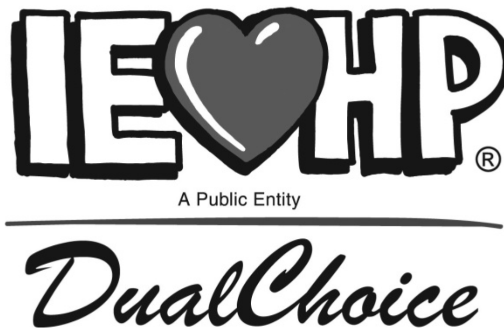
Prior Authorization Criteria
Last Updated: July 28, 2020
Effective Date: August 1, 2020



2020 Prior Authorizations

(List of Prior Authorizations)

PLEASE READ CAREFULLY: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE PRIOR AUTHORIZATIONS ON DRUGS THAT WE COVER IN THIS PLAN.

Note to existing members: Beneficiaries must use network pharmacies to access their prescription drug benefit. “Benefits, List of Covered Drugs, pharmacy and provider networks and copayments may change from time to time throughout the year and on January 1 of each year.”

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. You can get this information for free in other languages. Call 1-877-273-IEHP (4347), 8am – 8pm (PST) 7 days a week, including holidays. TTY users should call 1-800-718-4347. The call is free.

Usted puede obtener esta información gratis en otros idiomas. Llame al 1-877-273-IEHP (4347), 8am – 8pm (Hora del Pacífico), los 7 días de la semana, incluidos días festivos. Los usuarios de TTY deben llamar al 1-800-718-4347. La llamada es gratuita.

H5355_CMC_20_1778314

ABELCET

Products Affected
- ABELCET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.
Indications	All FDA-approved Indications.
Off Label Uses	

ABILIFY MAINTENA

Products Affected

- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 300 MG, 400 MG
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented history of receiving oral aripiprazole without any clinically significant side effects. Failure or clinically significant adverse effects to two of the formulary alternatives: Invega Sustenna, Invega Trinza or Risperdal Consta.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: calcipotriene, clobetasol, cyclosporine, fluocinonide, methotrexate, or Tazorac.
Indications	All FDA-approved Indications.
Off Label Uses	

ACTIMMUNE

Products Affected
- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist, Orthopedist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

ADEFOVIR

Products Affected

- *adefovir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ADHD

Products Affected

- *dexmethylphenidate oral tablet*
- *methylphenidate hcl oral capsule, er biphasic 30-70*
- *methylphenidate hcl oral capsule,er biphasic 50-50 10 mg, 20 mg, 30 mg, 40 mg*
- *methylphenidate hcl oral solution*
- *methylphenidate hcl oral tablet*
- *methylphenidate hcl oral tablet extended release*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALLI

Products Affected

- ALLI 60 MG CAPSULE STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BMI greater than or equal to 27 kg/m2 with one or more comorbidity (e.g. coronary heart disease, dyslipidemia, hypertension, type 2 diabetes mellitus, sleep apnea), OR BMI greater than or equal to 30 kg/m2. Reauthorization: Documented weight loss of 5% during the first 6 month period and lack of side effects. Therapy beyond the first year can be authorized every 6 months with documentation of weight maintenance and lack of side effects.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AMBISOME

Products Affected

- AMBISOME

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to the formulary alternative: conventional Amphotericin B.
Indications	All FDA-approved Indications.
Off Label Uses	

AMITRIPTYLINE

Products Affected

- *amitriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	

AMOXAPINE

Products Affected

- *amoxapine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	

AMPHOTERICIN B

Products Affected

- *amphotericin b*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

ANADROL

Products Affected
- ANADROL-50

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ANDROGENS

Products Affected

- ANDRODERM
- *testosterone transdermal gel in metered-dose pump*
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)*
- *testosterone transdermal solution in metered pump w/app*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ANTICONVULSANTS 1

Products Affected

- APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG
- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG
- EPIDIOLEX
- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, valproic acid or zonisamide.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ANTICONVULSANTS 2

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- VIMPAT ORAL SOLUTION
- VIMPAT ORAL TABLET
- XCOPRI MAINTENANCE PACK
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG
- XCOPRI TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, valproic acid or zonisamide.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ANTIFIBROTIC AGENTS

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG
- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	Esbriet: Severe hepatic impairment (Child-Pugh C). Ofev: Moderate or severe hepatic impairment (Child-Pugh B or C).
Required Medical Information	Initial authorization: Diagnosis of idiopathic pulmonary fibrosis confirmed by the presence of usual interstitial pneumonia on high resolution computed tomography (HRCT) and/or surgical lung biopsy. Documentation of liver function tests, documentation of baseline forced vial capacity (FVC) greater than or equal to 50 percent of the predicted value AND documentation of percent predicted diffusing capacity of the lungs for carbon monoxide (%DLCO) greater than or equal to 30 percent. Diagnosis of systemic sclerosis-associated interstitial lung disease for Ofev only. Documentation of liver function tests. Reauthorization only: Documentation of positive response to medication therapy AND documentation of liver function tests.
Age Restrictions	
Prescriber Restrictions	Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ANTINEOPLASTIC

Products Affected

- *abiraterone*
- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG
- ALECENSA
- ALUNBRIG
- AYVAKIT
- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG
- BOSULIF
- BRAFTOVI ORAL CAPSULE 75 MG
- BRUKINSA
- CABOMETYX
- CALQUENCE
- CAPRELSA
- COMETRIQ
- COPIKTRA
- COTELLIC
- DAURISMO ORAL TABLET 100 MG, 25 MG
- ERIVEDGE
- ERLEADA
- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*
- FARYDAK ORAL CAPSULE 10 MG, 20 MG
- GILOTRIF
- IBRANCE
- ICLUSIG ORAL TABLET 15 MG, 45 MG
- IDHIFA
- *imatinib oral tablet 100 mg, 400 mg*
- IMBRUVICA ORAL CAPSULE
- IMBRUVICA ORAL TABLET 280 MG, 420 MG, 560 MG
- INLYTA ORAL TABLET 1 MG, 5 MG
- INREBIC
- IRESSA
- JAKAFI
- KISQALI FEMARA CO-PACK
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)
- KOSELUGO ORAL CAPSULE 10 MG, 25 MG
- LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)
- LONSURF
- LORBRENA ORAL TABLET 100 MG, 25 MG
- LYNPARZA ORAL TABLET
- MATULANE
- MEKINIST ORAL TABLET 0.5 MG, 2 MG
- MEKTOVI
- NERLYNX
- NEXAVAR
- NINLARO
- NUBEQA
- ODOMZO
- PANRETIN
- PEMAZYRE
- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)
- POMALYST
- PURIXAN
- QINLOCK
- RETEVMO ORAL CAPSULE 40 MG, 80 MG
- REVLIMID
- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG
- RUBRACA
- RYDAPT
- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG
- STIVARGA
- SUTENT

- SYNRIBO
- TABLOID
- TAFINLAR
- TAGRISSO
- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG
- TASIGNA
- TAZVERIK
- THALOMID
- TIBSOVO
- TUKYSA ORAL TABLET 150 MG, 50 MG
- TURALIO
- TYKERB
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION
- VIZIMPRO
- VOTRIENT
- XALKORI
- XOSPATA
- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 60 MG/WEEK (20 MG X 3), 80 MG/WEEK (20 MG X 4), 80MG TWICE WEEK (160 MG/WEEK)
- XTANDI
- YONSA
- ZEJULA
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET
- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

APOKYN

Products Affected

- APOKYN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: antiparkinson drugs such as amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline.
Indications	All FDA-approved Indications.
Off Label Uses	

APREPITANT

Products Affected

- *aprepitant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months.
Other Criteria	Subject to Part B vs Part D determination. Failure or clinically significant adverse effects to one of the formulary 5-HT3 antagonist alternatives: ondansetron or granisetron except when the member is on any chemotherapy.
Indications	All FDA-approved Indications.
Off Label Uses	

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	Concurrently taking any tumor necrosis factor (TNF)-blocking agents such as Enbrel, Humira, or Remicade.
Required Medical Information	
Age Restrictions	Approve if 12 years old or older.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ARIPIPRAZOLE

Products Affected

- *aripiprazole oral solution*
- *aripiprazole oral tablet,disintegrating*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow or failure or clinically significant adverse effects to the formulary alternative: oral aripiprazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ATOVAQUONE

Products Affected
- *atovaquone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Pneumocystic pneumonia: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim/sulfamethoxazole.
Indications	All FDA-approved Indications.
Off Label Uses	

AUBAGIO

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AUSTEDO

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with an MAOI.
Required Medical Information	Chorea (Huntington's Disease): Failure or clinically significant adverse effects to the formulary alternative: tetrabenazine. Reauthorization only: Documentation of positive response to medication therapy.
Age Restrictions	
Prescriber Restrictions	Neurologist, Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CARISOPRODOL

Products Affected

- *carisoprodol oral tablet 350 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk.
Indications	All FDA-approved Indications.
Off Label Uses	

CASPOFUNGIN

Products Affected
- *caspofungin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

CLOMIPRAMINE

Products Affected
- *clomipramine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: fluoxetine, fluvoxamine, paroxetine, or sertraline.
Indications	All FDA-approved Indications.
Off Label Uses	

CLOZAPINE

Products Affected

- *clozapine oral tablet,disintegrating 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg*
- VERSACLOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow or failure or clinically significant adverse effects to the formulary alternative: oral clozapine.
Age Restrictions	
Prescriber Restrictions	Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CONSTIPATION AGENTS

Products Affected

- AMITIZA
- LINZESS
- MOVANTIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to one of the formulary alternatives: lactulose or polyethylene glycol.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CORLANOR

Products Affected

- CORLANOR ORAL SOLUTION
- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Heart failure in adult patients: Documented New York Association (NYHA) class II to IV heart failure with an ejection fraction of less than or equal to 35% and sinus rhythm with a resting heart rate greater than or equal to 70 beats per minute (bpm). Documentation that patient is on maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication or a hypersensitivity to beta blocker. Documented concurrent use with an ACE inhibitor or ARB, unless both are not tolerated or contraindicated. Heart failure in pediatric patients: Documented NYHA/Ross class II to IV heart failure with an ejection fraction of less than or equal to 45% and sinus rhythm with a resting heart rate greater than or equal to 105 bpm in the age subset 6-12 months, greater than or equal to 95 bpm in the age subset 1-3 years, greater than or equal to 75 bpm in the age subset 3-5 years, greater than or equal to 70 bpm in the age subset 5-18 years
Age Restrictions	
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CYCLOBENZAPRINE

Products Affected

- *cyclobenzaprine oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk
Indications	All FDA-approved Indications.
Off Label Uses	

DALFAMPRIDINE

Products Affected
- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Concurrently on a disease-modifying agent for multiple sclerosis. Documentation of difficulty walking (such as timed 25-foot walk test: Patient must be able to walk 25 feet within 8-45 sec). Reauthorization only: Documentation of positive response to medication therapy.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DALIRESP

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to two of the formulary alternatives: either Wixela or Fluticasone/Salmeterol, Anoro Ellipta, Serevent, Spiriva or Tudorza.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DAPTOMYCIN

Products Affected

- *daptomycin intravenous recon soln 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination
Indications	All FDA-approved Indications.
Off Label Uses	

DARAPRIM

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, HIV specialist, Infectious Disease specialist, Oncologist, Transplant specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Primary prophylaxis of toxoplasmic encephalitis: Failure or clinically significant adverse effects to the formulary alternative: trimethoprim-sulfamethoxazole.
Indications	All Medically-accepted Indications.
Off Label Uses	

DEFERASIROX

Products Affected

- *deferasirox oral tablet, dispersible*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DESIPRAMINE

Products Affected

- *desipramine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, venlafaxine, duloxetine, desvenlafaxine
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DIAZEPAM SOLUTION

Products Affected

- *diazepam oral concentrate*
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DISOPYRAMIDE

Products Affected

- *disopyramide phosphate oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: acebutolol, amiodarone, flecainide, mexiletine, propafenone, quinidine, or sotalol.
Indications	All FDA-approved Indications.
Off Label Uses	

DOXEPIN

Products Affected

- *doxepin oral capsule*
- *doxepin oral concentrate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	For the average daily dose of doxepin that is greater than 6 mg: Anxiety: Failure or clinically significant adverse effects to two of the formulary alternatives: buspirone, escitalopram, paroxetine, or venlafaxine. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	

DRIZALMA

Products Affected

- DRIZALMA SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow an intact capsule or failure or clinically significant adverse effects to the formulary alternative: duloxetine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DRONABINOL

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Chemotherapy-induced nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, metoclopramide, ondansetron, or prochlorperazine.
Indications	All FDA-approved Indications.
Off Label Uses	

DROXIDOPA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELIGARD

Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: phenelzine and tranylcypromine.
Indications	All FDA-approved Indications.
Off Label Uses	

ENBREL

Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to two of the following: acitretin, cyclosporine, methotrexate or phototherapy.
Indications	All FDA-approved Indications.
Off Label Uses	

ENTECAVIR

Products Affected

- BARACLUDE ORAL SOLUTION
- *entecavir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENTRESTO

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of Chronic Heart Failure (NYHA Class II-IV) and reduced ejection fraction less than or equal to 40%.
Age Restrictions	
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EPOGEN

Products Affected

- EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	Uncontrolled hypertension.
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodysplastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All Medically-accepted Indications.
Off Label Uses	

ERTAPENEM

Products Affected

- *ertapenem*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	14 days.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

ESTROGENS

Products Affected

- *estradiol oral*
- *estradiol transdermal patch weekly*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects all of the formulary alternatives: alendronic acid and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol cream or Premarin Cream.
Indications	All FDA-approved Indications.
Off Label Uses	

FENTANYL LOZENGE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	Acute, intermittent, or postoperative pain.
Required Medical Information	Documentation of opioid tolerance taking around-the-clock opioid therapy consisting of at least 60mg of oral morphine daily, at least 25mg transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8mg oral hydromorphone daily or an equianalgesic dose of another opioid daily for a week or longer for breakthrough pain of cancer. Patients must remain on around-the clock opioids when taking transmucosal immediate release fentanyl.
Age Restrictions	
Prescriber Restrictions	Pain Specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FETZIMA

Products Affected
- FETZIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	

FILGRASTIM

Products Affected

- FULPHILA
- NEUPOGEN
- ZARXIO
- ZIEXTENZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to formulary alternative: Nivestym.
Age Restrictions	
Prescriber Restrictions	Hematologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

FIRAZYR

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing.
Age Restrictions	
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FIRMAGON

Products Affected

- FIRMAGON KIT W DILUENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

GENOTROPIN

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AGHD(initial): diagnosis confirmed as a result of past diagnosis of childhood-onset GHD, or adult-onset GHD with documentation of hormone deficiency due to hypothalamic-pituitary disease from organic or known causes (eg: damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and documentation of one growth-hormone stimulant test (eg: insulin tolerance test, arginine/GHRH,glucagon,arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or documentated deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IFG-1/somatomedinC below age and gender adjusted normal range as provided by physicians lab. AGHD(reauthorization): Documentation of positive experience by the patient.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GEODON SOLUTION

Products Affected

- ZIPRASIDONE MESYLATE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

GILENYA

Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Class III or IV heart failure, decompensated heart failure requiring hospitalization, myocardial infarction, stroke, transient ischemic attack or unstable angina within the last 6 months. Concomitant use of Class Ia or Class III anti-arrhythmic drugs. Mobitz type II second-degree or third-degree atrioventricular block, or sick-sinus syndrome unless the patient has a functional pacemaker. QT interval at baseline 500 ms or greater.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
Indications	All FDA-approved Indications.
Off Label Uses	

GLATIRAMER

Products Affected

- *glatiramer*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GLATOPA

Products Affected

- *glatopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GLYBURIDE

Products Affected

- *glyburide micronized*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: glipizide and glimepiride.
Indications	All FDA-approved Indications.
Off Label Uses	

GUANFACINE

Products Affected

- *guanfacine oral tablet*
- *guanfacine oral tablet extended release 24 hr*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Hypertension: Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide. ADHD: Failure or clinically significant adverse effects to two of the formulary alternatives: amphetamine/dextroamphetamine, dexmethylphenidate, dextroamphetamine, or methylphenidate.
Indications	All FDA-approved Indications.
Off Label Uses	

HP ACTHAR

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist for infantile spasm and exacerbation of multiple sclerosis
Coverage Duration	Multiple sclerosis: 21 days. For other approved indications: 28 days.
Other Criteria	For acute exacerbations of multiple sclerosis, patients must be receiving concurrent immunomodulator therapy, such as Aubagio, glatiramer, or interferon beta 1a. For all other non-neurological indications, failure or clinically significant adverse effects to other first line or standard of care therapies must be submitted.
Indications	All FDA-approved Indications.
Off Label Uses	

HRM ANTIPSYCHOTICS

Products Affected

- *molindone oral tablet 10 mg, 25 mg, 5 mg*
- *thioridazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, ziprasidone, or aripiprazole.
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HUMIRA

Products Affected

- HUMIRA
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA(CF)
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis involving 3% of BSA or greater, or affecting crucial body areas such as hands, feet, face or genitals. Rheumatoid Arthritis: Failure or clinically significant adverse effects to two of the formulary alternatives: azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, or sulfasalazine. Psoriatic arthritis: Failure or clinically significant adverse effects to the formulary alternative: methotrexate. Ankylosing spondylitis: Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, indomethacin, naproxen, or sulindac. Plaque psoriasis: Failure or clinically significant adverse effects to two of the formulary alternatives: acitretin, cyclosporine, methotrexate or phototherapy. Crohn's disease and Ulcerative colitis: Failure or clinically significant adverse effects to two of the formulary alternatives: budesonide, mesalamine or sulfasalazine.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Gastroenterologist, Ophthalmologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HUMIRA PEDIATRIC CROHNS

Products Affected

- HUMIRA(CF) PEDI CROHNS STARTER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HUMIRA PSORIASIS

Products Affected

- HUMIRA PEN PSOR-UVEITS-ADOL HS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis involving 3% of BSA or greater, or affecting crucial body areas such as hands, feet, face or genitals. Failure or clinically significant adverse effects to two of the following: acitretin, cyclosporine, methotrexate or phototherapy.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist, Ophthalmologist, Gastroenterologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IMIPRAMINE

Products Affected

- *imipramine hcl*
- *imipramine pamoate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	For Depression Only: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, desvenlafaxine, duloxetine, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	

IMMUNOGLOBULIN

Products Affected

- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- GAMMAGARD LIQUID
- GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months.
Other Criteria	Approve under Part B for these types of Primary Humoral Immunodeficiency: Congenital agammaglobulinemia, Common variable immunodeficiency, Wiskott-Aldrich syndrome, X-linked agammaglobulinemia, Severe combined immunodeficiency. Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INDOMETHACIN

Products Affected

- *indomethacin oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: celecoxib, diclofenac, ibuprofen, meloxicam, nabumetone, naproxen, or sulindac.
Indications	All FDA-approved Indications.
Off Label Uses	

INGREZZA

Products Affected
- INGREZZA
- INGREZZA INITIATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to the formulary alternative: Austedo. Documentation of baseline Abnormal Involuntary Movement Scale (AIMS) scores. Reauthorization only: Documentation of positive response to medication therapy as evidenced by an improved AIMS score as compared to baseline.
Age Restrictions	
Prescriber Restrictions	Neurologist, Psychiatrist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INTERFERON BETA-1A

Products Affected

- PLEGRIDY
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INTRALIPID

Products Affected

- INTRALIPID INTRAVENOUS EMULSION 30 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

INVEGA SUSTENNA

Products Affected

- INVEGA SUSTENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to the formulary alternative: oral paliperidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INVEGA TRINZA

Products Affected

- INVEGA TRINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to all of the formulary alternatives: oral paliperidone and Invega Sustenna.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ISOTRETINOIN

Products Affected

- *claravis*
- *isotretinoin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist
Coverage Duration	20 weeks.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ITRACONAZOLE

Products Affected

- *itraconazole oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor.
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

KINEREET

Products Affected
- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Pediatrician, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.
Indications	All FDA-approved Indications.
Off Label Uses	

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of simvastatin, lovastatin and CYP3A substrates with narrow therapeutic ranges (e.g. cyclosporine, fentanyl, sirolimus, etc.). History of unexplained vaginal bleeding or endometrial hyperplasia with atypia or endometrial carcinoma.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LEDIPASVIR-SOFOSBUVIR

Products Affected

- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. Failure or clinically significant adverse effects to the formulary alternative: sofosbuvir-velpatasvir (generic Epclusa).
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	12 weeks.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LEUKINE

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	Excessive leukemia myeloid blasts in the bone marrow or peripheral blood equal to or greater than 10%.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hematologist, Oncologist
Coverage Duration	3 months.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Zarxio.
Indications	All FDA-approved Indications.
Off Label Uses	

LEUPROLIDE ACETATE

Products Affected

- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Urologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LEVALBUTEROL

Products Affected

- *levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml, 1.25 mg/3 ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to the formulary alternative: albuterol inhalant solution.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

LIDOCAINE PATCH

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternatives: gabapentin.
Indications	All FDA-approved Indications.
Off Label Uses	

LINEZOLID

Products Affected

- *linezolid in dextrose 5%*
- *linezolid oral suspension for reconstitution*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LUPRON DEPOT

Products Affected

- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Endometriosis: Patient has had surgical ablation to prevent recurrence, or history of failure, contraindication, or intolerance to oral contraceptives.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LYRICA

Products Affected

- *pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg*
- *pregabalin oral solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postherpetic neuralgia: Failure or clinically significant adverse effects to the formulary alternative: gabapentin. Diabetic neuropathy: Failure or clinically significant adverse effects to all of the formulary alternatives: duloxetine and gabapentin. Fibromyalgia: Failure or clinically significant adverse effects to two of the formulary alternatives: duloxetine, gabapentin or Savella.
Indications	All FDA-approved Indications.
Off Label Uses	

MEGESTROL

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Cachexia associated with AIDS: Failure or clinically significant adverse effects to all of the formulary alternatives: dronabinol and oxandrolone.
Indications	All Medically-accepted Indications.
Off Label Uses	

MEPROBAMATE

Products Affected

- *meprobamate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to at least two of the formulary alternatives: buspirone, duloxetine, escitalopram, paroxetine, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	

METHOCARBAMOL

Products Affected

- *methocarbamol oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Documentation explaining specific benefit established with the medication, and how that benefit outweighs the potential risk
Indications	All FDA-approved Indications.
Off Label Uses	

METHOXSALEN

Products Affected

- *methoxsalen*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: calcipotriene, clobetasol, cyclosporine, fluocinonide, methotrexate, or tazarotene.
Indications	All FDA-approved Indications.
Off Label Uses	

METHYLDOPA

Products Affected

- *methyldopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide.
Indications	All FDA-approved Indications.
Off Label Uses	

METHYLDOPA/HYDROCHLOROTHIAZIDE

Products Affected

- *methyldopa-hydrochlorothiazide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: benazepril, fosinopril, hydrochlorothiazide, irbesartan, lisinopril, losartan, losartan/hydrochlorothiazide, lisinopril/hydrochlorothiazide, quinapril/hydrochlorothiazide, quinapril, ramipril, or valsartan/hydrochlorothiazide.
Indications	All FDA-approved Indications.
Off Label Uses	

METYROSINE

Products Affected
- DEMSER

PA Criteria	Criteria Details
Exclusion Criteria	Essential hypertension.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MODAFINIL

Products Affected
- *modafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Narcolepsy: Failure or clinically significant adverse effects to all of the formulary alternatives: dextroamphetamine and methylphenidate.
Indications	All FDA-approved Indications.
Off Label Uses	

MULTAQ

Products Affected

- MULTAQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Cardiologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MYCAMINE

Products Affected

- *micafungin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

NAYZILAM

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NEUPRO

Products Affected
- NEUPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Parkinson's Disease: Failure or clinically significant adverse effects to two of the formulary alternatives: carbidopa/levodopa, pramipexole, ropinirole, or selegiline. Restless Legs Syndrome: Failure or clinically significant adverse effects to all of the formulary alternatives: pramipexole and ropinirole.
Indications	All FDA-approved Indications.
Off Label Uses	

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Asthma: Failure or clinically significant adverse effects to two of the formulary alternatives: 1) budesonide, Flovent, Arnuity Ellipta or Qvar and 2) fluticasone-salmeterol, Wixela, or Breo Ellipta.
Age Restrictions	
Prescriber Restrictions	Allergist, Immunologist, Pulmonologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

NUEDEXTA

Products Affected
- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NUPLAZID

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NUTRILIPID

Products Affected

- NUTRILIPID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

OCTREOTIDE

Products Affected

- *octreotide acetate injection solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

OLANZAPINE ODT

Products Affected

- *olanzapine oral tablet,disintegrating*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow or failure or clinically significant adverse effects to the formulary alternative: oral olanzapine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OLANZAPINE SOLUTION

Products Affected

- *olanzapine intramuscular*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

OMNITROPE

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AGHD (initial): diagnosis confirmed as a result of past diagnosis of childhood-onset GHD, or adult-onset GHD with documentation of hormone deficiency due to hypothalamic-pituitary disease from organic or known causes (eg: damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and documentation of one growth-hormone stimulant test (eg: insulin tolerance test, arginine/GHRH, glucagon, arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or documented deficiency of 3 anterior pituitary hormones (prolactin, ACTH, TSH, FSH/LH) and IFG-1/somatomedin C below age and gender adjusted normal range as provided by physicians lab. AGHD (reauthorization): Documentation of positive experience by the patient.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ORAL ANTIPSYCHOTICS

Products Affected

- CAPLYTA
- FANAPT
- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG
- *paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 6 mg, 9 mg*
- *quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg*
- SAPHRIS
- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone, ziprasidone or aripiprazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ORENCIA

Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.
Indications	All FDA-approved Indications.
Off Label Uses	

ORKAMBI

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of homozygous F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OXANDROLONE

Products Affected

- *oxandrolone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

OXBRYTA

Products Affected

- OXBRYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of at least 1 episode of vaso-occlusive crisis (VOC) in the past 12 months. Hemoglobin (Hgb) greater than or equal to 5.5 and less than or equal to 10.5 g/dL. Re-authorization: Increase from baseline hemoglobin (Hgb) by greater than or equal to 1g/dL.
Age Restrictions	
Prescriber Restrictions	Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OXERVATE

Products Affected
- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Stage 2 or 3 neurotrophic keratitis.
Age Restrictions	
Prescriber Restrictions	Ophthalmologist
Coverage Duration	8 weeks.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PAH

Products Affected
- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to the formulary alternative: sildenafil or tadalafil.
Age Restrictions	
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PARATHYROID HORMONE ANALOGS

Products Affected

- FORTEO
- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Bone mineral density (BMD) T score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and a history of fractures. Failure or clinically significant adverse effects to one of the formulary alternatives: alendronic acid or risedronate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Medical justification required for treatment duration beyond 24 months.
Indications	All FDA-approved Indications.
Off Label Uses	

PDE5 INHIBITORS

Products Affected

- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with nitrates or PDE5 inhibitors.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Cardiologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PEGASYS

Products Affected

- PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML
- PEGASYS SUBCUTANEOUS SOLUTION
- PEGASYS SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic Hepatitis C: Treatment length is determined by FDA labeling or AASLD recommendation
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PHENOBARBITAL

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide.
Indications	All FDA-approved Indications.
Off Label Uses	

PHENTERMINE

Products Affected

- *phentermine 15 mg capsule*
- *phentermine 30 mg capsule pelletized*
- *phentermine 37.5 mg tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BMI greater than or equal to 27 kg/m2 with one or more comorbidity (e.g. coronary heart disease, dyslipidemia, hypertension, type 2 diabetes mellitus, sleep apnea), OR BMI greater than or equal to 30 kg/m2. Reauthorization: Documented weight loss of 5% during the first 3 month period and lack of side effects.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PIMECROLIMUS

Products Affected

- *pimecrolimus*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to one of the topical formulary alternatives: clobetasol, betamethasone, fluocinolone or fluocinonide and failure or clinically significant adverse effects to the formulary alternative: tacrolimus ointment.
Indications	All FDA-approved Indications.
Off Label Uses	

POSACONAZOLE

Products Affected

- *noxafil oral suspension*
- *posaconazole oral tablet,delayed release (dr/ec)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to one of the formulary alternatives: fluconazole, itraconazole, or voriconazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PREMARIN TABLETS

Products Affected

- PREMARIN ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to the formulary alternative: estradiol cream. Other indication(s): Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol transdermal patch, estradiol tablet or estropipate.
Indications	All FDA-approved Indications.
Off Label Uses	

PREMPRO TABLETS

Products Affected

- PREMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Postmenopausal osteoporosis prophylaxis: Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid, and risedronate. Vulvar and vaginal atrophy: Failure or clinically significant adverse effects to the formulary alternative: estradiol cream. Other indication(s): Failure or clinically significant adverse effects to one of the formulary alternatives: estradiol transdermal patch, estradiol tablet or estropipate.
Indications	All FDA-approved Indications.
Off Label Uses	

PROCRIT

Products Affected

- PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	Uncontrolled hypertension.
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodysplastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All Medically-accepted Indications.
Off Label Uses	

PROLIA

Products Affected

- PROLIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of bone mineral density (BMD) T-score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR BMD T-score between -2.5 and -3.5 (greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and a history of fractures. Failure or clinically significant adverse effects to all of the formulary alternatives: alendronic acid and risedronate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of platelet count. Thrombocytopenia in hepatitis C infection: Documentation of concurrent or planned interferon-based treatment of chronic hepatitis C.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hematologist, Hepatologist, Infectious Disease specialist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Chronic immune (idiopathic) thrombocytopenia: Failure or clinically significant adverse effects to one of the formulary alternatives: dexamethasone, methylprednisolone, prednisolone or prednisone.
Indications	All FDA-approved Indications.
Off Label Uses	

PROMETHAZINE

Products Affected

- *promethazine oral*
- *promethazine rectal suppository 12.5 mg, 25 mg*
- *promethegan rectal suppository 25 mg, 50 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Allergy: Failure or clinically significant adverse effects to one of the formulary alternatives: cetirizine and levocetirizine. Nausea and vomiting: Failure or clinically significant adverse effects to two of the formulary alternatives: chlorpromazine, granisetron, ondansetron, or prochlorperazine.
Indications	All FDA-approved Indications.
Off Label Uses	

PROTRIPTYLINE

Products Affected

- *protriptyline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	

QUININE

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	Prevention or treatment of nocturnal leg cramps.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	10 days.
Other Criteria	Failure or clinically significant adverse effects to one of the formulary alternatives: chloroquine or hydroxychloroquine.
Indications	All FDA-approved Indications.
Off Label Uses	

RANOLAZINE

Products Affected

- *ranolazine*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with strong CYP3A inhibitors or CYP3A inducers.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RAYALDEE

Products Affected

- RAYALDEE

PA Criteria	Criteria Details
Exclusion Criteria	Stage 5 chronic kidney disease or end stage renal disease on dialysis.
Required Medical Information	Documented serum total 25-hydroxyvitamin D levels less than 30 ng/mL
Age Restrictions	
Prescriber Restrictions	Nephrologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

REPATHA

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Primary hyperlipidemia: Documentation of current LDL levels above 100mg/dL while taking maximally tolerated statin therapy and ezetimibe therapy, unless intolerant or contraindicated to statin or ezetimibe therapy. Secondary prevention of ASCVD: Documentation of at least one high risk feature: recent ACS (within the past 12 months), history of MI, history of ischemic stroke, or symptomatic peripheral arterial disease (history of claudication with ABI greater than 0.85, or previous revascularization or amputation). Heterozygous Familial Hypercholesterolemia (HeFH) or Homozygous Familial Hypercholesterolemia (HoFH): Documentation to confirm diagnosis by genetic testing or by clinical criteria (such as Simon Broome or the Dutch Lipid Clinic Network criteria, or history of untreated LDL-C greater than 180 mg/dL together with xanthoma or cornealis), or evidence of Familial Hypercholesterolemia in first or second-degree relatives.
Age Restrictions	
Prescriber Restrictions	Cardiologist, Endocrinologist, Lipid specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RESTASIS

Products Affected
- RESTASIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of test results confirming the diagnosis, such as: Tear break-up test (TBUT), Ocular surface disease index (OSDI), Schirmer's test, Visual analog scale (VAS), Symptom assessment in dry eye (SANDE), McMonnies questionnaire, etc.
Age Restrictions	
Prescriber Restrictions	Ophthalmologist, Optometrist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RETACRIT

Products Affected

- RETACRIT

PA Criteria	Criteria Details
Exclusion Criteria	Uncontrolled hypertension.
Required Medical Information	For anemia due to chronic kidney disease: Hemoglobin (Hgb) is less than 10g/dL and documentation of transferrin saturation greater than or equal to 20% and ferritin greater than or equal to 100ng/mL. For anemia due to chemotherapy: Hemoglobin (Hgb) is less than 10g/dL. For surgical FDA indications: Hemoglobin (Hgb) is 10g/dL-13g/dL and patient is not a candidate for autologous blood donation and significant blood loss is anticipated from elective, non cardiac, or nonvascular surgery. Zidovudine induced: Hemoglobin (Hgb) is less than 11g/dL. Myelodysplastic syndrome: Hemoglobin (Hgb) is less than 11g/dL and erythropoietin is less than or equal to 500 mU/mL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All Medically-accepted Indications.
Off Label Uses	

REXULTI

Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Schizophrenia: Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, risperidone, quetiapine, ziprasidone or aripiprazole. Depression: Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, sertraline, or venlafaxine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RISPERDAL CONSTA

Products Affected

- RISPERDAL CONSTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to the formulary alternative: oral risperidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RUFINAMIDE

Products Affected

- BANZEL ORAL SUSPENSION
- BANZEL ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to one of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, clobazam or zonisamide. For Rufinamide suspension: Failure or clinically significant adverse effects to one of the formulary alternatives: Rufinamide tablet.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SAPROPTERIN

Products Affected

- KUVAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SECUADO

Products Affected

- SECUADO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to two of the formulary alternatives: olanzapine, quetiapine, risperidone, ziprasidone or aripiprazole.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SIGNIFOR

Products Affected
- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

SITAGLIPTIN

Products Affected

- JANUMET
- JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-1,000 MG, 50-500 MG
- JANUVIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Failure or clinically significant adverse effects to two of the formulary alternatives: metformin containing products and alogliptin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SOFOSBUVIR-VELPATASVIR

Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	12 weeks.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SOMATULINE DEPOT

Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Endocrinologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: octreotide.
Indications	All FDA-approved Indications.
Off Label Uses	

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: octreotide.
Indications	All FDA-approved Indications.
Off Label Uses	

SPRITAM

Products Affected
- SPRITAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: levetiracetam oral solution.
Indications	All FDA-approved Indications.
Off Label Uses	

STELARA

Products Affected

- STELARA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Plaque psoriasis: documentation of psoriasis of greater than 5% BSA or affecting crucial body areas such as hands, feet, face or genitals.
Age Restrictions	
Prescriber Restrictions	Dermatologist, Gastroenterologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination. Crohn's Disease: Failure or clinically significant adverse effects to the formulary alternative: Humira. Plaque Psoriasis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira. Psoriatic arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira.
Indications	All FDA-approved Indications.
Off Label Uses	

SYLATRON

Products Affected

- SYLATRON SUBCUTANEOUS KIT
  200 MCG, 300 MCG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SYMDEKO

Products Affected
- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of homozygous F508del mutation or at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor.
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SYMLIN

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Exclusion Criteria	Confirmed gastroparesis.
Required Medical Information	Documentation of a history of HbA1C scores of 7% or higher after at least 3 months of optimal therapy with insulin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of difficulty or inability to swallow. Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, valproic acid or zonisamide.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SYNAREL

Products Affected
- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TACROLIMUS OINTMENT

Products Affected
- *tacrolimus topical*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the topical formulary alternatives: clobetasol, betamethasone, fluocinolone, or fluocinonide.
Indications	All FDA-approved Indications.
Off Label Uses	

TAKHZYRO

Products Affected

- TAKHZYRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of hereditary angioedema (HAE), must be confirmed by blood testing. Failure or clinically significant adverse effects to the formulary alternative: danazol.
Age Restrictions	
Prescriber Restrictions	Allergist, Immunologist, Hematologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TAZORAC

Products Affected

- *tazarotene*
- TAZORAC TOPICAL CREAM 0.05 %
- TAZORAC TOPICAL GEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Plaque psoriasis: Failure or clinically significant adverse effects to one of the topical formulary alternatives: calcipotriene, clobetasol or fluocinonide. Acne vulgaris: Failure or clinically significant adverse effects to two of the formulary alternatives: benzoyl peroxide/clindamycin topical, benzoyl peroxide/erythromycin topical, clindamycin topical, doxycycline oral, erythromycin topical, minocycline oral, tetracycline oral or tretinoin topical.
Indications	All FDA-approved Indications.
Off Label Uses	

TECFIDERA

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to all of the formulary alternatives: Aubagio and glatiramer.
Indications	All FDA-approved Indications.
Off Label Uses	

TESTOSTERONE

Products Affected

- *testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)*
- *testosterone enanthate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Hypogonadism: Documentation of testosterone levels below the lab reference range.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TESTOSTERONE PUMP

Products Affected

- *testosterone transdermal gel in metered-dose pump*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented pretreatment serum testosterone levels less than the laboratory's lower reference limit within the recent 3 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: Androderm, testosterone cypionate, testosterone enanthate or testosterone transdermal gel.
Indications	All FDA-approved Indications.
Off Label Uses	

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TIGECYCLINE

Products Affected
- *tigecycline*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

TOBI PODHALER

Products Affected

- TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TOBRAMYCIN SOLUTION

Products Affected
- *tobramycin in 0.225 % nacl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease specialist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

TOFACITINIB

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Rheumatoid Arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira. Psoriatic arthritis: Failure or clinically significant adverse effects to all of the formulary alternatives: Enbrel and Humira. Ulcerative colitis: Failure or clinically significant adverse effects to the formulary alternative: Humira.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TOLCAPONE

Products Affected
- *tolcapone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of concurrent use with levodopa and carbidopa.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline.
Indications	All FDA-approved Indications.
Off Label Uses	

TRIENTINE

Products Affected

- *trientine*

PA Criteria	Criteria Details
Exclusion Criteria	Biliary cirrhosis, rheumatoid arthritis.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to the formulary alternative: Depen.
Indications	All FDA-approved Indications.
Off Label Uses	

TRIHEXYPHENIDYL

Products Affected

- *trihexyphenidyl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Parkinsonism: Failure or clinically significant adverse effects to one of the formulary alternatives: amantadine, bromocriptine, carbidopa/levodopa, entacapone, pramipexole, ropinirole, or selegiline. Medication-induced movement disorder - extrapyramidal disease: Failure or clinically significant adverse effects to the formulary alternative: amantadine.
Indications	All FDA-approved Indications.
Off Label Uses	

TRIMIPRAMINE

Products Affected

- *trimipramine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approve if less than 65 years of age. If aged 65 years and older, prior authorization criteria will apply.
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, nortriptyline, sertraline, or venlafaxine.
Indications	All FDA-approved Indications.
Off Label Uses	

TRINTELLIX

Products Affected

- TRINTELLIX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, mirtazapine, paroxetine, or sertraline.
Indications	All FDA-approved Indications.
Off Label Uses	

VALCHLOR

Products Affected
- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Dermatologist, Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VANCOMYCIN CAPSULE

Products Affected

- *vancomycin oral capsule 125 mg, 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	C diff diarrhea: Reauthorization: Documentation of C. Difficile positive stool
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VEMLIDY

Products Affected
- VEMLIDY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Hepatologist, Gastroenterologist, Infectious Disease specialist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VIBERZI

Products Affected

- VIBERZI

PA Criteria	Criteria Details
Exclusion Criteria	History of gallbladder removal.
Required Medical Information	Failure or clinically significant adverse effects to the all of the formulary alternatives: dicyclomine and loperamide.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VIGABATRIN

Products Affected

- *vigabatrin oral powder in packet*
- *vigabatrin oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Refractory Complex Partial Seizures only: Failure or clinically significant adverse effects to two of the formulary alternatives: carbamazepine, clonazepam, divalproex, ethosuximide, felbamate, gabapentin, lamotrigine, levetiracetam, lorazepam, oxcarbazepine, phenytoin, tiagabine, topiramate, or zonisamide
Indications	All FDA-approved Indications.
Off Label Uses	

VIIBRYD

Products Affected

- VIIBRYD ORAL TABLET
- VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Failure or clinically significant adverse effects to two of the formulary alternatives: citalopram, escitalopram, fluoxetine, paroxetine, or sertraline.
Indications	All FDA-approved Indications.
Off Label Uses	

VORICONAZOLE

Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XATMEP

Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist, Pediatrician, Rheumatologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Oncologist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XIFAXAN

Products Affected

- XIFAXAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Hepatic encephalopathy: Failure or clinically significant adverse effects to the formulary alternative: lactulose. Irritable bowel syndrome with diarrhea: Failure or clinically significant adverse effects to all of the formulary alternative: loperamide. Traveler's diarrhea: Failure or clinically significant adverse effects to one of the formulary alternatives: ciprofloxacin or levofloxacin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XIIDRA

Products Affected

- XIIDRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of test results confirming the diagnosis, such as: Tear break-up test (TBUT), Ocular surface disease index (OSDI), Schirmer's test, Visual analog scale (VAS), Symptom assessment in dry eye (SANDE), McMonnies questionnaire, etc.
Age Restrictions	
Prescriber Restrictions	Ophthalmologist, Optometrist
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XOLAIR

Products Affected

- XOLAIR SUBCUTANEOUS RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Asthma (Initial): Forced expiratory volume in one second or peak expiratory flow less than or equal to 80% of predicted level, or measures of asthma control indicate uncontrolled asthma (eg, Asthma Control Test [ACT] score 19 or less). Baseline (pre-Xolair treatment) serum total IgE level greater than or equal to 30 IU/mL. Positive skin test or in vitro reactivity to a perennial aeroallergen.
Age Restrictions	
Prescriber Restrictions	Allergist, Dermatologist, Immunologist, Pulmonologist
Coverage Duration	Until the end of calendar year.
Other Criteria	Subject to Part B vs Part D determination.
Indications	All FDA-approved Indications.
Off Label Uses	

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	Daytime excessive sleepiness in patients with narcolepsy: Failure or clinically significant adverse effects to the formulary alternative: modafinil.
Indications	All FDA-approved Indications.
Off Label Uses	

ZEPATIER

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of chronic hepatitis C infection confirmed by a detectable serum hepatitis C virus RNA through quantitative assay. Documentation of genotype. Documentation of the absence or presence of cirrhosis and if compensated or decompensated. Documentation of any previous treatment. Documentation of liver transplant status. Treatment regimen will be approved based on genotype and previous treatment experience as defined by current AASLD guidelines. For genotype 1a: Documentation for NS5A polymorphism testing.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist, Hepatologist, Infectious Disease specialist
Coverage Duration	12 to 16 weeks dependent on genotype and polymorphism, cirrhosis, or previous treatment.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ZYPREXA RELPREVV

Products Affected

- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documented history of receiving oral olanzapine without any clinically significant side effects. Failure or clinically significant adverse effects to two of the formulary alternatives: Invega Sustenna, Invega Trinza or Risperdal Consta.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Until the end of calendar year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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