringe

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 2.5 MG/3 ML SOLN	CYCLOSPORINE 100 MG CAPSULE	Gamunex-C 2.5 gram/25 mL (10 %) injection solution	MYCOPHENOLATE 500 MG VIAL	Sustol 10 mg/0.4 mL liquid,extended release subcutaneous syringe
Aldurazyme 2.9 mg/5 mL intravenous solution	CYCLOSPORINE 100 MG/ML SOLN	Gamunex-C 20 gram/200 mL (10 %) injection solution	MYCOPHENOLIC ACID DR 180 MG TB	Sylvant 100 mg intravenous solution
Alimta 100 mg intravenous solution	CYCLOSPORINE 25 MG CAPSULE	Gamunex-C 40 gram/400 mL (10 %) injection solution	MYCOPHENOLIC ACID DR 360 MG TB	Sylvant 400 mg intravenous solution
Alimta 500 mg intravenous solution	CYCLOSPORINE 50 MG/ML AMPUL	Gamunex-C 5 gram/50 mL (10 %) injection solution	Myfortic 180 mg tablet,delayed release	Syndros 5 mg/mL oral solution
Aliqopa 60 mg intravenous solution	CYCLOSPORINE MODIFIED 100 MG	GANCICLOVIR 500 MG VIAL	Myfortic 360 mg tablet,delayed release	Synribo 3.5 mg subcutaneous solution
Alkeran 2 mg tablet	CYCLOSPORINE MODIFIED 25 MG	Gazyva 1,000 mg/40 mL intravenous solution	Mylotarg 4.5 mg (1 mg/mL initial concentration) intravenous solution	Synthamin 17 without Electrolyte 10 % intravenous solution
Alkeran 50 mg intravenous solution	CYCLOSPORINE MODIFIED 50 MG	GEMCITABINE 1 GRAM/26.3 ML VL	Naglazyme 5 mg/5 mL intravenous solution	TACROLIMUS 0.5 MG CAPSULE
AmBisome 50 mg intravenous suspension	Cyramza 10 mg/mL intravenous solution	GEMCITABINE 2 GRAM/52.6 ML VL	Navelbine 10 mg/mL intravenous solution	TACROLIMUS 1 MG CAPSULE
AMIFOSTINE 500 MG VIAL	CYTARABINE 100 MG/5 ML VIAL	GEMCITABINE 200 MG/5.26 ML VL	Navelbine 50 mg/5 mL intravenous solution	TACROLIMUS 5 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.				
AMINO ACID 3%-D10W BAG	CYTARABINE 1000 MG/50 ML VIAL	GEMCITABINE HCL 1 GRAM VIAL	Nebupent 300 mg solution for inhalation	Taxotere 20 mg/mL (1 mL) intravenous solution
AMINO ACID 4%-D10W BAG	CYTARABINE 2 G/20 ML VIAL	GEMCITABINE HCL 2 GRAM VIAL	NebuSal 3 % solution for nebulization	Taxotere 80 mg/4 mL (20 mg/mL) intravenous solution
amino acids 15 % intravenous solution	CYTARABINE 20 MG/ML VIAL	GEMCITABINE HCL 200 MG VIAL	NebuSal 6 % solution for nebulization	Tecentriq 1,200 mg/20 mL (60 mg/mL) intravenous solution
Aminosyn 10 % intravenous solution	CytoGam 50 mg/mL intravenous solution	Gemzar 1 gram intravenous solution	Neoral 100 mg capsule	Temodar 100 mg intravenous solution
Aminosyn 7 % with electrolytes intravenous solution	Cytovene 500 mg intravenous solution	Gemzar 200 mg intravenous solution	Neoral 100 mg/mL oral solution	TENIPOSIDE 50 MG/5 ML AMPULE
Aminosyn 8.5 % intravenous solution	DACARBAZINE 100 MG VIAL	Gengraf 100 mg capsule	Neoral 25 mg capsule	Tepadina 15 mg solution for injection
Aminosyn 8.5 % with electrolytes intravenous solution	DACARBAZINE 200 MG VIAL	Gengraf 100 mg/mL oral solution	Nephramine 5.4 % intravenous solution	THERACYS 81 MG VIAL
Aminosyn II 10 % intravenous solution	Dacogen 50 mg intravenous solution	Gengraf 25 mg capsule	Neulasta 6 mg/0.6 mL subcutaneous syringe	THIOTEPA 15 MG VIAL
Aminosyn II 15 % intravenous solution	DACTINOMYCIN 0.5 MG VIAL	Gengraf 50 mg capsule	Neulasta 6 mg/0.6 mL with wearable subcutaneous injector	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 7 % intravenous solution	Darzalex 20 mg/mL intravenous solution	GRANISETRON HCL 1 MG TABLET	Neupogen 300 mcg/0.5 mL injection syringe	Tigan 300 mg capsule
Aminosyn II 8.5 % intravenous solution	DAUNORUBICIN 20 MG VIAL	Granix 300 mcg/0.5 mL subcutaneous syringe	Neupogen 300 mcg/mL injection solution	Tobi 300 mg/5 mL solution for nebulization
Aminosyn II 8.5 % with electrolytes intravenous solution	DAUNORUBICIN 20 MG/4 ML VIAL	Granix 480 mcg/0.8 mL subcutaneous syringe	Neupogen 480 mcg/0.8 mL injection syringe	TOBRAMYCIN 300 MG/5 ML AMPULE
Aminosyn M 3.5 % intravenous solution	DAUNOXOME 50 MG (2 MG/ML) VIAL	Halaven 1 mg/2 mL (0.5 mg/mL) intravenous solution	Neupogen 480 mcg/1.6 mL injection solution	TOBRAMYCIN PAK 300 MG/5 ML
Aminosyn-HBC 7% intravenous solution	DECITABINE 50 MG VIAL	Hepatamine 8% intravenous solution	Nipent 10 mg intravenous solution	Toposar 20 mg/mL intravenous solution
Aminosyn-PF 10 % intravenous solution	Defitelio 80 mg/mL intravenous solution	Herceptin 150 mg intravenous solution	Nucala 100 mg subcutaneous solution	TOPOTECAN HCL 4 MG VIAL
Aminosyn-PF 7 % (sulfite-free) intravenous solution	Deltasone 20 mg tablet	Herceptin 440 mg intravenous solution	Nulojix 250 mg intravenous solution	TOPOTECAN HCL 4 MG/4 ML VIAL
Aminosyn-RF 5.2 % intravenous solution	DEPOCYT 50 MG/5 ML VIAL	Hycamtin 4 mg intravenous solution	Nutrilipid 20 % intravenous emulsion	Torisel 30 mg/3 mL (10 mg/mL) (first dilution) intravenous solution
AMPHOTERICIN B 50 MG VIAL	DEXRAZOXANE 250 MG VIAL	HYDROXYPROGESTERONE 1.25 G/5ML	Ocrevus 30 mg/mL intravenous solution	Travasol 10 % 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.				
Anzemet 100 mg tablet	DEXRAZOXANE 500 MG VIAL	HyperRAB S/D (PF) 150 unit/mL intramuscular solution	Octagam 10 % intravenous solution	Treanda 100 mg intravenous powder for solution
Anzemet 50 mg tablet	Docefrez 20 mg intravenous solution	IBANDRONATE 3 MG/3 ML SYRINGE	Octagam 5 % intravenous solution	TREANDA 180 MG/2 ML VIAL
APREPITANT 125 MG CAPSULE	Docefrez 80 mg intravenous solution	IBANDRONATE 3 MG/3 ML VIAL	Oncaspar 750 unit/mL injection solution	Treanda 25 mg intravenous powder for solution
APREPITANT 125-80-80 MG PACK	DOCETAXEL 140 MG/7 ML VIAL	Idamycin PFS 1 mg/mL intravenous solution	ONDANSETRON 4 MG/5 ML SOLUTION	TREANDA 45 MG/0.5 ML VIAL
APREPITANT 40 MG CAPSULE	DOCETAXEL 160 MG/16 ML VIAL	IDARUBICIN HCL 10 MG/10 ML VL	ONDANSETRON HCL 24 MG TABLET	Trelstar 11.25 mg intramuscular suspension
APREPITANT 80 MG CAPSULE	DOCETAXEL 160 MG/8 ML VIAL	IDARUBICIN HCL 20 MG/20 ML VL	ONDANSETRON HCL 4 MG TABLET	Trelstar 11.25 mg/2 mL intramuscular syringe
Aranesp 10 mcg/0.4 mL (in polysorbate) injection syringe	DOCETAXEL 20 MG/2 ML VIAL	IDARUBICIN HCL 5 MG/5 ML VIAL	ONDANSETRON HCL 8 MG TABLET	Trelstar 22.5 mg intramuscular suspension
Aranesp 100 mcg/0.5 mL (in polysorbate) injection syringe	DOCETAXEL 20 MG/ML VIAL	Ifex 1 gram intravenous solution	ONDANSETRON ODT 4 MG TABLET	Trelstar 22.5 mg/2 mL intramuscular syringe
Aranesp 100 mcg/mL (in polysorbate) Injection	DOCETAXEL 200 MG/10 ML VIAL	Ifex 3 gram intravenous solution	ONDANSETRON ODT 8 MG TABLET	Trelstar 3.75 mg intramuscular suspension
Aranesp 150 mcg/0.3 mL (in polysorbate) injection syringe	DOCETAXEL 200 MG/20 ML VIAL	IFOSFAMIDE 1 GM VIAL	Onivyde 4.3 mg/mL intravenous dispersion	Trelstar 3.75 mg/2 mL intramuscular syringe

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.				
Aranesp 150 mcg/0.75 mL (in polysorbate) Injection	DOCETAXEL 80 MG/4 ML VIAL	IFOSFAMIDE 1 GM/20 ML VIAL	Opdivo 100 mg/10 mL intravenous solution	Triesence (PF) 40 mg/mL intraocular suspension
Aranesp 200 mcg/0.4 mL (in polysorbate) injection syringe	DOCETAXEL 80 MG/8 ML VIAL	IFOSFAMIDE 3 GM VIAL	Opdivo 40 mg/4 mL intravenous solution	TRIMETHOBENZAMIDE 300 MG CAP
Aranesp 200 mcg/mL (in polysorbate) Injection	Doxil 2 mg/mL intravenous suspension	IFOSFAMIDE 3 GM/ 60 ML VIAL	OXALIPLATIN 100 MG VIAL	Triptodur 22.5 mg intramuscular suspension
Aranesp 25 mcg/0.42 mL (in polysorbate) injection syringe	DOXORUBICIN 10 MG VIAL	IFOSFAMIDE-MESNA KIT	OXALIPLATIN 100 MG/20 ML VIAL	TRISENOX 10 MG/10 ML AMPULE
Aranesp 25 mcg/mL (in polysorbate) Injection	DOXORUBICIN 10 MG/5 ML VIAL	Imfinzi 50 mg/mL intravenous solution	OXALIPLATIN 50 MG VIAL	Trisenox 2 mg/mL intravenous solution
Aranesp 300 mcg/0.6 mL (in polysorbate) injection syringe	DOXORUBICIN 150 MG/75 ML VIAL	Imlygic 10exp6 (1 million) PFU/mL suspension for injection	OXALIPLATIN 50 MG/10 ML VIAL	TrophAmine 10 % intravenous solution
Aranesp 300 mcg/mL (in polysorbate) Injection	DOXORUBICIN 20 MG/10 ML VIAL	Imlygic 10exp8 (100 million) PFU/mL suspension for injection	PACLITAXEL 100 MG/16.7 ML VIAL	Trophamine 6% intravenous solution
Aranesp 40 mcg/0.4 mL (in polysorbate) injection syringe	DOXORUBICIN 200 MG/100 ML VIAL	Imogam Rabies-HT (PF) 150 unit/mL intramuscular solution	PACLITAXEL 150 MG/25 ML VIAL	Tysabri 300 mg/15 mL intravenous solution
Aranesp 40 mcg/mL (in polysorbate) Injection	DOXORUBICIN 50 MG VIAL	Imovax Rabies Vaccine (PF) 2.5 unit intramuscular solution	PACLITAXEL 30 MG/5 ML VIAL	Tyvaso 1.74 mg/2.9 mL (0.6 mg/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.				
Aranesp 500 mcg/mL (in polysorbate) injection syringe	DOXORUBICIN 50 MG/25 ML VIAL	Imuran 50 mg tablet	PACLITAXEL 300 MG/50 ML VIAL	Tyvaso Institutional Starter Kit 1.74 mg/2.9 mL soln for nebulization
Aranesp 60 mcg/0.3 mL (in polysorbate) injection syringe	DOXORUBICIN LIPOSOME 20MG/10ML	Inflectra 100 mg intravenous solution	Parsabiv 5 mg/mL intravenous solution	Tyvaso Refill Kit 1.74 mg/2.9 mL (0.6 mg/mL) solution for nebulization
Aranesp 60 mcg/mL (in polysorbate) Injection	DOXORUBICIN LIPOSOME 50MG/25ML	Intralipid 20 % intravenous emulsion	Perforomist 20 mcg/2 mL solution for nebulization	Tyvaso Starter Kit 1.74 mg/2.9 mL solution for nebulization
Arzerra 1,000 mg/50 mL intravenous solution	DRONABINOL 10 MG CAPSULE	Intralipid 30 % intravenous emulsion	Perikabiven 2.36 %-6.8 %-3.5 % intravenous emulsion	Unituxin 3.5 mg/mL intravenous solution
Arzerra 100 mg/5 mL intravenous solution	DRONABINOL 2.5 MG CAPSULE	Intron A 10 million unit (1 mL) solution for injection	Perjeta 420 mg/14 mL (30 mg/mL) intravenous solution	Uvadex 20 mcg/mL injection solution
Astagraf XL 0.5 mg capsule,extended release	DRONABINOL 5 MG CAPSULE	Intron A 10 million unit/mL injection solution	Photofrin 75 mg intravenous solution	Valstar 40 mg/mL intravesical solution
Astagraf XL 1 mg capsule,extended release	Duopa 4.63 mg-20 mg/mL suspension in j-tube pump	Intron A 18 million unit (1 mL) solution for injection	Portrazza 800 mg/50 mL (16 mg/mL) intravenous solution	Varizig 125 unit intramuscular powder for solution
Astagraf XL 5 mg capsule,extended release	Elaprase 6 mg/3 mL intravenous solution	Intron A 50 million unit (1 mL) solution for injection	PREDNISONE 1 MG TABLET	Varizig 125 unit/1.2 mL intramuscular solution
Asthmanefrin Refill 2.25 % solution for nebulization	Elelyso 200 unit intravenous solution	Intron A 6 million unit/mL injection solution	PREDNISONE 10 MG TABLET	Varubi 166.5 mg/92.5 mL intravenous emulsion

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.				
Atgam 50 mg/mL intravenous solution	Eligard 22.5 mg (3 month) subcutaneous syringe	IPRAT-ALBUT 0.5-3(2.5) MG/3 ML	PREDNISONE 2.5 MG TABLET	Varubi 90 mg tablet
Avastin 25 mg/mL intravenous solution	Eligard 30 mg (4 month) subcutaneous syringe	IPRATROPIUM BR 0.02% SOLN	PREDNISONE 20 MG TABLET	Vectibix 100 mg/5 mL (20 mg/mL) intravenous solution
Aveed 750 mg/3 mL (250mg/mL) intramuscular solution	Eligard 45 mg (6 month) subcutaneous syringe	IRINOTECAN HCL 100 MG/5 ML VL	PREDNISONE 5 MG TABLET	Vectibix 400 mg/20 mL (20 mg/mL) intravenous solution
AZACITIDINE 100 MG VIAL	Eligard 7.5 mg (1 month) subcutaneous syringe	IRINOTECAN HCL 40 MG/2 ML VIAL	PREDNISONE 5 MG/5 ML SOLUTION	Velcade 3.5 mg solution for injection
Azasan 100 mg tablet	Elitek 1.5 mg intravenous solution	IRINOTECAN HCL 500 MG/25 ML VL	PREDNISONE 50 MG TABLET	Veletri 0.5 mg intravenous solution
Azasan 75 mg tablet	Elitek 7.5 mg intravenous solution	Istodax 10 mg/2 mL intravenous solution	Prednisone Intensol 5 mg/mL oral concentrate	Veletri 1.5 mg intravenous solution
AZATHIOPRINE 50 MG TABLET	Ellence 200 mg/100 mL intravenous solution	Ixempra 15 mg intravenous solution	Premasol 10 % intravenous solution	Ventavis 10 mcg/mL solution for nebulization
AZATHIOPRINE SOD 100 MG VIAL	Ellence 50 mg/25 mL intravenous solution	Ixempra 45 mg intravenous solution	Premasol 6 % intravenous solution	Ventavis 20 mcg/mL solution for nebulization
Bavencio 20 mg/mL intravenous solution	Emend (fosaprepitant) 150 mg intravenous solution	Jevtana 10 mg/mL (first dilution) intravenous solution	Prevymis 240 mg/12 mL intravenous solution	Vidaza 100 mg solution for injection

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.				
Beleodaq 500 mg intravenous solution	Emend 125 mg (1)-80 mg (2) capsules in a dose pack	Kabiven 3.31 %-9.8 %-3.9 % intravenous emulsion	Prevymis 480 mg/24 mL intravenous solution	VINBLASTINE 1 MG/ML VIAL
Bendeka 25 mg/mL intravenous solution	Emend 125 mg (25 mg/mL final conc.) oral suspension	Kadcyla 100 mg intravenous solution	Prialt 100 mcg/mL intrathecal solution	Vincasar PFS 1 mg/mL intravenous solution
Benlysta 120 mg intravenous solution	Emend 125 mg capsule	Kadcyla 160 mg intravenous solution	Prialt 25 mcg/mL intrathecal solution	Vincasar PFS 2 mg/2 mL intravenous solution
Benlysta 200 mg/mL subcutaneous auto-injector	Emend 40 mg capsule	Kanuma 2 mg/mL intravenous solution	Privigen 10 % intravenous solution	VINCRISTINE 1 MG/ML VIAL
Benlysta 200 mg/mL subcutaneous syringe	Emend 80 mg capsule	Keytruda 25 mg/mL intravenous solution	Procalamine 3% intravenous solution	VINCRISTINE 2 MG/2 ML VIAL
Benlysta 400 mg intravenous solution	Empliciti 300 mg intravenous solution	Kitabis Pak 300 mg/5 mL solution for nebulization	PROCHLORPERAZINE 10 MG TAB	VINORELBINE 10 MG/ML VIAL
Besponsa 0.9 mg(0.25 mg/mL initial concentration) intravenous solution	Empliciti 400 mg intravenous solution	Kyprolis 30 mg intravenous solution	PROCHLORPERAZINE 5 MG TABLET	VINORELBINE 50 MG/5 ML VIAL
Bethkis 300 mg/4 mL solution for nebulization	Engerix-B (PF) 20 mcg/mL intramuscular suspension	Kyprolis 60 mg intravenous solution	Procrit 10,000 unit/mL injection solution	Virazole 6 gram solution for inhalation
BiCNU 100 mg intravenous solution	Engerix-B (PF) 20 mcg/mL intramuscular syringe	Lartruvo 10 mg/mL intravenous solution	Procrit 2,000 unit/mL injection solution	Vivitrol 380 mg intramuscular suspension,extended release

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.				
Bivigam 10 % intravenous solution	ENGERIX-B 10 MCG/0.5 ML PED VL	Lemtrada 12 mg/1.2 mL intravenous solution	Procrit 20,000 unit/2 mL injection solution	VPRIV 400 unit intravenous solution
Bleo 15K 15 unit solution for injection	Engerix-B Pediatric (PF) 10 mcg/0.5 mL intramuscular syringe	LEUCOVORIN CALCIUM 100 MG VIAL	Procrit 20,000 unit/mL injection solution	Vyxeos 44 mg-100 mg intravenous solution
BLEOMYCIN SULFATE 15 UNIT VIAL	Entyvio 300 mg intravenous solution	LEUCOVORIN CALCIUM 200 MG VIAL	Procrit 3,000 unit/mL injection solution	WinRho SDF 1,500 unit/1.3 mL injection solution
BLEOMYCIN SULFATE 30 UNIT VIAL	Envarsus XR 0.75 mg tablet,extended release	LEUCOVORIN CALCIUM 350 MG VIAL	Procrit 4,000 unit/mL injection solution	WinRho SDF 15,000 unit/13 mL injection solution
Boniva 3 mg/3 mL intravenous syringe	Envarsus XR 1 mg tablet,extended release	LEUCOVORIN CALCIUM 50 MG VIAL	Procrit 40,000 unit/mL injection solution	WinRho SDF 2,500 unit/2.2 mL injection solution
Brovana 15 mcg/2 mL solution for nebulization	Envarsus XR 4 mg tablet,extended release	LEUCOVORIN CALCIUM 500 MG VL	Prograf 0.5 mg capsule	WinRho SDF 5,000 unit/4.4 mL injection solution
BUDESONIDE 0.25 MG/2 ML SUSP	EPIRUBICIN 200 MG/100 ML VIAL	Leukine 250 mcg solution for injection	Prograf 1 mg capsule	Xgeva 120 mg/1.7 mL (70 mg/mL) subcutaneous solution
BUDESONIDE 0.5 MG/2 ML SUSP	EPIRUBICIN 50 MG/25 ML VIAL	LEVALBUTEROL 0.31 MG/3 ML SOL	Prograf 5 mg capsule	Xolair 150 mg subcutaneous solution
BUDESONIDE 1 MG/2 ML INH SUSP	EPIRUBICIN HCL 200 MG VIAL	LEVALBUTEROL 0.63 MG/3 ML SOL	Prograf 5 mg/mL intravenous solution	Xopenex 0.31 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.				
BUSULFAN 60 MG/10 ML VIAL	EPIRUBICIN HCL 50 MG VIAL	LEVALBUTEROL 1.25 MG/3 ML SOL	Prosol 20 % intravenous solution	Xopenex 0.63 mg/3 mL solution for nebulization
Busulfex 60 mg/10 mL intravenous solution	Epogen 10,000 unit/mL injection solution	LEVALBUTEROL CONC 1.25 MG/0.5	Pulmicort 0.25 mg/2 mL suspension for nebulization	Xopenex 1.25 mg/3 mL solution for nebulization
Camptosar 100 mg/5 mL intravenous solution	Epogen 2,000 unit/mL injection solution	LEVOLEUCOVORIN 175 MG VIAL	Pulmicort 0.5 mg/2 mL suspension for nebulization	Xopenex Concentrate 1.25 mg/0.5 mL solution for nebulization
Camptosar 300 mg/15 mL intravenous solution	Epogen 20,000 unit/2 mL injection solution	LEVOLEUCOVORIN 175 MG/17.5 ML	Pulmicort 1 mg/2 mL suspension for nebulization	Yervoy 200 mg/40 mL (5 mg/mL) intravenous solution
Camptosar 40 mg/2 mL intravenous solution	Epogen 20,000 unit/mL injection solution	LEVOLEUCOVORIN 250 MG/25 ML VL	Pulmozyme 1 mg/mL solution for inhalation	Yervoy 50 mg/10 mL (5 mg/mL) intravenous solution
CARBOPLATIN 150 MG VIAL	Epogen 3,000 unit/mL injection solution	LEVOLEUCOVORIN 50 MG VIAL	RabAvert (PF) 2.5 unit intramuscular suspension	Yondelis 1 mg intravenous solution
CARBOPLATIN 150 MG/15 ML VIAL	Epogen 4,000 unit/mL injection solution	Lioresal 2,000 mcg/mL intrathecal solution	RACEPINEPHRINE 2.25% SOLN	Zaltrap 100 mg/4 mL (25 mg/mL) intravenous solution
CARBOPLATIN 450 MG/45 ML VIAL	EPOPROSTENOL SODIUM 0.5 MG VL	Lioresal 50 mcg/mL intrathecal solution	Radicava 30 mg/100 mL intravenous piggyback	Zaltrap 200 mg/8 mL (25 mg/mL) intravenous solution
CARBOPLATIN 50 MG/5 ML VIAL	EPOPROSTENOL SODIUM 1.5 MG VL	Lioresal 500 mcg/mL intrathecal solution	Rapamune 0.5 mg tablet	Zanosar 1 gram 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.				
CARBOPLATIN 600 MG/60 ML VIAL	Erbitux 100 mg/50 mL intravenous solution	Lipodox 2 mg/mL intravenous suspension	Rapamune 1 mg tablet	Zarxio 300 mcg/0.5 mL injection syringe
Carimune NF Nanofiltered 12 gram intravenous solution	Erbitux 200 mg/100 mL intravenous solution	Lipodox 50 2 mg/mL intravenous suspension	Rapamune 1 mg/mL oral solution	Zarxio 480 mcg/0.8 mL injection syringe
Carimune NF Nanofiltered 6 gram intravenous solution	Erwinaze 10,000 unit solution for injection	Lupron Depot (6 Month) 45 mg intramuscular syringe kit	Rapamune 2 mg tablet	Zilretta 32 mg intra-articular suspension,extended release
CellCept 200 mg/mL oral suspension	Ethyol 500 mg intravenous solution	Lupron Depot 11.25 mg (3 month) intramuscular syringe kit	Rayos 1 mg tablet,delayed release	Zinecard (as HCl) 250 mg intravenous solution
CellCept 250 mg capsule	Etopophos 100 mg intravenous solution	Lupron Depot 22.5 mg (3 month) intramuscular syringe kit	Rayos 2 mg tablet,delayed release	Zinecard (as HCl) 500 mg intravenous solution
CellCept 500 mg tablet	ETOPOSIDE 1,000 MG/50 ML VIAL	Lupron Depot 3.75 mg intramuscular syringe kit	Rayos 5 mg tablet,delayed release	Zinplava 25 mg/mL intravenous solution
CellCept Intravenous 500 mg intravenous solution	ETOPOSIDE 100 MG/5 ML VIAL	Lupron Depot 30 mg (4 month) intramuscular syringe kit	Reclast 5 mg/100 mL intravenous piggyback	Zofran 4 mg tablet
Cesamet 1 mg capsule	ETOPOSIDE 500 MG/25 ML VIAL	Lupron Depot 7.5 mg intramuscular syringe kit	Recombivax HB (PF) 10 mcg/mL intramuscular suspension	Zofran 4 mg/5 mL oral solution
CHLORPROMAZINE 10 MG TABLET	Exondys 51 50 mg/mL intravenous solution	Lupron Depot-Ped 11.25 mg (3 month) intramuscular syringe kit	Recombivax HB (PF) 10 mcg/mL intramuscular syringe	Zofran 8 mg tablet

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	Fasenra 30 mg/mL subcutaneous syringe	Lupron Depot-Ped 11.25 mg intramuscular kit	Recombivax HB (PF) 40 mcg/mL intramuscular suspension	Zofran ODT 4 mg disintegrating tablet
Cinqair 10 mg/mL intravenous solution	Faslodex 250 mg/5 mL intramuscular syringe	Lupron Depot-Ped 15 mg intramuscular kit	Recombivax HB (PF) 5 mcg/0.5 mL intramuscular suspension	Zofran ODT 8 mg disintegrating tablet
Cinvanti 7.2 mg/mL intravenous emulsion	Firmagon 120 mg subcutaneous solution	Lupron Depot-Ped 30 mg (3 month) intramuscular syringe kit	Recombivax HB (PF) 5 mcg/0.5 mL intramuscular syringe	Zoladex 10.8 mg subcutaneous implant
CISPLATIN 100 MG/100 ML VIAL	Firmagon kit with diluent syringe 120 mg subcutaneous solution	Lupron Depot-Ped 7.5 mg (Ped) intramuscular kit	Remicade 100 mg intravenous solution	Zoladex 3.6 mg subcutaneous implant
CISPLATIN 200 MG/200 ML VIAL	Firmagon kit with diluent syringe 80 mg subcutaneous solution	Makena 250 mg/mL intramuscular oil	Remodulin 1 mg/mL injection solution	ZOLEDRONIC ACID 4 MG VIAL
CISPLATIN 50 MG/50 ML VIAL	Flebogamma DIF 5 % intravenous solution	Marinol 10 mg capsule	Remodulin 10 mg/mL injection solution	ZOLEDRONIC ACID 4 MG/100 ML
CLADRIBINE 10 MG/10 ML VIAL	Flolan 0.5 mg intravenous solution	Marinol 2.5 mg capsule	Remodulin 2.5 mg/mL injection solution	ZOLEDRONIC ACID 4 MG/5 ML VIAL
CLINDAMYCIN 300 MG/50 ML-NS	Flolan 1.5 mg intravenous solution	Marinol 5 mg capsule	Remodulin 5 mg/mL injection solution	ZOLEDRONIC ACID 5 MG/100 ML

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.				
CLINDAMYCIN 600 MG/50 ML-NS	FLOXURIDINE 500 MG VIAL	Marqibo 5 mg/31 mL (0.16 mg/mL) (Final Conc.) intravenous kit	Renflexis 100 mg intravenous solution	Zometa 4 mg/100 mL intravenous piggyback
CLINDAMYCIN 900 MG/50 ML-NS	FLUDARABINE 50 MG VIAL	Medrol 16 mg tablet	RIBAVIRIN 6 GM INHALATION VIAL	Zometa 4 mg/5 mL intravenous solution
Clinimix 2.75 % in 5 % dextrose Sulfite Free intravenous solution	FLUDARABINE 50 MG/2 ML VIAL	Medrol 2 mg tablet	Rituxan 10 mg/mL concentrate,intravenous	Zortress 0.25 mg tablet
Clinimix 4.25 % in 10 % dextrose Sulfite Free intravenous solution	FLUOROURACIL 1,000 MG/20 ML VL	Medrol 32 mg tablet	Rituxan Hycela 1,400 mg/11.7 mL (120 mg/mL) subcutaneous solution	Zortress 0.5 mg tablet
Clinimix 4.25 % in 20 % dextrose (sulfite-free) intravenous solution	FLUOROURACIL 2,500 MG/50 ML VL	Medrol 4 mg tablet	Rituxan Hycela 1,600 mg/13.4 mL (120 mg/mL) subcutaneous solution	Zortress 0.75 mg tablet
Clinimix 4.25 % in 25 % dextrose (sulfite-free) intravenous solution	FLUOROURACIL 2.5 GM/50 ML BTL	Medrol 8 mg tablet	S2 Racepinephrine 2.25 % solution for nebulization	Zuplenz 4 mg oral soluble film
Clinimix 4.25 % in 5 % dextrose Sulfite Free intravenous solution	FLUOROURACIL 2.5 GM/50 ML VIAL	MELPHALAN 2 MG TABLET	Sandimmune 100 mg capsule	Zuplenz 8 mg oral soluble film

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 5 % in 15 % dextrose Sulfite Free intravenous solution	FLUOROURACIL 5 GM/100 ML BTL	MELPHALAN 50 MG VIAL W-DILUENT		

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  - Qualified sign language interpreters
  - Written information in other formats
- Provides free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number on the back of your Member ID Card or contact Member Services using the information below.

If you believe that CarePlus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CarePlus Health Plans, Inc.
Attention: Member Services Department
11430 NW 20th Street, Suite 300
Miami, FL 33172

Telephone: 1-800-794-5907 (TTY users should call 711)
8 a.m. to 8 p.m., 7 days a week
From February 15th to September 30th, we are open Monday-Friday from 8 a.m. to 8 p.m.

Fax: 1-800-956-4288

You can file a grievance in person or by mail, phone or fax. If you need help filing a grievance, our Member Services Representatives are available to help you at the contact information listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
1-800–368–1019; 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-794-5907 (TTY:711).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-794-5907 (TTY:711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-794-5907 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-794-5907 (TTY:711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-800-794-5907 (TTY:711) 번으로 전화해 주십시오 .

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maari kang gumamit ng mga serbisyo ng tulong sa wika nang bayad. Tumawag sa 1-800-794-5907 (TTY:711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-794-5907 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-794-5907 (TTY: 711).

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-794-5907 (ATS: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-794-5907 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-794-5907 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-794-5907 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-794-5907 (TTY: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-794-5907 (TTY:711).

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-794-5907 (TTY:711).

Diné Bizzad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-794-5907 (TTY:711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-794-5907 (رقم هاتف الصم والبكم: 711).