ACTEMRA

MEDICATION(S)
ACTEMRA 162 MG/0.9 ML SYRINGE

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

EXCLUSION CRITERIA
Active infection, live vaccines, concomitant use with biological Disease Modifying Anti-Rheumatic Drugs (DMARDs).

REQUIRED MEDICAL INFORMATION
Documented diagnosis of adult Rheumatoid Arthritis (RA) or Giant Cell Arteritis (GCA). For RA: Documentation that patient had a trial or inadequate response to at least one DMARD OR is intolerant to DMARDs (such as sulfasalazine, leflunomide, hydroxychloroquine, methotrexate), Documentation of inadequate response or inability to tolerate one tumor necrosis factor antagonist (such as Enbrel or Humira). For RA and GCA: Documented evaluation of tuberculosis (TB), hepatitis B, and active infection. Lab results must be attached: absolute neutrophil count (ANC), platelet count, aspartate transaminase (AST) and alanine transaminase (ALT).

AGE RESTRICTION
18 years of age or greater.

PRESCRIBER RESTRICTION
An appropriate specialist or in consultation with a rheumatologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

MEDICATION(S)

FENTANYL CIT OTFC 1,200 MCG, FENTANYL CIT OTFC 1,600 MCG, FENTANYL CITRATE OTFC 200 MCG, FENTANYL CITRATE OTFC 400 MCG, FENTANYL CITRATE OTFC 600 MCG, FENTANYL CITRATE OTFC 800 MCG

COVERED USES

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

EXCLUSION CRITERIA

Prescribers and patients not enrolled in TIRF REMs Access Program. Must not be used in opioid non-tolerant patients.

REQUIRED MEDICAL INFORMATION

For use in the management of breakthrough pain in cancer patients (documentation must be attached) who are already receiving and have become tolerant to around-the-clock opioid therapy for persistent cancer pain. Opioid tolerant is defined as patients taking at least 60 mg of oral morphine daily, at least 25 mcg of transdermal fentanyl/hour, at least 30 mg oral oxyocodone daily, at least 8 mg of oral hydromorphone daily, at least 25 mg oral oxymorphone daily or an equianalgesic dose of another opioid daily for 1 week or longer. Patients must remain on around-the-clock opioids when taking fentanyl citrate transmucosal lozenges. For renewal: assessment of pain severity and functional ability, progress towards achieving therapeutic goals, presence of adverse effects, plan of care including duration of treatment. Chart notes that assess the patient for possible aberrant drug-related behaviors, substance use, and psychological issues. Patients remain on around-the-clock opioids when taking fentanyl citrate transmucosal lozenges.

AGE RESTRICTION

16 years or older

PRESCRIBER RESTRICTION

Pain management specialist or oncologist

COVERAGE DURATION

6 months

OTHER CRITERIA

N/A

ADCIRCA (TADALAFIL)

MEDICATION(S)
ADCIRCA

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

EXCLUSION CRITERIA
Concomitant organic nitrates. Concomitant Guanylate Cyclase (GC) Stimulators.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of pulmonary arterial hypertension (PAH) WHO Group 1. Diagnosis confirmed by a complete right heart catheterization (RHC). PAH defined as a resting mean pulmonary artery pressure (mPAP) of greater than or equal to 25 mm Hg, pulmonary capillary wedge pressure (PCWP) of less than or equal to 15 mm Hg, and pulmonary vascular resistance (PVR) of greater than or equal to 3 Wood units (RHC report must be attached).

AGE RESTRICTION
18 years or older.

PRESCRIBER RESTRICTION
Cardiologist, Pulmonologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

MEDICATION(S)
ADEMPAS

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

EXCLUSION CRITERIA
Female patients who are pregnant or planning on becoming pregnant. Concurrent use with nitrates or nitric oxide donors in any form. Concurrent use with phosphodiesterase-5 inhibitors.

REQUIRED MEDICAL INFORMATION
Chart notes that show that diagnosis of Pulmonary Arterial Hypertension has been confirmed with a complete right heart catheterization (RHC) report attached. Chart notes that show that an acute vasodilator test has been performed and the patient's response to the acute vasodilator test. Documentation that supports patient's World Health Organization (WHO) Group and Functional Class classification. For WHO group 1: Pharmacy records or chart notes documenting trial of or inadequate response to two alternatives (used alone or in combination) from the following list of medications: Prostacyclin Analogues (treprostinil), Endothelin Receptor Antagonists (bosentan, ambrisentan, macitentan), Phosphodiesterase-5 inhibitors (Revatio, Adcirca), Prostacyclin receptor agonists (selexipag). For WHO group IV: Confirmed diagnosis of Chronic Thromboembolic Pulmonary Hypertension (CTEPH) with documentation verifying that patient has recurrent or persisting pulmonary hypertension following pulmonary thromboendarterectomy or inoperable CTEPH. For all diagnosis: Chart notes which contain the treatment plan that discusses concurrent therapy.

AGE RESTRICTION
18 years or older.

PRESCRIBER RESTRICTION
Cardiologist or Pulmonologist as prescribing physician or in consultation.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

MEDICATION(S)
BOTOX

COVERED USES
All FDA-approved indications not otherwise excluded from Part D. Sialorrhea associated with disorders of the nervous system or neurologic dysfunction. Hemifacial spasm. Laryngeal dystonia. Spasticity associated with cerebral palsy.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
FOR ALL REQUESTS: Documentation of diagnosis, proposed injection site(s) and the dose that will be injected into each site. IN ADDITION: FOR INITIAL REQUESTS: (1)For OAB with symptoms of urge urinary incontinence, urgency, and frequency: documentation of inadequate response or intolerance to an anticholinergic medication, dose no more than 100 units/treatment. (2)For urinary incontinence due to detrusor overactivity associated with a neurologic condition: inadequate response or intolerance to an anticholinergic medication, dose no more than 200 units/treatment. (3)For prophylaxis of headaches in adult patients with chronic migraine (at least 15 days per month with headache lasting 4 hours a day or longer): documentation of inadequate response or intolerance to at least 2 different classes of prophylactic medications (i.e., beta blockers [such as propranolol, metoprolol], amitriptyline, topiramate, valproic acid or its derivatives, verapamil), dose no more than 155 units/treatment. (4)For severe primary axillary hyperhidrosis: documentation of dose no more than 100 units/treatment. (5)For upper or lower limb spasticity in muscle groups FDA-approved for treatment: documentation of dose no more than 400 units/treatment. (6)For blepharospasm associated with dystonia: dose no more than 200 units/treatment. (7)For strabismus associated with dystonia: dose no more than 25 units per muscle per injection. (8)For sialorrhea associated with disorders of the nervous system or neurologic dysfunction, documentation of diagnosis and inadequate response or intolerance to at least 1 anticholinergic medication (e.g., glycopyrrolate). (9)For cervical dystonia: dose no more than 300 units/treatment. FOR RENEWAL REQUESTS: Dose consistent with total units for diagnosis (per initial request criteria). Documentation supporting the need for repeat treatment(s) occurring no sooner than every 3 months.

AGE RESTRICTION
18 years of age or greater for diagnoses of OAB, urinary incontinence, prophylaxis of headaches in patients with chronic migraine, severe primary axillary hyperhidrosis. 16 years of age or greater for

diagnosis of cervical dystonia. 12 years of age or greater for diagnoses of blepharospasm or strabismus associated with dystonia.

PRESCRIBER RESTRICTION

Urologist: OAB, urinary incontinence. Neurologist: Migraine headaches. Neurologist/Physiatrist: Upper limb spasticity, cervical dystonia. Ophthalmologist: Blepharospasm, strabismus. Dermatologist/Neurologist/Physiatrist: Severe primary axillary hyperhidrosis.

COVERAGE DURATION

12 months.

OTHER CRITERIA

N/A

BUPRENORPHINE

MEDICATION(S)
BUPRENORPHINE 2 MG TABLET SL, BUPRENORPHINE 8 MG TABLET SL

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient is either undergoing induction therapy, is pregnant, or has a documented intolerance to buprenorphine/naloxone combination. Diagnosis of opioid use disorder according to Diagnostic and Statistical Manual of Mental Health Disorders, with chart notes or initial urine drug screen attached. Dosing of buprenorphine less than or equal to 16 mg per day OR dosing of buprenorphine less than or equal to 24 mg per day with a documented inadequate response to treatment with buprenorphine less than or equal to 16 mg per day.

AGE RESTRICTION
16 years or greater.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months.

OTHER CRITERIA
N/A

MEDICATION(S)

BUNAVAIL, BUPRENORPHINE-NALOXONE, SUBOXONE, ZUBSOLV 1.4-0.36 MG TABLET SL, ZUBSOLV 11.4-2.9 MG TABLET SL, ZUBSOLV 2.9-0.71 MG TABLET SL, ZUBSOLV 5.7-1.4 MG TABLET SL, ZUBSOLV 8.6-2.1 MG TABLET SL

COVERED USES

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

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Diagnosis of opioid use disorder according to Diagnostic and Statistical Manual of Mental Health Disorders, with either chart notes or initial urine drug screen attached. Dosing less than or equal to 16 mg per day of buprenorphine equivalents (Bunavail less than or equal to 8.4/1.4 mg per day, Suboxone sublingual film and buprenorphine/naloxone tablets less than or equal to 16/4 mg per day, Zubsolv tablet less than or equal to 11.4/2.9 mg per day) OR dosing less than or equal to 24 mg per day of buprenorphine equivalents (Bunavail less than or equal to 12.6/2.1 mg per day, Suboxone sublingual film and buprenorphine/naloxone tablets 24/6 mg per day, Zubsolv tablet less than or equal to 17.2/4.2 mg per day) with a documented inadequate response to treatment with 16 mg per day or less of buprenorphine equivalents.

AGE RESTRICTION

16 years or greater

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

N/A

CHORIONIC GONADOTROPIN

MEDICATION(S)
CHORIONIC GONAD 10,000 UNIT VL

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

EXCLUSION CRITERIA
Precocious puberty, prostatic carcinoma or other androgen dependent neoplasm, prior allergic reaction to HCG.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis. Cover under Medicare Part B if the medication will be furnished by the prescriber/office, administered in the prescriber's office or ambulatory setting, and will be billed by the prescriber/office. Cover under Medicare Part D, if the prescriber wants to have the medication provided by a pharmacy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

COSENTYX

MEDICATION(S)
COSENTYX (2 SYRINGES), COSENTYX PEN, COSENTYX PEN (2 PENS), COSENTYX SYRINGE

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

EXCLUSION CRITERIA
Concomitant use with biological Disease Modifying Anti-Rheumatic Drugs (DMARDs).

REQUIRED MEDICAL INFORMATION
For moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy: Documentation of an inadequate response, intolerance, or contraindication to one tumor necrosis factor antagonist (such as Enbrel OR Humira). For active psoriatic arthritis and active ankylosing spondylitis: Documentation of an inadequate response, intolerance, or contraindication to at least one DMARD (such as methotrexate, hydroxychloroquine, sulfasalazine, NSAIDs) AND documentation of an inadequate response, intolerance, or contraindication to one tumor necrosis factor antagonist (such as Enbrel OR Humira). For all indications: Documented evaluation of tuberculosis (TB) and active infection.

AGE RESTRICTION
18 years of age and older.

PRESCRIBER RESTRICTION
An appropriate specialist or in consultation with a Rheumatologist or Dermatologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

MEDICATION(S)
EMFLAZA

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documented diagnosis of Duchenne Muscular Dystrophy confirmed by genetic testing.

AGE RESTRICTION
5 years of age and older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

ENBREL

MEDICATION(S)
ENBREL, ENBREL SURECLICK

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of the results of PPD test and treatment plan to address latent or active infection. For rheumatoid arthritis (RA) or psoriatic arthritis (PsA): Documentation that patient had a trial of or inadequate response to at least one or more DMARD OR intolerant to DMARDs. For psoriasis (Ps) (with greater than 5% body involvement): Documentation that patient is a candidate for systemic therapy or phototherapy and documentation that patient had a trial of or an inadequate response to methotrexate OR UVB therapy OR Acitretin. For psoriasis (Ps) (with less than 5% of body involvement): Documentation that patient had a trial of or an inadequate response to one topical steroid (high or very high potency) AND Calcipotriene. For moderately to severely active polyarticular-course juvenile rheumatoid arthritis (JIA): Documentation that patient had a trial of or an inadequate response to one or more DMARD OR is intolerant to DMARDs. For ankylosing spondylitis (AS): Documentation that patient had a trial of or an inadequate response to at least one DMARD OR is intolerant to DMARDs.

AGE RESTRICTION
2 years of age or greater

PRESCRIBER RESTRICTION
An appropriate specialist or in consultation with Rheumatologist or Dermatologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MEDICATION(S)
EPCLUSA

COVERED USES
All FDA-approved indications not otherwise excluded from Part D, per current American Association for the Study of Liver Diseases (AASLD) - Infectious Disease Society of America (IDSA) Hepatitis C Virus (HCV) Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C.

EXCLUSION CRITERIA
Patients whose medication profile shows treatment with any contraindicated drug-drug interactions (Risk X). Patients who have renal impairment (calculated glomerular filtration rate less than 30 mL/min). Patients who have end stage renal disease (ESRD). Patients who are treated with other Direct Acting Agent (DAA).

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of chronic Hepatitis C (CHC). Lab results must be attached: Hepatitis C virus (HCV) genotype and subtype, quantitative HCV RNA, complete blood count (CBC), international normalized ratio (INR), hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels), serum creatinine/calculated glomerular filtration rate, liver biopsy or other indirect markers (such as FibroTest or Fibroscan), HBsAg and anti-HBc. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

AGE RESTRICTION
18 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 weeks. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

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

MEDICATION(S)
ESBRIET

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

EXCLUSION CRITERIA
Other known causes of interstitial lung disease (ILD) (e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity).

REQUIRED MEDICAL INFORMATION
INITIAL REQUESTS: Documented diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by: usual interstitial pneumonia (UIP) pattern present on high resolution computed tomography (HRCT) in patients without lung biopsy, or the combination of HRCT and biopsy pattern in patients with lung biopsy. Documented forced vital capacity (FVC) greater than or equal to 50%. Documented liver function tests (ALT, AST, and bilirubin) and documentation that liver function tests (ALT, AST, and bilirubin) will be monitored periodically throughout the course of treatment as clinically necessary. RENEWAL REQUESTS: Documentation of rationale for continued therapy (e.g., stability or improvement in the rate of decline for FVC, IPF symptoms, or other prescriber-assessed benefit of therapy). Documentation that liver function tests (ALT, AST, and bilirubin) will be monitored periodically throughout the course of treatment as clinically necessary.

AGE RESTRICTION
18 years of age or greater

PRESCRIBER RESTRICTION
An appropriate specialist such as a pulmonologist, or in consultation with an appropriate specialist such as a pulmonologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MEDICATION(S)
HARVONI

COVERED USES
All FDA-approved indications not otherwise excluded from Part D, per current American Association for the Study of Liver Diseases (AASLD) - Infectious Disease Society of America (IDSA) Hepatitis C Virus (HCV) Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C.

EXCLUSION CRITERIA
Patients whose medication profile shows treatment with any contraindicated drug-drug interactions (Risk X). Patients who have renal impairment (calculated glomerular filtration rate less than 30mL/min). Patients who have end stage renal disease (ESRD). Patients who are treated with other Direct Acting Agent (DAA).

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of chronic Hepatitis C (CHC). Lab results must be attached: Hepatitis C virus (HCV) genotype and subtype, quantitative HCV RNA, complete blood count (CBC), international normalized ratio (INR), hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels), serum creatinine/calculated glomerular filtration rate, liver biopsy or other indirect markers (such as FibroTest or Fibroscan), HBsAg and anti-HBc. Patients must have HCV genotype 1a, 1b, 4, 5 or 6. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

AGE RESTRICTION
12 years of age or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 to 24 weeks. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

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

MEDICATION(S)
HETLIOZ

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of complete blindness. Documentation of diagnosis of Non-24-Hour Sleep Wake Disorder indicated by actigraphy or sleep log or diary. Documentation of baseline nighttime sleep time and daytime naptime per sleep log or diary.

AGE RESTRICTION
18 years or older.

PRESCRIBER RESTRICTION
Prescribed by or in consultation with a sleep specialist, psychiatrist or neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For renewal: Documentation of response indicated by improvement in nighttime sleep time or reduction in daytime naptime compared to baseline per sleep log or diary.

HIGH RISK MEDICATION

MEDICATION(S)

DIPYRIDAMOLE 25 MG TABLET, DIPYRIDAMOLE 50 MG TABLET, DIPYRIDAMOLE 75 MG TABLET, DISOPYRAMIDE PHOSPHATE, ERGOLOID MESYLATES 1 MG TAB, GUANFACINE HCL, METHYLDOPA, METHYLDOPA-HYDROCHLOROTHIAZIDE, NIFEDIPINE 10 MG CAPSULE, NIFEDIPINE 20 MG CAPSULE

COVERED USES

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

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

For patients 65 years of age and older: Chart notes that document the patient's diagnosis and indication for use of the High Risk Medication. Chart notes documenting that a risk-versus-benefit assessment has been completed for use of the High Risk Medication. Chart notes documenting a detailed explanation of the specific benefit established and how the benefit outweighs the potential risk. Chart notes that document that the patient has been counseled on the potential side effects and risks of the High Risk Medication.

AGE RESTRICTION

Apply if patient is 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Patients under 65 years of age are not subject to the prior authorization requirements.

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

HIGH RISK MEDICATION - BUTALBITAL COMBINATIONS

MEDICATION(S)

ASA-BUTALB-CAFFEINE-CODEINE, BUTALB-CAFF-ACETAMINOPH-CODEIN, BUTALBITAL COMPOUND-CODEINE, BUTALBITAL-ACETAMINOPHN 50-325, BUTALB-ACETAMIN-CAFF 50-325-40, BUTALBIT-ACETAMINOPHEN-CAFF CP, BUTALBITAL-ASA-CAFFEINE CAP

COVERED USES

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

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

For patients 65 years of age and older: Chart notes that document the patient's diagnosis and indication for use of the High Risk Medication. Chart notes documenting that a risk-versus-benefit assessment has been completed for use of the High Risk Medication. Chart notes documenting a detailed explanation of the specific benefit established and how the benefit outweighs the potential risk. Chart notes that document that the patient has been counseled on the potential side effects and risks of the High Risk Medication. For migraine headache, chart notes documenting an inadequate response or inability to tolerate two (2) safer formulary alternatives, such as sumatriptan, naratriptan, rizatriptan, or zolmitriptan.

AGE RESTRICTION

Apply if patient is 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Patients under 65 years of age are not subject to the prior authorization requirements.

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

HIGH RISK MEDICATION - FIRST GENERATION ANTIHISTAMINES

MEDICATION(S)

CARBINOXAMINE 4 MG/5 ML LIQUID, CARBINOXAMINE MALEATE 4 MG TAB, CLEMASTINE FUM 2.68 MG TAB, PROMETHAZINE 12.5 MG TABLET, PROMETHAZINE 25 MG TABLET, PROMETHAZINE 50 MG TABLET, PROMETHAZINE 6.25 MG/5 ML SOLN, PROMETHAZINE 6.25 MG/5 ML SYRP, PROMETHAZINE VC, PROMETHAZINE-PHENYLEPHRINE

COVERED USES

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

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

For patients 65 years of age and older: Chart notes that document the patient's diagnosis and indication for use of the High Risk Medication. Chart notes documenting that a risk-versus-benefit assessment has been completed for use of the High Risk Medication. Chart notes documenting a detailed explanation of the specific benefit established and how the benefit outweighs the potential risk. Chart notes that document that the patient has been counseled on the potential side effects and risks of the High Risk Medication. For allergic conditions, chart notes documenting an inadequate response or inability to tolerate two (2) safer formulary alternatives, such as levocetirizine, desloratadine, azelastine nasal spray, fluticasone propionate nasal spray, or budesonide nasal spray.

AGE RESTRICTION

Apply if patient is 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Patients under 65 years of age are not subject to the prior authorization requirements.

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

HIGH RISK MEDICATION - NON-BENZODIAZEPINE SEDATIVE HYPNOTICS

MEDICATION(S)

ESZOPICLONE, ZALEPLON, ZOLPIDEM TARTRATE 10 MG TABLET, ZOLPIDEM TARTRATE ER

COVERED USES

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

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

For patients 65 years of age and older: Chart notes that document the patient's diagnosis and indication for use of the High Risk Medication. Chart notes documenting that a risk-versus-benefit assessment has been completed for use of the High Risk Medication. Chart notes documenting a detailed explanation of the specific benefit established and how the benefit outweighs the potential risk. Chart notes that document that the patient has been counseled on the potential side effects and risks of the High Risk Medication. Chart notes documenting an inadequate response or inability to tolerate two (2) safer formulary alternatives, such as temazepam, Rozerem, or Silenor.

AGE RESTRICTION

Apply if patient is 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Patients under 65 years of age are not subject to the prior authorization requirements.

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

HIGH RISK MEDICATION - NON-COX-SELECTIVE NSAIDS

MEDICATION(S)
INDOMETHACIN 25 MG CAPSULE, INDOMETHACIN 50 MG CAPSULE, INDOMETHACIN ER

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For patients 65 years of age and older: Chart notes that document the patient's diagnosis and indication for use of the High Risk Medication. Chart notes documenting that a risk-versus-benefit assessment has been completed for use of the High Risk Medication. Chart notes documenting a detailed explanation of the specific benefit established and how the benefit outweighs the potential risk. Chart notes that document that the patient has been counseled on the potential side effects and risks of the High Risk Medication. Chart notes documenting an inadequate response or inability to tolerate two (2) safer formulary alternatives, such as ibuprofen, naproxen, nabumetone, etodolac, diclofenac, meloxicam, or topical diclofenac 1% gel.

AGE RESTRICTION
Apply if patient is 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Patients under 65 years of age are not subject to the prior authorization requirements.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MEDICATION(S)
H.P. ACTHAR

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

EXCLUSION CRITERIA
Scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, sensitivity to proteins of porcine origin, a congenital infection suspected in an infant, or administration of a live or live attenuated vaccine in a patient receiving immunosuppressive doses of H.P. Acthar Gel.

REQUIRED MEDICAL INFORMATION
Documented diagnosis of a FDA-approved indication not otherwise excluded from Part D. Cover under Medicare Part B, if the medication will be furnished by the prescriber/office, administered in the prescriber’s office or ambulatory setting, and will be billed by the prescriber/office. Cover under Medicare Part D, if the prescriber wants to have the medication provided by a pharmacy.

AGE RESTRICTION
Infantile Spasms: Less than 2 years of age. Multiple Sclerosis: Greater than or equal to 18 years of age. Other FDA-approved indications not otherwise excluded from Part D: Greater than 2 years of age.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Infantile Spasms: 1 year. Other FDA-approved indications: 1 month.

OTHER CRITERIA
N/A

MEDICATION(S)

HUMIRA, HUMIRA PEDIATRIC CROHN'S, HUMIRA PEN, HUMIRA PEN CROHN-UC-HS STARTER, HUMIRA PEN PSORIASIS-UVEITIS

COVERED USES

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

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Documentation of PPD test results and treatment plan for active or latent infection. For rheumatoid arthritis or psoriatic arthritis: Documentation of an inadequate response to at least 1 DMARD OR an intolerance to DMARDs (e.g. methotrexate, hydroxychloroquine, sulfasalazine). For juvenile idiopathic arthritis: Documentation of an inadequate response to 1 or more DMARD or an intolerance to DMARDs (e.g. NSAIDs, sulfasalazine, methotrexate, azathioprine, cyclosporine, prednisone). For ankylosing spondylitis: Documentation of an inadequate response to 1 or more DMARD or an intolerance to DMARDs (e.g. azathioprine, hydroxychloroquine, D-penicillamine, sulfasalazine, methotrexate and NSAIDs). For chronic to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. For psoriasis (greater than 10% BSA): Documentation of inadequate response to methotrexate or UVB therapy (alone or in combination with other medications) or Acitretin. For psoriasis (less than 10% BSA): Documentation of an inadequate response to 1 topical steroid (high to very high potency) AND calcipotriene 0.005% cream. For active Crohn's Disease, Pediatric Crohn’s Disease or active Ulcerative Colitis: Documentation of an inadequate response or intolerance to corticosteroids and methotrexate (for Crohn's disease) or azathioprine, or lost response to or been intolerant to infliximab. For hidradenitis suppurativa/acne inversa: Documentation of an inadequate response or intolerance to 2 of the following: topical antibiotics (e.g. clindamycin), oral antibiotics (e.g. doxycycline, minocycline, amoxicillin-clavulanic acid, clindamycin, rifampin, dapsone), intralesional triamcinolone injections. For uveitis: Documentation of an inadequate response or intolerance to 1 or more oral or topical glucocorticoid (e.g. prednisone, methylprednisolone, prednisolone), immunosuppressant agent (e.g. azathioprine, methotrexate, cyclosporine) or periocular or intraocular injection (e.g. triamcinolone).

AGE RESTRICTION

JIA: 2 years or greater, pediatric CD: 6 years or greater

PRESCRIBER RESTRICTION

An appropriate specialist or in consultation with Rheumatologist, Dermatologist, Gastroenterologist or Ophthalmologist

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

MEDICATION(S)
INGREZZA

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

EXCLUSION CRITERIA
Congenital long QT syndrome, Arrhythmias associated with prolonged QT interval, Severe renal impairment, Pregnancy. Concurrent use of MAO inhibitors or strong CYP3A4 inducers. Documentation that use in other movement disorders (such as Parkinson’s disease, Huntington’s chorea) have been excluded.

REQUIRED MEDICAL INFORMATION
Documented diagnosis of tardive dyskinesia including copy of Abnormal Involuntary Movement Scale (AIMS) assessment. Documentation of current or former chronic use of a dopamine antagonist (e.g., antipsychotic [first or second generation], metoclopramide, prochlorperazine, droperidol, promethazine, etc) with documentation attached.

AGE RESTRICTION
18 years or older.

PRESCRIBER RESTRICTION
Neurologist or psychiatrist as prescribing physician or in consultation.

COVERAGE DURATION
12 months.

OTHER CRITERIA
For renewal: Improvement in symptoms of tardive dyskinesia with both medical records and an updated AIMS assessment attached.

MEDICATION(S)
JUXTAPID

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

EXCLUSION CRITERIA
Pregnancy, hepatic impairment (Child-Pugh category B or C) and patients with active liver disease, use of Juxtapid in combination with moderate or strong CYP3A4 inhibitors and/or Kynamro. Prescribers who are not enrolled in the Juxtapid REMS program.

REQUIRED MEDICAL INFORMATION
Chart notes that document a diagnosis of Homozygous Familial Hypercholesterolemia (HoFH) with genetic testing attached or post-treatment (if ongoing on therapy) liver function test and lipid profile. Documentation of inadequate response, intolerance or contraindication to standard lipid-lowering regimen containing high potency statins. Documentation of inadequate response or medical reason for not utilizing a PCSK9 inhibitor (Repatha) to manage condition. Documentation that Juxtapid therapy will be used in combination with other lipid-lowering treatments such as statins, fenofibrates, ezetimibe, or niacin.

AGE RESTRICTION
18 years or older.

PRESCRIBER RESTRICTION
Cardiologist or Endocrinologist as prescribing physician or in consultation

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

KALYDECO

MEDICATION(S)
KALYDECO

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes that show that the diagnosis of cystic fibrosis is confirmed. Chart notes that show that appropriate genetic testing has been conducted (confirmation of one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data). Chart notes showing that lab work (baseline liver function, including alanine aminotransferase and asparatate aminotransferase) has been assessed prior to initiation of treatment.

AGE RESTRICTION
For oral granules: 2 years of age and older. For oral tablets: 6 years of age and older

PRESCRIBER RESTRICTION
Pulmonologist, Endocrinologist, Pediatrician

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MEDICATION(S)
KYNAMRO

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

EXCLUSION CRITERIA
Hepatic impairment (Child-Pugh Category B or C) and patients with active liver disease, use of Kynamro in combination with a Microsomal Triglyceride Transfer Protein (MTP) inhibitor. Prescribers who are not enrolled in the Kynamro REMS program.

REQUIRED MEDICAL INFORMATION
Chart notes that document a diagnosis of Homozygous Familial Hypercholesterolemia (HoFH) with genetic testing attached or post-treatment (if ongoing on therapy) liver function test and lipid profile. Documentation of intolerance or contraindication to standard lipid-lowering regimen containing high potency statins. Documentation of inadequate response or medical reason for not utilizing a PCSK9 inhibitor (Repatha) to manage condition. Documentation that Kynamro therapy will be used in combination with other lipid-lowering treatments such as statins, fenofibrates, ezetimibe, or niacin.

AGE RESTRICTION
18 years or older.

PRESCRIBER RESTRICTION
Cardiologist or Endocrinologist as prescribing physician or in consultation.

COVERAGE DURATION
6 months.

OTHER CRITERIA
N/A

LETAIRIS

MEDICATION(S)
LETAIRIS

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

EXCLUSION CRITERIA
Pregnancy. Idiopathic Pulmonary Fibrosis.

REQUIRED MEDICAL INFORMATION
If female of child bearing age, documentation that she will use reliable forms of contraception and that she will have monthly pregnancy tests performed during therapy. Documentation of diagnosis of pulmonary arterial hypertension (PAH) WHO Group 1. Diagnosis confirmed by a complete right heart catheterization (RHC), PAH defined as a resting mean pulmonary artery pressure (mPAP) of greater than or equal to 25 mm Hg, pulmonary capillary wedge pressure (PCWP) of less than or equal to 15 mm Hg, and pulmonary vascular resistance (PVR) of greater than or equal to 3 Wood units (RHC report must be attached). Documentation showing that hemoglobin and hematocrit are being monitored (baseline, at 1 month, and periodically thereafter).

AGE RESTRICTION
18 years or older

PRESCRIBER RESTRICTION
Cardiologist, Pulmonologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

LIDOCAINE PATCHES

MEDICATION(S)
LIDOCAINE 5% PATCH

COVERED USES
All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Patients with a known history of sensitivity to local anesthetics of the amide type, or to any other component of the product.

REQUIRED MEDICAL INFORMATION
Documentation to confirm the diagnosis of pain associated with post-herpetic neuralgia or diabetic peripheral neuropathy.

AGE RESTRICTION
18 years or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MEDICATION(S)
LYRICA CR

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation to confirm the diagnosis of pain associated with post-herpetic neuralgia (PHN) or diabetic peripheral neuropathy (DPN). Documentation of an inadequate response or inability to tolerate gabapentin and immediate release Lyrica. Dosage prescribed within package insert requirements (maximum of 330 mg per day for DPN, maximum of 660 mg per day for PHN).

AGE RESTRICTION
18 years or older.

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

MYALEPT

MEDICATION(S)
MYALEPT

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

EXCLUSION CRITERIA
Patients with general obesity not associated with congenital leptin deficiency. Patients with HIV-related lipodystrophy. Patients with metabolic disease, including diabetes mellitus and hypertriglyceridemia, without concurrent evidence of congenital or acquired generalized lipodystrophy.

REQUIRED MEDICAL INFORMATION
Documentation showing confirmation of a diagnosis of congenital or acquired generalized lipodystrophy, documentation of prescriber enrollment in Myalept REMS program, and chart notes documenting baseline hemoglobin A1C, glucose, and triglycerides. For members who have been previously approved, chart notes documenting updated hemoglobin A1C, glucose, and triglycerides.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
An appropriate specialist or in consultation with an endocrinologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MEDICATION(S)
NEULASTA

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For primary prophylaxis of febrile neutropenia: Documentation that shows that patient is receiving myelosuppressive chemotherapy. Documentation that shows that patient is at increased risk for febrile neutropenia. Documentation that shows that patient is receiving dose-dense or high-dose chemotherapy. For secondary prophylaxis of febrile neutropenia: documentation that shows the patient is receiving myelosuppressive chemotherapy with a history of febrile neutropenia during previous course of chemotherapy (for which primary prophylaxis was not received). Include treatment plan. For alternative indication, documentation supporting diagnosis of Hematopoietic Subsyndrome of Acute Radiation Syndrome. For all diagnosis, documentation that shows lab work (complete blood count with differential including ANC and platelet count) is being monitored.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months.

OTHER CRITERIA
N/A

MEDICATION(S)
NEUPOGEN, ZARXIO

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation or chart notes supporting medication is being used for all FDA-approved indications not otherwise excluded from Part D. For all diagnosis, chart notes that show that lab work (complete blood count with differential including ANC and platelet count) is being monitored prior to initiation of medication and during therapy based on recommendation for that specific diagnosis.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months.

OTHER CRITERIA
N/A

MEDICATION(S)
NORDITROPIN FLEXPRO

COVERED USES
All FDA-approved indications not otherwise excluded from Part D. For children: growth failure due to growth hormone deficiency, short stature associated with Noonan syndrome or Turner syndrome, growth failure/short stature associated with Prader-Willi syndrome, short stature born small for gestational age with no catch-up growth by age 2-4 years. For adults: growth hormone deficiency.

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
INITIAL REQUESTS: For children: (1) For growth failure due to growth hormone deficiency (GHD), chart notes that show growth chart, height, chronological age, bone age, and GHD diagnosis confirmed by either (a) at least 2 subnormal GH stimulation test results (peak GH levels less than 10 ng/mL), (b) 1 subnormal GH stimulation test result + 1 subnormal insulin-like growth factor-1 (IGF-1) level, or (c) 1 subnormal IGF-1 level + a history of panhypopituitarism/pituitary disease/hypothalamic disease/hypothalamic surgery/pituitary surgery/radiation therapy/trauma. (2) For short stature associated with Noonan syndrome, chart notes documenting genetic testing or clinical signs/symptoms consistent with diagnosis. (3) For short stature associated with Turner syndrome or Prader-Willi syndrome, chart notes documenting genetic testing consistent with diagnosis. (4) For short stature born small for gestational age with no catch-up growth by age 2-4 years, chart notes confirming diagnosis. For adults: Chart notes that show that the patient's GHD has been confirmed as an adult before replacement therapy is started or after at least 1 month off of GH therapy, including either (a) at least 2 subnormal GH stimulation test results (peak GH levels less than 5 ng/mL) or (b) a history of panhypopituitarism/pituitary disease/hypothalamic disease/hypothalamic surgery/pituitary surgery/radiation therapy/trauma + either 1 subnormal GH stimulation test result (peak GH level less than 5 ng/mL) or a subnormal IGF-1 level. RENEWAL REQUESTS: chart notes (which, for children, include documentation of growth chart, height, chronological age, bone age, and linear growth potential remaining with open epiphyses) documenting that the patient has tolerated the medication, and has an IGF-1 level that is within the appropriate reference range or will have their growth hormone dose adjusted to target an IGF-1 level that is within the appropriate reference range.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION

Endocrinologist

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

NUVIGIL (ARMODAFINIL)

MEDICATION(S)
ARMODAFINIL

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
A confirmed diagnosis of either narcolepsy (with sleep study attached), obstructive sleep apnea (with sleep study attached), or shift work disorder.

AGE RESTRICTION
17 years of age and older

PRESCRIBER RESTRICTION
Sleep specialist or neurologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MEDICATION(S)
OPSUMIT

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

EXCLUSION CRITERIA
Pregnancy.

REQUIRED MEDICAL INFORMATION
If a woman is of childbearing potential, documentation that she will use reliable forms of contraception and that she will have pregnancy tests performed prior to initiation of therapy and monthly during therapy. Documentation of diagnosis of pulmonary arterial hypertension (PAH) WHO Group 1. Diagnosis confirmed by a complete right heart catheterization (RHC), PAH defined as a resting mean pulmonary artery pressure (mPAP) of greater than or equal to 25 mm Hg, pulmonary capillary wedge pressure (PCWP) of less than or equal to 15 mm Hg, and pulmonary vascular resistance (PVR) of greater than or equal to 3 Wood units (RHC report must be attached). Documentation should be submitted showing that liver enzymes, hemoglobin and hematocrit are being monitored (at baseline, after the first month and repeated as clinically necessary).

AGE RESTRICTION
18 years or older.

PRESCRIBER RESTRICTION
Cardiologist, Pulmonologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

ORENCIA

MEDICATION(S)
ORENCIA, ORENCIA CLICKJECT

COVERED USES
All FDA-Approved indications not otherwise excluded from Part D.

EXCLUSION CRITERIA
Concomitant use with tumor necrosis factor antagonists and/or other biological rheumatoid arthritis (RA) therapy such as Kineret (anakinra).

REQUIRED MEDICAL INFORMATION
Documented diagnosis of Adult Rheumatoid Arthritis,Juvenile Idiopathic Arthritis, or Adult Psoriatic Arthritis. Documented evaluation of Tuberculosis (TB). Documentation of inadequate response or inability to tolerate one tumor necrosis factor antagonist (such as Enbrel or Humira). Cover under Medicare Part B, if the medication will be furnished by the prescriber/office, administered in the prescriber’s office or ambulatory setting, and will be billed by the prescriber/office. Cover under Medicare Part D, if the prescriber wants to have the medication provided by a pharmacy.

AGE RESTRICTION
For intravenous Orencia: 6 years of age or greater. For subcutaneous Orencia: 2 years of age or greater.

PRESCRIBER RESTRICTION
An appropriate specialist such as a rheumatologist, or in consultation with an appropriate specialist such as a rheumatologist

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

MEDICATION(S)
ORKAMBI

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes that show that the diagnosis of cystic fibrosis is confirmed. Chart notes that show that appropriate genetic testing has been conducted (homozygous for the F508del mutation in the CFTR gene). Chart notes showing that lab work (baseline liver function tests, including alanine aminotransferase, aspartate aminotransferase and bilirubin) has been assessed prior to initiation of treatment.

AGE RESTRICTION
For lumacaftor 100 mg/ivacaftor 125 mg tablets: Ages 6-11 years. For lumacaftor 200 mg/ivacaftor 125 mg tablets: Ages 12 and older.

PRESCRIBER RESTRICTION
Pulmonologist, Endocrinologist or Pediatrician.

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

OXYCONTIN (OXYCODONE ER)

MEDICATION(S)
OXYCODONE HCL ER, OXYCONTIN

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Quantity less than or equal to 2 tablets per day. For all diagnoses, chart notes that document that the patient has an intolerance or failure with sustained release morphine sulfate and fentanyl patches.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Pain management specialist or HIV specialist: chronic pain due to HIV-related neuropathy. Pain management specialist or oncologist: chronic pain due to cancer.

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

MEDICATION(S)

ABELCET, ACETYLCYSTEINE 10% VIAL, ACETYLCYSTEINE 20% VIAL, ACTEMRA 200 MG/10 ML VIAL, ACTEMRA 400 MG/20 ML VIAL, ACTEMRA 80 MG/4 ML VIAL, ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML VIAL, ALBUTEROL 15 MG/3 ML SOLUTION, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL 20 MG/4 ML SOLUTION, ALBUTEROL 5 MG/ML SOLUTION, ALBUTEROL SUL 0.63 MG/3 ML SOL, ALBUTEROL SUL 1.25 MG/3 ML SOL, ALBUTEROL SUL 2.5 MG/3 ML SOLN, ALIMTA 500 MG VIAL, ALIQOPA, AMBISOME, AMINOSYN II, AMINOSYN II WITH ELECTROLYTES, AMINOSYN 8.5%-ELECTROLYTES SOL, AMPHOTERICIN B 50 MG VIAL, APREPITANT, ASTAGRAF XL, AVASTIN, AZACITIDINE, AZACTAM, AZACTAM-ISO-OSMOTIC DEXTROSE, AZASAN, AZATHIOPRINE 50 MG TABLET, AZATHIOPRINE SODIUM, BAVENCIO, BCG VACCINE (TICE STRAIN), BELEODAQ, BIVIGAM, BLEOMYCIN SULFATE 30 UNIT VIAL, BORTEZOMIB, BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, CARIMUNE NF 6 GM VIAL, CELLCEPT 500 MG VIAL, CLADRIBINE, CLINIMIX, CLINIMIX E 4.25%-5% SOLUTION, CLINIMIX E 5%-20% SOLUTION, CLOFARABINE, COSMEGEN, CROMOLYN 20 MG/2 ML NEB SOLN, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 100 MG/ML SOLN, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE 50 MG/ML AMPUL, CYCLOSPORINE MODIFIED, CYRAMZA, CYTARABINE 2 G/20 ML VIAL, CYTARABINE 20 MG/ML VIAL, DACTINOMYCIN, DECITABINE, DEXRAZOXANE 250 MG VIAL, DEXTROSE 10%-WATER IV SOLUTION, DOCETAXEL 140 MG/7 ML VIAL, DOCETAXEL 160 MG/16 ML VIAL, DOCETAXEL 160 MG/8 ML VIAL, DOCETAXEL 20 MG/2 ML VIAL, DOCETAXEL 20 MG/ML VIAL, DOCETAXEL 200 MG/20 ML VIAL, DOCETAXEL 80 MG/4 ML VIAL, DOCETAXEL 80 MG/8 ML VIAL, DOXORUBICIN 50 MG/25 ML VIAL, DRONABINOL, ELIGARD, EMEND 125 MG POWDER PACKET, EMEND 150 MG VIAL, EMPLICITI, ENGERIX-B 20 MCG/ML SYRN, ENGERIX-B PEDIATRIC-ADOLESCENT, ENVARSUS XR, EXONDYS 51, FIRMAGON 2 X 120 MG KIT, FIRMAGON 80 MG KIT, FLUOROURACIL 1,000 MG/20 ML VL, FLUOROURACIL 2,500 MG/50 ML VL, FLUOROURACIL 2.5 GM/50 ML BTL, FLUOROURACIL 2.5 GM/50 ML VIAL, FLUOROURACIL 5 GM/100 ML BTL, FLUOROURACIL 5 GM/100 ML VIAL, FLUOROURACIL 5,000 MG/100 ML, FLUOROURACIL 500 MG/10 ML VIAL, GAMASTAN S-D, GAMMAGARD LIQUID, GAMMAGARD S-D, GAMMAPLEX, GAMUNEX-C 1 GRAM/10 ML VIAL, GANCICLOVIR SODIUM, GEMCITABINE HCL 1 GRAM VIAL, GRANISETRON HCL 1 MG TABLET, HERCEPTIN 150 MG VIAL, IBANDRONATE 3 MG/3 ML VIAL, IDARUBICIN HCL, IMFINZI, INFLECTRA, INTRALIPID, IPRATROPIUM BR 0.02% SOLN, IPRATROPIUM-ALBUTEROL, IRINOTECAN HCL 100 MG/5 ML VL, KEYTRUDA, KYPROLIS, LEUPROLIDE 1 MG/0.2 ML VIAL, LEUPROLIDE 2WK 1 MG/0.2 ML KIT, LEUPROLIDE 2WK 14 MG/2.8 ML KT, LEVALBUTEROL CONCENTRATE, LEVALBUTEROL HCL, LEVOLEUCOVORIN 175 MG/17.5 ML, LEVOLEUCOVORIN 250 MG/25 ML VL, LUMIZYME, LUPRON DEPOT, LUPRON DEPOT (LUPANETA), LUPRON DEPOT-PED, MAGNESIUM SULFATE 50% SYRINGE,

MELPHALAN HCL, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID, MYLOTARG, NEBUPENT, NIPENT, NULOJIX, ONDANSETRON 4 MG/5 ML SOLUTION, ONDANSETRON HCL 24 MG TABLET, ONDANSETRON HCL 4 MG TABLET, ONDANSETRON HCL 8 MG TABLET, ONDANSETRON ODT, OPDIVO 100 MG/10 ML VIAL, OPDIVO 40 MG/4 ML VIAL, OXALIPLATIN 100 MG VIAL, OXALIPLATIN 100 MG/20 ML VIAL, POTASSIUM CL 10 MEQ/5 ML CONC, POTASSIUM CL 2 MEQ/ML VIAL, POTASSIUM CL 20 MEQ/10 ML CONC, POTASSIUM CL 40 MEQ/20 ML CONC, PRIVIGEN, PROGRAF 5 MG/ML AMPULE, PULMOZYME, RAPAMUNE 1 MG/ML ORAL SOLN, RECOMBIVAX HB 10 MCG/ML SYR, RECOMBIVAX HB 10 MCG/ML VIAL, RECOMBIVAX HB 40 MCG/ML VIAL, RECOMBIVAX HB 5 MCG/0.5 ML SYR, REMODULIN, RENFLEXIS, SANDIMMUNE 100 MG/ML SOLN, SENSIPAR, SIMULECT 20 MG VIAL, SIROLIMUS 0.5 MG TABLET, SIROLIMUS 1 MG TABLET, SIROLIMUS 2 MG TABLET, SYLVANT 100 MG VIAL, SYNRIBO, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 1 MG CAPSULE, TACROLIMUS 5 MG CAPSULE, TECENTRIQ, THIOTEPA 15 MG VIAL, THYMOGLOBULIN, TOBRAMYCIN 300 MG/5 ML AMPULE, TOPOTECAN HCL 4 MG VIAL, TPN ELECTROLYTES, TRAVASOL, TREANDA 100 MG VIAL, TREANDA 25 MG VIAL, TRELSTAR, TRIMETHOBENZAMIDE 300 MG CAP, TRISENOX 12 MG/6 ML VIAL, TROPHAMINE, TYSABRI, VECTIBIX 100 MG/5 ML VIAL, VELCADE, VINBLASTINE SULFATE, VINCASAR PFS 1 MG/ML VIAL, VINCRISTINE 1 MG/ML VIAL, VPRIV, VYXEOS, ZANOSAR, ZOLEDRONIC ACID 5 MG/100 ML, ZORTRESS

DETAILS

This drug may be covered under Medicare Part B or D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

PRALUENT

MEDICATION(S)
PRALUENT PEN

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For Heterozygous Familial Hypercholesterolemia (HeFH): Documentation of either genetic confirmation OR WHO/Dutch Lipid Network Criteria score greater than 6. For patients with clinical atherosclerotic cardiovascular disease (ASCVD): Documentation of diagnosis. For both HeFH and clinical ASCVD: Documentation of prior treatment with at least one high intensity statin therapy (such as atorvastatin 40 mg or 80 mg or rosuvastatin 20 or 40 mg) for at least 3 continuous months with failure to reach target LDL-C (70 mg/dl for ASCVD, 100 mg/dL for HeFH). Documentation discussing statin intolerance, adverse reaction (rhabdomyolysis, muscle pain, muscle weakness associated with statin use) or contraindication (active liver disease, persistent elevation of serum transaminases) if statin therapy cannot be used. Either baseline or post-treatment labs (lipid profile) required for all indications.

AGE RESTRICTION
18 years or older

PRESCRIBER RESTRICTION
Cardiologist, Endocrinologist or Lipidologist as prescribing physician or in consultation

COVERAGE DURATION
3 month initial therapy, 12 month ongoing therapy

OTHER CRITERIA
N/A

PROCRIT

MEDICATION(S)
PROCRIT

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Documentation or chart notes supporting medication is being used for all FDA-approved indications not otherwise excluded from Part D. For all diagnosis chart notes that show that lab work (hemoglobin and iron stores) will be monitored periodically is required. Medication may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

MEDICATION(S)
PROMACTA

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

EXCLUSION CRITERIA
For Chronic hepatitis C infection: Patients who are being treated with direct-acting antiviral agents without interferon.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis: 1) chronic immune (idiopathic) thrombocytopenia (ITP), 2) thrombocytopenia in patients with chronic hepatitis C, or 3) severe aplastic anemia. For ITP: Documentation of an insufficient response to or intolerance to glucocorticoids (prednisone, high-doses dexamethasone or methylprednisolone), immunoglobulins, or splenectomy. For chronic hepatitis C: Documentation of patient's degree of thrombocytopenia that prevents the initiation of interferon-based therapy or limits the ability to maintain interferon-based therapy. For severe aplastic anemia: Documentation of an insufficient response to immunosuppressive therapy.

AGE RESTRICTION
For ITP: 1 year or older. For chronic hepatitis C or severe aplastic anemia: 18 years or older.

PRESCRIBER RESTRICTION
For Thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia (ITP) and for patients with severe aplastic anemia: Hematologist. For Thrombocytopenia in patients with chronic hepatitis C: Hematologist or Hepatologist.

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MEDICATION(S)
RADICAVA

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

EXCLUSION CRITERIA
Patients with a history of hypersensitivity to edaravone or any of the inactive ingredients of this product.

REQUIRED MEDICAL INFORMATION
Documented diagnosis of clinically definite or probable amytrophic lateral sclerosis (ALS) based on El Escorial revised criteria or Awaji criteria. Documentation of baseline ALS Functional Rating Scale-Revised (ALSFRS-R). Cover under Medicare Part B if the medication will be furnished by the prescriber/office, administered in the prescriber's office or ambulatory setting, and will be billed by the prescriber/office. Cover under Medicare Part D if the prescriber wants to have the medication provided by a pharmacy.

AGE RESTRICTION
18 years or older.

PRESCRIBER RESTRICTION
An appropriate specialist such as a neurologist, or in consultation with an appropriate specialist such as a neurologist.

COVERAGE DURATION
12 months.

OTHER CRITERIA
N/A

MEDICATION(S)
REPATHA PUSHTRONEX, REPATHA SURECLICK, REPATHA SYRINGE

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For Homozygous Familial Hypercholesterolemia (HoFH): Genetic confirmation of 2 mutant alleles in the LDL receptor, Apo B-100 PCSK9 gene OR untreated LDL-C greater than 500 mg/dL OR treated LDL-C greater than or equal to 300 mg/dL with cutaneous or tendonous xanthoma before the age of 10 OR untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia (HeFH) in both parents with documentation attached. Dosing as 420 mg once a month. For HeFH: Documentation of either genetic confirmation OR WHO/Dutch Lipid Network Criteria score greater than 6 with documentation attached. For patients with clinical atherosclerotic cardiovascular disease (ASCVD) or primary hyperlipidemia: Documentation of diagnosis. For both primary hyperlipidemia (including HeFH) and clinical ASCVD: Documentation of prior treatment of at least one high intensity statin therapy (such as atorvastatin 40 mg or 80 mg or rosuvastatin 20mg or 40 mg) for at least 3 continuous months with failure to reach target LDL-C levels. Documentation discussing statin intolerance, adverse reaction (rhabdomyolysis, muscle pain, muscle weakness associated with statin use) or contraindication (active liver disease, persistent elevation of serum transaminases) if statin therapy cannot be used. Either baseline or post-treatment labs (lipid profile) required for all indications.

AGE RESTRICTION
13 years or older for HoFH, 18 years or older for HeFH and ASCVD.

PRESCRIBER RESTRICTION
Cardiologist, Endocrinologist, or Lipidologist as prescribing physician or in consultation

COVERAGE DURATION
3 month initial therapy, 12 month ongoing therapy

OTHER CRITERIA
N/A

REVATIO (SILDENAFIL)

MEDICATION(S)
REVATIO 10 MG/ML ORAL SUSP, SILDENAFIL, SILDENAFIL 10 MG/12.5 ML VIAL

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

EXCLUSION CRITERIA
Concomitant organic nitrates. Concomitant Guanylate Cyclase (GC) Stimulators.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of pulmonary arterial hypertension (PAH) WHO Group 1. Diagnosis confirmed by a complete right heart catheterization (RHC), PAH defined as a resting mean pulmonary artery pressure (mPAP) of greater than or equal to 25 mm Hg, pulmonary capillary wedge pressure (PCWP) of less than or equal to 15 mm Hg, and pulmonary vascular resistance (PVR) of greater than or equal to 3 Wood units (RHC report must be attached).

AGE RESTRICTION
18 years or older

PRESCRIBER RESTRICTION
Cardiologist, Pulmonologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

RIBAVIRIN

MEDICATION(S)

REBETOL 40 MG/ML SOLUTION, RIBASPHERE 200 MG CAPSULE, RIBASPHERE 200 MG TABLET, RIBAVIRIN 200 MG CAPSULE, RIBAVIRIN 200 MG TABLET

COVERED USES

All FDA-approved indications not otherwise excluded from Part D, per current American Association for the Study of Liver Diseases (AASLD) - Infectious Disease Society of America (IDSA) Hepatitis C Virus (HCV) Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C

EXCLUSION CRITERIA

Ribavirin is being used as monotherapy. Patients who have contraindications to ribavirin (RBV). Patient or the partner of the patient is pregnant.

REQUIRED MEDICAL INFORMATION

Documentation of diagnosis of chronic Hepatitis C (CHC). Lab results must be attached: Hepatitis C virus (HCV) genotype and subtype, quantitative HCV RNA, complete blood count (CBC), international normalized ratio (INR), hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels), serum creatinine/calculated glomerular filtration rate, liver biopsy or other indirect markers (such as FibroTest or Fibroscan). Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

AGE RESTRICTION

3 years of age or older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 to 48 weeks. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

OTHER CRITERIA

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

MEDICATION(S)
SOVALDI

COVERED USES
All FDA-approved indications not otherwise excluded from Part D, per current American Association for the Study of Liver Diseases (AASLD) - Infectious Disease Society of America (IDSA) Hepatitis C Virus (HCV) Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C.

EXCLUSION CRITERIA
Patients whose medication profile shows treatment with any contraindicated drug-drug interactions (Risk X). Patients who have renal impairment (calculated glomerular filtration rate less than 30mL/min). Patients who have end stage renal disease (ESRD). Sovaldi is being used as monotherapy. Criteria will be applied consistent with current AASLD-IDSA guidance.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of chronic Hepatitis C (CHC). Lab results must be attached: Hepatitis C virus (HCV) genotype and subtype, quantitative HCV RNA, complete blood count (CBC), international normalized ratio (INR), hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, and alkaline phosphatase levels), serum creatinine/calculated glomerular filtration rate, liver biopsy or other indirect markers (such as FibroTest or Fibroscan), HBsAg and anti-HBc. Patients must have viral genotype 1, 2, 3 or 4. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

AGE RESTRICTION
12 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 to 48 weeks. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

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

SYNAGIS

MEDICATION(S)
SYNAGIS 50 MG/0.5 ML VIAL

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Discharge summary or chart notes are needed to verify the following: Infants being treated are born before 29 weeks, 0 days' gestation that is younger than 12 months at the start of RSV season. Infants born 29 weeks, 0 days' gestation or later may qualify to receive prophylaxis on the basis of congenital heart disease (CHD), chronic lung disease (CLD), or another condition (such as pulmonary abnormality or neuromuscular disease) and younger than 12 months at the start of RSV season. In the first year of life, palivizumab prophylaxis is recommended for preterm infants with CLD of prematurity, defined as birth at less than 32 weeks, 0 days' gestation and a requirement for greater than 21% oxygen for at least 28 days after birth. During the second year of life, consideration of palivizumab prophylaxis is recommended only for infants who satisfy this definition of CLD of prematurity and continue to require medical support during the 6-month period before the start of the second RSV season. Certain children who are 12 months or younger with hemodynamically significant CHD, as defined by American Academy of Pediatrics, may benefit from palivizumab prophylaxis. Children younger than 24 months who will be profoundly immunocompromised during the RSV season may be considered for prophylaxis. Additional considerations for prophylaxis include: Infant with cystic fibrosis with clinical evidence of CLD and/or nutritional compromise who is younger than or equal to 12 months at the start of the RSV season. Children less than or equal to 24 months of age with cystic fibrosis with manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable) or weight for length less than the 10th percentile at the start of the RSV season. Children younger than 24 months who will be undergoing cardiac transplantation during the RSV season.

AGE RESTRICTION
less than 24 months (dependent upon gestational age and comorbid conditions)

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION

3 to 5 doses

OTHER CRITERIA

N/A

THALOMID

MEDICATION(S)
THALOMID

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Confirmation that the patient and prescriber are enrolled in the Thalomid REMS program. Lab results - CBC with differential, platelets, viral load for patients who are HIV-seropositive. Chart notes that show the patient has been evaluated for signs of neuropathy. For multiple myeloma, pharmacy records showing that Thalomid is being used in combination with dexamethasone.

AGE RESTRICTION
12 year or older

PRESCRIBER RESTRICTION
Oncologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MEDICATION(S)
TRACLEER

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

EXCLUSION CRITERIA
Pregnancy. Use with cyclosporine A and/or glyburide.

REQUIRED MEDICAL INFORMATION
If female of child bearing age, documentation that she will use reliable forms of contraception and that she will have monthly pregnancy tests performed during therapy. For pediatric patient aged 3 to 15 years, documentation of diagnosis of idiopathic or congenital pulmonary arterial hypertension (PAH), confirmed by mean pulmonary artery pressure (mPAP) of greater than or equal to 25 mmHg. For patients 15 years or older, documentation of diagnosis of PAH WHO Group 1 with New York Heart Association (NYHA) Functional Class II, III or IV symptoms. Diagnosis confirmed by a complete right heart catheterization (RHC), PAH defined as a resting mPAP of greater than or equal to 25 mmHg, pulmonary capillary wedge pressure (PCWP) of less than or equal to 15 mmHg, and pulmonary vascular resistance (PVR) of greater than or equal to 3 Wood units (RHC report must be attached). Documentation that show that serum transaminases (AST/ALT) and bilirubin are being monitored (prior to initiation of treatment and then monthly).

AGE RESTRICTION
3 years or older

PRESCRIBER RESTRICTION
Cardiologist, Pulmonologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MEDICATION(S)
UPTRAVI

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Chart notes that show that diagnosis of pulmonary arterial hypertension has been confirmed with a complete right heart catheterization (RHC)-report must be attached. Chart notes that show that an acute vasodilator test has been performed and the patient's response to the acute vasodilator test. Documentation that supports patient's World Health Organization Group (WHO Group 1) and Functional Class Pharmacy records or chart notes documenting trial of or inadequate response to two alternatives (used alone or in combination) from the following list of medications: Prostocyclin Analogues (Treprostinil), Endothelin Receptor Antagonists (Bosentan, Ambrisentan, Macitentan), Phosphodiesterase-5 inhibitors (Revatio, Adcirca), Guanylate Cyclase stimulators (Riociguat). Chart notes which contain the treatment plan that discusses concurrent therapy. Chart notes that document required lab monitoring (hepatic impairment status (Child Pugh Class)) and dosing adjustments as needed.

AGE RESTRICTION
18 years of age or greater

PRESCRIBER RESTRICTION
Cardiologist or Pulmonologist as prescribing physician or in consultation

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

XIFAXAN

MEDICATION(S)
XIFAXAN

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

EXCLUSION CRITERIA
Hypersensitivity to rifaximin, any of the rifamycin antimicrobial agents, or any component of the formulation.

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of Traveler's Diarrhea (TD) caused by noninvasive strains of Escherichia coli and trial of or inadequate response to a fluoroquinolone (e.g., ciprofloxacin, levofloxacin) or azithromycin. Dosing as 200 mg tablet 3 times a day. Documentation of diagnosis of Hepatic Encephalopathy (HE) and trial of or inadequate response to lactulose. Dosing as 550 mg tablet 2 times a day. Documentation of Irritable Bowel Syndrome (IBS) with diarrhea and trial of or inadequate response to one antispasmodic agent (e.g., dicyclomine) or one anti-diarrheal agent (e.g., diphenoxylate/atropine, loperamide). Dosing as 550 mg tablet 3 times a day.

AGE RESTRICTION
12 years or older for Traveler's Diarrhea. 18 years or older for IBS with diarrhea or Hepatic Encephalopathy.

PRESCRIBER RESTRICTION
An appropriate specialist or in consultation with a Gastroenterologist, Hepatologist, Infectious Disease

COVERAGE DURATION
TD: 3 days. HE: 12 months. IBS w/ diarrhea: 14 days up to 3 treatments.

OTHER CRITERIA
N/A

MEDICATION(S)
XOLAIR

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For moderate to severe persistent asthma: Chart notes that show patient had a trial of OR intolerance to oral corticosteroids and/or combination therapies (inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline). Chart notes that show patient has daily asthma symptoms (coughing, wheezing, dyspnea), daily use of rescue inhalers (such as short acting beta2-agonist), asthma attacks/exacerbations two or more times per week, multiple emergency room visits within the past 12 months or one or more nights of nocturnal asthma causing awakening. Chart notes that show patient's FEV1 is greater than 40% and less than 80% of predicted normal pre-inhaled steroids.Chart notes that show positive skin test, RAST, or in vitro reactivity to at least one perennial aeroallergen and IgE levels between 30-700 IU/mL. For chronic idiopathic urticaria: chart notes that show patient remained symptomatic despite H1 antihistamine treatment or has an intolerance or contraindication to H1 antihistamine treatment. For renewal for moderate to severe persistent asthma: chart notes that show that the patient has improvement in FEV1. Chart notes showing documentation of decreased steroid dose requirements and documented decrease of rescue medications.

AGE RESTRICTION
6 years and older

PRESCRIBER RESTRICTION
Pulmonologist, Allergist, Immunologist, Dermatologist

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MEDICATION(S)
ZEPATIER

COVERED USES
All FDA-approved indications not otherwise excluded from Part D, per current American Association for the Study of Liver Diseases (AASLD) - Infectious Disease Society of America (IDSA) Hepatitis C Virus (HCV) Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C.

EXCLUSION CRITERIA
Patients whose medication profile shows treatment with any contraindicated drug-drug interactions (Risk X). Patients who have decompensated cirrhosis or Child-Pugh (CTP) class B or C. Patients who are treated with other Direct Acting Agent (DAA).

REQUIRED MEDICAL INFORMATION
Documentation of diagnosis of chronic Hepatitis C (CHC). Lab results must be attached: Hepatitis C virus (HCV) genotype and subtype, quantitative HCV RNA, complete blood count (CBC), international normalized ratio (INR), hepatic function panel (albumin, total and direct bilirubin, alanine aminotransferase, aspartate aminotransferase, alkaline phosphatase levels), liver biopsy or other indirect markers (such as FibroTest or Fibroscan), HBsAg and anti-HBc. Additional labs for genotype 1a only: Baseline NS5A polymorphisms. Patients must have viral genotype 1, 3, or 4. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

AGE RESTRICTION
18 years of age or older

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 to 16 weeks. Criteria will be applied consistent with current AASLD-IDSA HCV guidance.

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

ZYVOX (LINEZOLID)

MEDICATION(S)
LINEZOLID

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For Vancomycin-resistant Enterococcus faecium infection, with or without concurrent bacteremia: chart notes documenting culture results. For nosocomial pneumonia caused by Staphylococcus aureus methicillin-susceptible and -resistant strains (MSSA and MRSA) or Streptococcus pneumoniae and community-acquired pneumonia caused by Streptococcus pneumoniae, including cases with concurrent bacteremia, or MSSA: chart notes that show an inadequate response or inability to tolerate vancomycin IV and clindamycin PO/IV. For uncomplicated skin and skin structure infection caused by MSSA or Streoptococcus pyogenes: chart notes that show an inadequate response or inability to tolerate at least two (2) of the following: clindamycin PO, trimethoprim-sulfamethoxazole PO, and doxycycline PO or minocycline PO. For complicated skin and skin structure infection, including diabetic foot infections, without concomitant osteomyelitis, caused by MSSA and MRSA, Streptococcus pyogenes, or Streptococcus agalactiae: chart notes that show an inadequate response or inability to tolerate vancomycin IV and clindamycin PO/IV. For MRSA osteomyelitis or septic arthritis: chart notes that show an inadequate response or inability to tolerate at least two (2) of the following: vancomycin IV, clindamycin PO/IV, and trimethoprim-sulfamethoxazole plus rifampin PO/IV. For all diagnoses: Chart notes showing that lab work (sensitivities, culture results) are being monitored and an Infectious Disease consult.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
10 days to 8 weeks

OTHER CRITERIA

N/A