HEALTH CHOICE GENERATIONS (PDP)
2017 Prior Authorization Criteria

ADCIRCA

Products Affected

- Adcirca

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	concomitant administration of riociguat with a specific PDE5 inhibitor (eg, sildenafil, tadalafil, vardenafil)
Required Medical Information	Treatment of pulmonary arterial hypertension (PAH) (World Health Organization group 1)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	None

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ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy, coadministration with nitrates or nitric oxide donors (eg, amyl nitrite), phosphodiesterase (PDE) inhibitors, or nonspecific PDE inhibitors (eg, dipyridamole or theophylline)
Required Medical Information	Diagnosis of persistent/recurrent chronic thromboembolic pulmonary HTN (WHO group 4) after surgical tmt or inoperable chronic thromboembolic pulmonary hypertension or PAH (WHO group 1)
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	None

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic anaplastic lymphoma kinase positive non-small cell lung cancer. Documentation of intolerance or disease progression following therapy with crizotinib
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

ARMODAFINIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome confirmed by sleep lab evaluation, e.g., multiple sleep latency test, polysomnography), B) excessive sleepiness associated with narcolepsy confirmed by sleep lab evaluation and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine), OR C) excessive sleepiness associated with shift work disorder with a primary complaint of excessive sleepiness or insomnia which temporally associated with a work period (usually night work) that occurs during the habitual sleep phase or polysomnography and the MSLT demonstrate loss of a normal sleep-wake pattern.
Age Restrictions	17 years of age or older
Prescriber Restrictions	None
Coverage Duration	OSA/hypopnea syndrome: 6 months (initial), 12 months (renewal). Other diagnoses: 12 months.
Other Criteria	None

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. First clinical episode with MRI features consistent with multiple sclerosis.
Exclusion Criteria	Severe hepatic impairment. Current treatment with leflunomide. Patients who are pregnant or women of childbearing potential not using reliable contraception.
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (e.g., relapsing-remitting MS or progressive-relapsing MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease)

BEXAROTENE

Products Affected

- Bexarotene

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	Patient must meet one of following criteria: received prior systemic therapy for CTCL OR advanced-stage MF (stage IIB, III or IV) or SS OR early-stage MF (stage IA, IB or IIA) with folliculotropic/large cell transformation OR early-stage MF (stage IA, IB or IIA) refractory to skin directed therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Patient has been instructed on the importance and proper utilization of appropriate contraceptive methods.

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Signed statement of diagnosis from the physician, hepatic panel and CBC, trial and failure ofofimiatinib or dasatinibi and documentation of a 90 day response
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

BRIVIACT

Products Affected

- Briviact

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of partial-onset seizures, member must have history of inadequate response, contraindication, or intolerance to levetiracetam prior to approval.
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients who have or are at risk for severe hemorrhage and/or patients with a recent history of bleeding or hemoptysis.
Required Medical Information	Diagnosis of advanced renal cell carcinoma (RCC) AND patient have received prior antiangiogenic therapy.
Age Restrictions	Adults 18 years of age or older
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

CIALIS

Products Affected

- Cialis ORAL TABLET 2.5 MG
- Cialis Oral TABLET 5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician and prior trial and failure of at least one alpha blocker and one alpha reductase inhibitor
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of life-threatening immediate hypersensitivity reactions, including anaphylaxis to the product.
Required Medical Information	Diagnosis of hereditary angioedema AND Medication will be used for routine prophylaxis against angioedema.
Age Restrictions	None
Prescriber Restrictions	prescribed or overseen by a hematologist or immunologist
Coverage Duration	365 days
Other Criteria	None

COPAXONE

Products Affected

- Copaxone Subcutaneous Solution Prefilled Syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing-remitting multiple sclerosis OR diagnosis of first clinical episode with MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	For renewal, patient does not have progressive disease and responding to therapy.

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable OR metastatic malignant melanoma with BRAF V600E OR V600K mutation. Documentation of combination therapy with vemurafenib
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

CYSTARAN

Products Affected

- Cystaran

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Demonstrated cysteamine hypersensitivity or penicillamine hypersensitivity
Required Medical Information	Patient has a diagnosis of cystinosis AND patient has corneal cystine crystal accumulation
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

DARZALEX

Products Affected

- Darzalex Intravenous SOLUTION 100 MG/5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma, documented pretreatment with 3 prior therapies one of which must have included a proteasome inhibitor and an immunomodulatory agent OR the patient is double-refractory to proteasome inhibitor and immunomodulatory agent.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

DRONABINOL

Products Affected

- Dronabinol

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with cannabinoid hypersensitivity or sesame oil hypersensitivity.
Required Medical Information	Diagnosis of chemotherapy-induced nausea and vomiting AND patient has tried and failed conventional antiemetic treatments (e.g., aprepitant/fosaprepitant,t-hydroxytriptamine-3 serotonin receptor antagonists) OR Patient has a diagnosis of anorexia associated with weight loss due to AIDS.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	Part B if related to cancer treatment and is a full replacement for IV antiemetic within 48 hrs of cancer treatment. Part D if related to cancer treatment after the 48-hour period, or for any other medically accepted diagnosis.

EMPLICITI

Products Affected

- Empliciti

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma, documentation of combination therapy with lenalidomide and dexamethasone. Prescriber must document prior treatment with 1 to 3 previous therapies.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

ERWINAZE

Products Affected

- Erwinaze INJECTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

ESBRIET

Products Affected

- Esbriet ORAL CAPSULE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Appropriate diagnosis (idiopathic pulmonary fibrosis [IPF]), monitoring (hepatic function/LFTs)
Age Restrictions	none
Prescriber Restrictions	Pulmonologist
Coverage Duration	365 days
Other Criteria	None

ESRD THERAPY

Products Affected

- Procrit INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Hemogloblin less than 10 g/dl for patients receiving Cancer Chemotherapy and Hemoglobin less than 12 and Hematacrit less than 33 for other approved FDA indications in addition to supporting statement of diagnosis from physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	None

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	statement of diagnosis from physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

FENTANYL

Products Affected

- Fentora BUCCAL TABLET 200 MCG, 400 MCG, 600 MCG, 800 MCG
- Lazanda

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

FLECTOR

Products Affected

- Flector

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary, pancreatic), colorectal cancer, or small bowel cancer
Required Medical Information	Diagnosis of short bowel syndrome AND patient is receiving specialized nutritional support (i.e. parenteral nutrition)
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

GILENYA

Products Affected

- Gilenya

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. First clinical episode with MRI features consistent with multiple sclerosis.
Exclusion Criteria	Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500 ms. Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (quinidine, procainamide, amiodarone, sotalol).
Required Medical Information	Diagnosis of a relapsing form of multiple sclerosis or diagnosis of first clinical episode with MRI features consistent with MS AND Patient will be observed for signs and symptoms of bradycardia in a controlled setting for at least 6 hours after the first dose
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	For renewal, the patient has experienced no or slowed disease progression.

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician in patients with: 1) metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or 2) metastatic squamous NSCLC, progressing after platinum-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

GONADOTROPIN

Products Affected

- Chorionic Gonadotropin Intramuscular

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Fertility indications in females are excluded.
Required Medical Information	Diagnosis of Hypogonadotrophic hypogonadism or Prepubertal cryptorchidism
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

GROWTH HORMONE

Products Affected

- Norditropin FlexPro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

HEPATITIS C

Products Affected

- Daklinza
- Epclusa
- Harvoni
- Sovaldi
- Zepatier

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Must submit documentation of HCV genotype, subtype and quantitative HCV RNA (viral load) testing any time prior to therapy. Must document the following within 12 weeks of starting therapy, (1) CBC, INR, hepatic function panel, GFR, and TSH if interferon is being used. Must document cirrhosis status, prior treatment history (if any), and planned duration of treatment. FOR GENOTYPE 1,4,5,6 : Must include, trial/failure, contraindication to, or intolerance to Zepatier prior to approval of Epclusa, Harvoni or other non-formulary products. FOR GENOTYPE 2,3, : Must include, trial/failure, contraindication to, or intolerance to Epclusa prior to approval of Daklinza, Sovaldi or other non-formulary products.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Duration of approval per AASLD Guidelines
Other Criteria	None

HRM-ANALGESICS

Products Affected

- Allzital
- Ascomp-Codeine
- Butalbital-Acetaminophen ORAL TABLET 50-325 MG
- Butalbital-APAP-Caff-Cod
- Butalbital-APAP-Caffeine Oral CAPSULE
- Butalbital-APAP-Caffeine Oral TABLET 50-325-40 MG
- Butalbital-ASA-Caff-Codeine
- Butalbital-Aspirin-Caffeine ORAL CAPSULE
- Pentazocine-Naloxone HCl
- Tencon ORAL TABLET 50-325 MG
- Zebutal ORAL CAPSULE 50-325-40 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Analgesics: APAP/codeine,Embeda,hydrocodone/APAP,hydrocodone/IBU,hydromorphone,methadone,morphine sulfate,opana er,oxymorphone, oxycontin er,oxycodone,oxycodone/APAP,oxycodone/ASA,oxycodone/ibuprofen,oxymorphone IR,tramadol, tramadol/APAP, formulary NSAID (non-HRM)

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HRM-ANTIARRYTHMICS

Products Affected

- Digitek ORAL TABLET 250 MCG
- Digox Oral TABLET 250 MCG
- Digoxin INJECTION
- Digoxin ORAL SOLUTION
- Digoxin Oral TABLET 250 MCG
- Disopyramide Phosphate ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Anti-arrhythmics: DIGOXIN: digoxin 0.125mg dose, propranolol, or sotalol for atrial fibrillation, DISOPYRAMIDE: dofetilide, amiodarone, propafenone, mexiletine, multaq

HRM-ANTICONVULSANTS

Products Affected

- PHENobarbital ORAL ELIXIR
- PHENobarbital ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Anticonvulsants: Aptiom,Banzel,carbamazepine,Celontin,Cerebyx,clonazepam,diazepam,Dilantin,divalproex, Equetro,ethosuximide,felbamate,fosphenytoin,Fycompa,gabapentin,gabitril,lamotrigine,levetiracetam, Lyrica,Onfi,oxcarbazine,Oxtellar,Peganone,phenytoin,Potiga,Primidone, Qudexy XR,Sabril,Tegretol-XR, Tiagabine,topirimate,Trokendi-XR,valproate,Vimpat,zonisamide

HRM-ANTIDEMENTIA

Products Affected

- Ergoloid Mesylates ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Antidementia: donepezil,Exelon patch,galantamine,memantine,Namenda XR,Namzaric,rivastigmine cap

HRM-ANTIHISTAMINES

Products Affected

- Cyproheptadine HCl Oral TABLET
- Phenadoz
- Promethazine HCl Injection
- Promethazine HCl Oral TABLET
- Promethazine HCl Rectal
- Promethegan

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Antihistamines: desloratadine, cetirizine solution, diphenhydramine injectable

HRM-ANTIINFLAMMATORY

Products Affected

- Indomethacin ER
- Indomethacin Oral
- Ketorolac Tromethamine INJECTION SOLUTION 15 MG/ML, 30 MG/ML
- Ketorolac Tromethamine Intramuscular SOLUTION 60 MG/2ML
- Ketorolac Tromethamine ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Anti-inflammatories: celecoxib,diclofenac,diflunisal,etodolac,fenoprofen,flurbiprofen,ibuprofen,ketoprofen,meclofenamate,meloxicam,nabumetone,naproxen,oxaprozin,piroxicam,sulindac,tolmetin

HRM-ANTINEOPLASTICS

Products Affected

- Megestrol Acetate ORAL SUSPENSION 40 MG/ML, 625 MG/5ML
- Megestrol Acetate Oral TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	For Megestrol: dronabinol

HRM-ANTIPARKINSON

Products Affected

- Benztropine Mesylate Oral
- Trihexyphenidyl HCl

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Antiparkinsons': amantadine,Apokyn,Azilect,carbidopa/levodopa,entacapone,Neupro,pramipexole,ropinirole,selegiline

HRM-ANTIPLATELET

Products Affected

- Dipyridamole ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Anti-platelets: Anagrelide, asa/dipyridamole, Brilinta, clostazol, clopidogrel

HRM-CARDIOVASCULAR

Products Affected

- GuanFACINE HCl ER
- Methyldopa ORAL
- Methyldopa-Hydrochlorothiazide
- Methyldopate HCl
- NIFEdipine ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Cardiovascular agents: acebutolol,amilor/hctz,amlod/benazp,amlod/valsar,amlodipine,atenol/chlorth,atenolol,benazep/hctz,benazepril,benicar,benicar hct,betaxolol,bisopr/hctz,bisoprolol,candesartan,candesartan/hctz,captopril/hctz,captopril,cartia xt,carvedilol,chlorothiazide,diltiazem,dilt-xr,doxazosin,enalapril,enalapril/hctz,eprosartan,felodipine,fosinopril,fosinopril/hctz, hctz,indapamide,irbesart/hctz,irbesartan,isradipine,labetalol,lisinopril,lisinopril/hctz,losartan/losartan/hctz,methylclothia,metolazone,metoprol/hctz, metoprolol,midodrine,moexipril/hctz,moexipril,nadolol,nadolol/bend,nicardipine,nifedical xl,nimodipine,nifedipine

PA Criteria	Criteria Details
	er,nisoldipine,perindopril,pindolol,prazosin,propran/hctz,propranolol,quinapril/quinapril/hctz,ramipril,spirono/hctz,taztiaxt,telmis/amlod,telmis/hctz,telmisartan,terazosin,timolol,trandolapril,trandolapril/verapamil,triam/hctz,valsart/hctz,valsartan,verapamil

HRM-ESTROGENS

Products Affected

- Estradiol Oral
- Fyavolv
- Menest ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- Premarin Oral
- Premphase
- Prempro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Estrogens: Premarin Vaginal cream, premarin inj, raloxifene

HRM-SEDATIVE HYPNOTICS

Products Affected

- Butisol Sodium ORAL TABLET 30 MG
- Zaleplon
- Zolpidem Tartrate Oral

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Sleep disorder agents: estazolam, flurazepam, rozerem ,temazepam, triazolam

HRM-SKELETAL MUSCLE RELAXANTS

Products Affected

- Cyclobenzaprine HCl Oral TABLET 10 MG, 5 MG
- Methocarbamol Injection SOLUTION 1000 MG/10ML
- Methocarbamol Oral
- Orphenadrine Citrate ER
- Orphenadrine Citrate INJECTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

HRM-SULFONYLUREAS

Products Affected

- ChlorproPAMIDE
- GlyBURIDE Micronized
- GlyBURIDE Oral
- GlyBURIDE-MetFORMIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) listed in OTHER CRITERIA.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	Anti-Diabetics: acarbose, Avandia, cycloset, glimepiride, glimepiride/metformin, glipizide, Invokamet, Jadenu, Janumet, Januvia, Jentadueto, metformin, nateglinide, pioglitazone, pioglitazone/glim, pioglitazone/metformin, repaglinide, repaglinide/met, Riomet, Symlinpen, tolazamide, tolbutamide, Tradjenta, Victoza

HYDROXYPROGESTERONE

Products Affected

- Hydroxyprogesterone Caproate Intramuscular

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Breast, cervical, hepatocellular, uterine, or vaginal cancers, hepatic or thromboembolic disease, jaundice, or vaginal bleeding
Required Medical Information	Supporting statement of diagnosis from physician
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	Up to 21 weeks
Other Criteria	None

HYSINGLA

Products Affected

- Hysingla ER

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Must have severe pain requiring around the clock long term opioid AND all of these: 1-One of the following formulary opioid options: hydrocodone IR, oxycodone IR, morphine IR, hydromorphone IR, OR oxymorphone IR are ineffective, not tolerated or inadequate for controlling pain AND fentanyl patches are ineffective, not tolerated, or inadequate for controlling pain, 2-Must discontinue all other around-the-clock opioids when initiated, 3-Agreement for opioid therapy has been established, patient advised of risks and provides informed consent for chronic opioid therapy, 4-Pt assessed for all these (i)pain severity, (ii)suitability of non-opioids, (iii)physical & emotional functional status, (iv)risk of or current aberrant drug behavior, 5-Prescriber attestation of intent to monitor for side effects AND one of these: A-Opioid naive/non-tolerant must start at 10mg twice day for 7 days before titrating up OR B-Opioid tolerant, receiving one of these doses per day for at least 1 week: 60mg oral morphine, 25mcg transdermal fentanyl/hr, 30mg oral oxycodone, 8mg oral hydromorphone, 25mg oral oxymorphone
Age Restrictions	Adults: 18 years and older.
Prescriber Restrictions	Prescriber is knowledgeable in the use of potent opioids for the management of chronic pain
Coverage Duration	90 days
Other Criteria	None

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hormone receptor (HR)-positive, HER2-negative advanced breast cancer in postmenopausal women, in combination with letrozole as initial endocrine-based therapy or hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer, in combination with fulvestrant after disease progression following endocrine-based therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) in adult patients who are T315I-positive or for whom no other tyrosine kinase inhibitor therapy is indicated OR Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) in adult patients who are T315I-positive or for whom no other tyrosine kinase inhibitor therapy is indicated.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Metastatic, Non-small cell lung cancer, EGFR-positive OR Treatment of epidermal growth factor receptor mutation-positive non-small cell lung cancer
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

JUXTAPID

Products Affected

- Juxtapid ORAL CAPSULE 10 MG, 20 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia and patient is receiving other lipid-lowering therapies, i.e. statins. Reauthorization: demonstration of a positive clinical response to Juxtapid therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

KANUMA

Products Affected

- Kanuma

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Lysosomal acid lipase deficiency
Age Restrictions	None
Prescriber Restrictions	Prescribed by hepatologist
Coverage Duration	365 days
Other Criteria	None

KEYTRUDA

Products Affected

- Keytruda

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable or metastatic melanoma OR diagnosis of metastatic non-small cell lung cancer (NSCLC) in patients with PD-L1 expressing tumors who have disease progression on or after platinum-containing chemotherapy (patients with EGFR or ALK genomic tumor aberrations should have disease progression on approved therapy for these aberrations prior to receiving Keytruda) OR recurrent or metastatic squamous cell carcinoma of the head and neck in patients with disease progression on or after platinum-containing chemotherapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

KISQALI

Products Affected

- Kisqali 200 Dose
- Kisqali 400 Dose
- Kisqali 600 Dose

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer and intended to be used in combination with an aromatase inhibitor in postmenopausal women.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	365 Days
Other Criteria	None

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Supporting statement of diagnosis and relevant medical information from physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

KYNAMRO

Products Affected

- Kynamro Subcutaneous Solution Prefilled Syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests.
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia as evidenced by one of the following: A) genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or autosomal recessive hypercholesterolemia (ARH) adaptor protein gene locus OR B) untreated/pre-treatment LDL greater than 500 mg/dL with at least one of the following: cutaneous or tendonous xanthoma before age 10 years, history of early vascular disease (men younger than 55 years, women younger than 60 years) on both sides of the family if parenteral LDL levels are unknown, elevated LDL cholesterol levels before lipid-lowering therapy consistent with heterozygous FH in both parents AND Patient has tried and had an inadequate response to the maximum tolerated dose of a high potency statin (e.g., atorvastatin, rosuvastatin), unless all statins are contraindicated.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months.
Other Criteria	For renewal, patient has responded to therapy with a decrease in LDL levels from baseline AND patient does not have contraindications to therapy.

LARTRUVO

Products Affected

- Lartruvo Intravenous SOLUTION 500 MG/50ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of soft tissue sarcoma (STS), histologic subtype for which an anthracycline-containing regimen is appropriate, previous treatment failure with radiotherapy or surgery and must document being used in combination with doxorubicin for the first 8 cycles.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Oncologist
Coverage Duration	365 Days
Other Criteria	None

LIDOCAINE PAD

Products Affected

- Lidocaine EXTERNAL PATCH 5 %

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting documentation of diagnosis of post herpetic neuropathy or diabetic neuropathy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

LINEZOLID

Products Affected

- Linezolid ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered with concomitant use of MAOI therapy
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	VRE: 4 weeks. Nosocomial and community acquired pneumonia: 3 weeks. All other indications: 2 weeks
Other Criteria	None

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic colorectal cancer, previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based regimens, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	For initial treatment: Absolute neutrophil count 1,500/mm(3) or greater or febrile neutropenia resolved, platelet count 75,000/mm(3) or greater, and grade 3 or 4 nonhematological reactions resolved to grade 0 or 1

LYNPARZA

Products Affected

- Lynparza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Appropriate diagnosis and testing for BRCA mutation (deleterious or suspected deleterious germline BRCA mutated (as detected by an FDA approved test) advanced ovarian cancer that has been treated with 3 or more prior lines of chemotherapy)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

MAKENA

Products Affected

- Makena

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Breast, cervical, hepatocellular, uterine, or vaginal cancers, hepatic or thromboembolic disease, jaundice, or vaginal bleeding
Required Medical Information	Supporting statement of diagnosis from physician
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	21 weeks
Other Criteria	None

MODAFINIL

Products Affected

- Modafinil

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

MOZOBIL

Products Affected

- Mozobil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Mozobil will be used to mobilize hematopoietic stem cells for collection prior to autologous transplantation and used in combination with granulocyte-colony stimulating factor (ie, filgrastim or pegfilgrastim). Patient diagnosed with either non-Hodgkin's lymphoma or multiple myeloma.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None

MS INTERFERONS

Products Affected

- Avonex
- Avonex Pen Intramuscular Auto-injector Kit
- Avonex Prefilled Intramuscular Prefilled Syringe Kit
- Betaseron Subcutaneous KIT

PA Criteria	Criteria Details
Covered Uses	All-FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease)

MYTESI

Products Affected

- Mytesi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	CLINICAL NOTES TO SUPPORT A DIAGNOSIS OF CHRONIC DIARRHEA, DEFINED AS DIARRHEA PERSISTING FOR MORE THAN FOUR WEEKS, CAUSED BY THEIR MEDICATION REGIMEN OR HIV ENTEROPATHY PROVEN BY BIOPSY, AND NOT A VIRUS, PARASITE OR BACTERIUM AS EVIDENCED BY STOOL SAMPLE TAKEN IN THE PREVIOUS 3 MONTHS. PATIENT MUST HAVE TRIED AND FAILED OR HAD INTOLERANCE TO LOPERAMIDE OR DIPHENOXYLATE-ATROPINE TRIALS OF A MINIMUM OF 30 DAYS.
Age Restrictions	Adults 18 years of age or older
Prescriber Restrictions	Infectious Disease Specialist or GI Consult for new starts
Coverage Duration	365 Days
Other Criteria	None

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma, documentation of combination therapy with lenalidomide and dexamethasone. History of 1 prior therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	statement of diagnosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of severe asthma (eosinophilic phenotype)
Age Restrictions	12 years of age or older
Prescriber Restrictions	Must be prescribed by a pulmonologist or immunologist
Coverage Duration	365 days
Other Criteria	None

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Parkinson disease psychosis including hallucinations and/or delusions
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced basal cell carcinoma of the skin and specific documentation of negative pregnancy status
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

OPDIVO

Products Affected

- Opdivo Intravenous SOLUTION 40 MG/4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Appropriate diagnosis (BRAF V600 wild-type or BRAF V600 mutation-positive unresectable or metastatic melanoma and used as single agent OR unresectable or metastatic melanoma in combination with ipilimumab [Yervoy] OR Treatment of metastatic squamous cell non small cell lung cancer (NSCLC) that has progressed on or after platinum-based chemotherapy and patients with EGFR or ALK genomic tumor aberrations should have disease progression (on FDA-approved EGFR- or ALK-directed therapy) prior to receiving nivolumab OR advanced renal cell carcinoma who have received prior anti-angiogenic therapy OR recurrent or metastatic squamous cell carcinoma of the head and neck in patients with disease progression on or after platinum-based chemotherapy OR classical Hodgkin lymphoma in patients who have relapsed or progressed following autologous hematopoietic stem cell transplant (HSCT) and post-transplant brentuximab vedotin OR locally advanced or metastatic urothelial carcinoma in patients with disease progression during or following a platinum-containing therapy or disease progression within 12 months of neoadjuvant or adjuvant treatment with a platinum-containing therapy).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Initial Therapy: Diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test AND if less than 18 years of age, baseline ophthalmological exam completed. Continuation of therapy: Documentation patient is tolerating and responding to medication (i.e. improved FEV1, weight gain, decreased exacerbations, etc.)
Age Restrictions	Must be greater than or equal to 12 years of age
Prescriber Restrictions	Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation
Coverage Duration	365 days
Other Criteria	None

OXYCONTIN

Products Affected

- OxyCONTIN Oral Tablet ER 12 Hour Abuse-Deterrent 15 MG, 30 MG, 60 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Must have severe pain requiring around the clock long term opioid AND all of these: 1-One of the following formulary opioid options: hydrocodone IR, oxycodone IR, morphine IR, hydromorphone IR, OR oxymorphone IR are ineffective, not tolerated or inadequate for controlling pain AND fentanyl patches are ineffective, not tolerated, or inadequate for controlling pain, 2-Must discontinue all other around-the-clock opioids when initiated, 3-Agreement for opioid therapy has been established, patient advised of risks and provides informed consent for chronic opioid therapy, 4-Pt assessed for all these (i)pain severity, (ii)suitability of non-opioids, (iii)physical & emotional functional status, (iv)risk of or current aberrant drug behavior, 5-Prescriber attestation of intent to monitor for side effects AND one of these: A-Opioid naive/non-tolerant must start at 10mg twice day for 7 days before titrating up OR B-Opioid tolerant, receiving one of these doses per day for at least 1 week: 60mg oral morphine, 25mcg transdermal fentanyl/hr, 30mg oral oxycodone, 8mg oral hydromorphone, 25mg oral oxymorphone
Age Restrictions	11 years and older.
Prescriber Restrictions	Prescriber is knowledgeable in the use of potent opioids for the management of chronic pain
Coverage Duration	90 days
Other Criteria	None

PCSK9 INHIBITOR

Products Affected

- Praluent Subcutaneous Solution Pen-injector
- Repatha
- Repatha Pushtronex System
- Repatha SureClick

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	FOR PRALUENT: MUST MEET CRITERIA #1 OR #3. FOR REPATHA: MUST MEET CRITERIA #1, #2 OR #3. 1. Diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by genotyping OR Simon Broome criteria: Total cholesterol greater than 290mg/dL or LDL cholesterol greater than 190mg/dL, PLUS ONE OF THE FOLLOWING: Tendon xanthomas in patient, or 1st degree relative (parent, sibling, child), or 2nd degree relative (grandparent, uncle, aunt) OR DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation 2. Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genotyping OR diagnosis based on the following: a. History of untreated LDL-C greater than 500 mg/dL AND xanthoma before 10 years of age OR b. Documentation of HeFH in both parents 3. Diagnosis of clinical atherosclerotic cardiovascular disease (CVD) as defined as one of the following: a. acute coronary syndrome, b. history of myocardial infarction, c. stable/unstable angina, d. coronary or other arterial revascularization, e. stroke, f. transient ischemic stroke (TIA), g. peripheral arterial disease presumed to be atherosclerotic region. AND MEETS CRITERIA #4, #5, and #6, 4. Provide baseline and current LDL-C 5. LDL-C greater than or equal to 100 mg/dL 6. Used in combination with maximally tolerated high-intensity statin OR MEETS CRITERIA #7 AND #8. 7. Statin intolerant 8. LDL-C greater than or equal to 100 mg/dL CONTINUING THERAPY: 1. Documented response to Praluent or Repatha, defined as ONE of the following: a. The patient is tolerating medication b. Will continue to be used in combination with maximally tolerated statin (unless statin intolerant).
Age Restrictions	Repatha: 13 years of age or older for diagnosis HoFM, Diagnosis CVD or HeFH AND Praluent or Repatha : 18 years of age or older

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HEALTH CHOICE GENERATIONS (PDP)
2017 Prior Authorization Criteria

PA Criteria	Criteria Details
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist
Coverage Duration	Initial approval: 8 weeks, Renewal approval: Plan Year
Other Criteria	None

QUININE

Products Affected

- QuiNINE Sulfate ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis and relevant medical information from physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diabetic Neuropathic Ulcers: Diabetic patient with ulcer wound. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Diabetic Neuropathic Ulcers: Maximum 5 months.
Other Criteria	None

REXULTI

Products Affected

- Rexulti

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Statement of Diagnosis from the prescriber and documented trial and failure, contraindication, or intolerance to aripiprazole
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Advanced Ovarian Cancer and all of the following criteria: 1. BRCA mutation positive as detected by an approved FDA laboratory test, 2. Previous trial/failure with two or more chemotherapy regimens, 3. Used as monotherapy, 4. Agreement of provider to perform a complete blood count (CBC) at baseline and monthly thereafter, 5. Women of reproductive potential must use an effective method of contraception during therapy and for 6 months after the last dose. Renewal will be based on lack of disease progression or unacceptable toxicity.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Hematologist or Oncologist
Coverage Duration	365 Days
Other Criteria	None

SAMSCA

Products Affected

- Samsca

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

SILDENAFIL

Products Affected

- Sildenafil Citrate Oral

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

SUBOXONE

Products Affected

- Buprenorphine HCl-Naloxone HCl
- Suboxone SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

SYNAGIS

Products Affected

- Synagis Intramuscular SOLUTION 50 MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic, non-small cell lung cancer with confirmed presence of T790M EGFR tumor mutation by cobas EGFR Mutation Test v2
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	None

TECFIDERA

Products Affected

- Tecfidera

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting MS or progressive-relapsing MS, or secondary-progressive MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	none

TOBI POD

Products Affected

- Tobi Podhaler

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with aminoglycoside hypersensitivity
Required Medical Information	Diagnosis of cystic fibrosis AND patient has evidence of P. aeruginosa in the lungs
Age Restrictions	6 years of age or older
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	For renewal, patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations)

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	CLL for patients with 17p deletion and have had at least 1 prior therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 Days
Other Criteria	none

VPRIV

Products Affected

- Vpriv

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use of miglustat (Zavesca)
Required Medical Information	Diagnosis confirmed by bone marrow histology, DNA testing, or measurement of beta-glucocerebrosidase enzyme activity of less than 30 percent. Patient must have at least one of the following conditions as a result of Type 1 Gaucher disease: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. Patients who have previously received 24 months of VPRIV therapy must have one of the following responses to continue therapy: 1) A decrease in liver and spleen volume 2) An increase in platelet count, or 3) An increase in hemoglobin concentration.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	365 days
Other Criteria	None

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician that establishes the cancer as anaplastic lymphoma kinase (ALK)-positive or ROS1-positive
Age Restrictions	None
Prescriber Restrictions	must be prescribed by an oncologist
Coverage Duration	365 days
Other Criteria	None

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	DIAGNOSIS OF MULTIPLE MYELOMA
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	none
Prescriber Restrictions	none
Coverage Duration	365 days
Other Criteria	none

YONDELIS

Products Affected

- Yondelis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis and lab values: ANC, platelet count, serum creatine phosphokinase, serum creatinine, liver function tests, and left ventricular ejection fraction.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Must be prescribed by an oncologist
Coverage Duration	365 Days
Other Criteria	None

PART B VERSUS PART D

Products Affected

- Abelcet Intravenous SUSPENSION 5 MG/ML
- Abraxane Intravenous SUSPENSION RECONSTITUTED 100 MG
- Acetylcysteine INHALATION SOLUTION 10 %, 20 %
- Acyclovir Sodium Intravenous SOLUTION 50 MG/ML
- Adriamycin Intravenous SOLUTION 2 MG/ML
- Adrucil Intravenous SOLUTION 500 MG/10ML
- Akynzeo Oral CAPSULE 300-0.5 MG
- Albuterol Sulfate INHALATION NEBULIZATION SOLUTION (2.5 MG/3ML) 0.083%, (5 MG/ML) 0.5%, 0.63 MG/3ML, 1.25 MG/3ML
- AmBisome Intravenous SUSPENSION RECONSTITUTED 50 MG
- Aminosyn II Intravenous SOLUTION 10 %, 7 %, 8.5 %
- Aminosyn II/Electrolytes Intravenous SOLUTION 8.5 %
- Aminosyn/Electrolytes Intravenous SOLUTION 7 %
- Aminosyn/Electrolytes Intravenous SOLUTION 8.5 %
- Aminosyn-HBC Intravenous SOLUTION 7 %
- Aminosyn-PF Intravenous SOLUTION 10 %, 7 %
- Aminosyn-RF Intravenous SOLUTION 5.2 %
- Amphotericin B INJECTION SOLUTION RECONSTITUTED 50 MG
- Aprepitant ORAL CAPSULE 125 MG, 40 MG, 80 & 125 MG, 80 MG
- Argatroban Intravenous SOLUTION 250 MG/2.5ML
- Arranon Intravenous SOLUTION 5 MG/ML
- Astagraf XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
- Atgam Intravenous INJECTABLE 50 MG/ML
- Azasan ORAL TABLET 100 MG, 75 MG
- AzaTHIOprine Sodium INJECTION SOLUTION RECONSTITUTED 100 MG
- Azithromycin Intravenous SOLUTION RECONSTITUTED 500 MG
- Benlysta Intravenous SOLUTION RECONSTITUTED 120 MG, 400 MG
- BiCNU Intravenous SOLUTION RECONSTITUTED 100 MG
- Bivigam Intravenous SOLUTION 10 GM/100ML
- Bleomycin Sulfate INJECTION SOLUTION RECONSTITUTED 30 UNIT
- Budesonide INHALATION SUSPENSION 0.25 MG/2ML, 0.5 MG/2ML, 1 MG/2ML
- Busulfex Intravenous SOLUTION 6 MG/ML
- CARBOplatin Intravenous SOLUTION 150 MG/15ML
- Carimune NF Intravenous SOLUTION RECONSTITUTED 6 GM
- CISplatin Intravenous SOLUTION 100 MG/100ML
- Cladribine Intravenous SOLUTION 10 MG/10ML
- Clindamycin Phosphate INJECTION SOLUTION 300 MG/2ML, 900 MG/6ML
- Clinimix E/Dextrose (2.75/10) Intravenous SOLUTION 2.75 %
- Clinimix E/Dextrose (2.75/5) Intravenous SOLUTION 2.75 %
- Clinimix E/Dextrose (4.25/10) Intravenous SOLUTION 4.25 %
- Clinimix E/Dextrose (4.25/25) Intravenous SOLUTION 4.25 %
- Clinimix E/Dextrose (4.25/5) Intravenous SOLUTION 4.25 %
- Clinimix E/Dextrose (5/15) Intravenous SOLUTION 5 %
- Clinimix E/Dextrose (5/20) Intravenous SOLUTION 5 %

- Clinimix E/Dextrose (5/25) Intravenous SOLUTION 5 %
- Clinimix/Dextrose (2.75/5) Intravenous SOLUTION 2.75 %
- Clinimix/Dextrose (4.25/10) Intravenous SOLUTION 4.25 %
- Clinimix/Dextrose (4.25/20) Intravenous SOLUTION 4.25 %
- Clinimix/Dextrose (4.25/25) Intravenous SOLUTION 4.25 %
- Clinimix/Dextrose (4.25/5) Intravenous SOLUTION 4.25 %
- Clinimix/Dextrose (5/15) Intravenous SOLUTION 5 %
- Clinimix/Dextrose (5/20) Intravenous SOLUTION 5 %
- Clinimix/Dextrose (5/25) Intravenous SOLUTION 5 %
- Clolar Intravenous SOLUTION 1 MG/ML
- Cosmegen Intravenous SOLUTION RECONSTITUTED 0.5 MG
- Cromolyn Sodium INHALATION NEBULIZATION SOLUTION 20 MG/2ML
- CycloSPORINE Intravenous SOLUTION 50 MG/ML
- CycloSPORINE Modified Oral CAPSULE 100 MG, 25 MG, 50 MG
- CycloSPORINE Modified ORAL SOLUTION 100 MG/ML
- CycloSPORINE ORAL CAPSULE 100 MG, 25 MG
- Cyramza Intravenous SOLUTION 100 MG/10ML, 500 MG/50ML
- Cytarabine (PF) INJECTION SOLUTION 100 MG/ML
- Cytarabine INJECTION SOLUTION 20 MG/ML
- Dacarbazine Intravenous SOLUTION RECONSTITUTED 200 MG
- DAUNOrubicin HCl Intravenous INJECTABLE 5 MG/ML
- DOXOrubicin HCl Intravenous SOLUTION 2 MG/ML
- DOXOrubicin HCl Liposomal Intravenous INJECTABLE 2 MG/ML
- Emend Intravenous SOLUTION RECONSTITUTED 150 MG
- Emend ORAL SUSPENSION RECONSTITUTED 125 MG
- Engerix-B INJECTION SUSPENSION 10 MCG/0.5ML, 10 MCG/0.5ML (0.5ML SYRINGE), 20 MCG/ML
- Envarsus XR Oral Tablet Extended Release 24 Hour 0.75 MG, 1 MG, 4 MG
- Epirubicin HCl Intravenous SOLUTION 200 MG/100ML
- Erbitux Intravenous SOLUTION 100 MG/50ML
- Etopophos Intravenous SOLUTION RECONSTITUTED 100 MG
- Etoposide Intravenous SOLUTION 500 MG/25ML
- Flebogamma DIF Intravenous SOLUTION 5 GM/50ML
- Fluconazole in Sodium Chloride Intravenous SOLUTION 200-0.9 MG/100ML-%, 400-0.9 MG/200ML-%
- Fluorouracil Intravenous SOLUTION 2.5 GM/50ML
- Folotyn Intravenous SOLUTION 40 MG/2ML
- FreAmine HBC Intravenous SOLUTION 6.9 %
- GamaSTAN S/D Intramuscular INJECTABLE , (10ML), (2ML)
- Gammagard INJECTION SOLUTION 2.5 GM/25ML
- Gammagard S/D Less IgA Intravenous SOLUTION RECONSTITUTED 10 GM, 5 GM
- Gammaked INJECTION SOLUTION 1 GM/10ML
- Gammaplex Intravenous SOLUTION 10 GM/200ML
- Gamunex-C INJECTION SOLUTION 1 GM/10ML
- Ganciclovir Sodium Intravenous SOLUTION RECONSTITUTED 500 MG

- Gengraf ORAL CAPSULE 100 MG, 25 MG, 50 MG
- Gengraf ORAL SOLUTION 100 MG/ML
- Granisetron HCl Intravenous SOLUTION 0.1 MG/ML, 1 MG/ML
- Granisetron HCl Oral TABLET 1 MG
- Hepatamine Intravenous SOLUTION 8 %
- Herceptin Intravenous SOLUTION RECONSTITUTED 440 MG
- HYDROmorphone HCl PF INJECTION SOLUTION 10 MG/ML, 50 MG/5ML
- IDArubicin HCl Intravenous SOLUTION 10 MG/10ML
- Ifosfamide Intravenous SOLUTION RECONSTITUTED 1 GM
- Ipratropium Bromide Inhalation SOLUTION 0.02 %
- Ipratropium-Albuterol Inhalation SOLUTION 0.5-2.5 (3) MG/3ML
- Irinotecan HCl Intravenous SOLUTION 100 MG/5ML
- Jevtana Intravenous SOLUTION 60 MG/1.5ML
- Kepivance Intravenous SOLUTION RECONSTITUTED 6.25 MG
- Kyprolis Intravenous SOLUTION RECONSTITUTED 30 MG, 60 MG
- Leucovorin Calcium INJECTION SOLUTION RECONSTITUTED 100 MG
- Levalbuterol HCl INHALATION NEBULIZATION SOLUTION 0.31 MG/3ML, 0.63 MG/3ML, 1.25 MG/0.5ML, 1.25 MG/0.5ML (2.5mg/mL), 1.25 MG/3ML
- Levoleucovorin Calcium Intravenous SOLUTION 175 MG/17.5ML
- Melphalan HCl Intravenous SOLUTION RECONSTITUTED 50 MG
- Mesna Intravenous SOLUTION 100 MG/ML
- Methotrexate Sodium INJECTION SOLUTION RECONSTITUTED 1 GM
- Metoprolol Tartrate Intravenous SOLUTION 1 MG/ML, 5 MG/5ML
- Metoprolol Tartrate Intravenous Solution Cartridge 5 MG/5ML
- MetroNIDAZOLE in NaCl Intravenous SOLUTION 500-0.79 MG/100ML-%
- Mircera Injection Solution Prefilled Syringe 100 MCG/0.3ML, 50 MCG/0.3ML, 75 MCG/0.3ML
- Mitomycin Intravenous SOLUTION RECONSTITUTED 20 MG, 40 MG
- Mitomycin Intravenous SOLUTION RECONSTITUTED 5 MG
- Mustargen INJECTION SOLUTION RECONSTITUTED 10 MG
- Mycophenolate Mofetil HCl Intravenous SOLUTION RECONSTITUTED 500 MG
- Mycophenolate Mofetil ORAL CAPSULE 250 MG
- Mycophenolate Mofetil ORAL SUSPENSION RECONSTITUTED 200 MG/ML
- Mycophenolate Mofetil ORAL TABLET 500 MG
- Mycophenolate Sodium ORAL TABLET DELAYED RELEASE 180 MG, 360 MG
- Mycophenolic Acid ORAL TABLET DELAYED RELEASE 180 MG, 360 MG
- Nebupent INHALATION SOLUTION RECONSTITUTED 300 MG
- NephrAmine Intravenous SOLUTION 5.4 %
- Nulojix Intravenous SOLUTION RECONSTITUTED 250 MG
- Nutrilipid Intravenous EMULSION 20 %
- Octagam Intravenous SOLUTION 1 GM/20ML, 2 GM/20ML
- Ondansetron HCl INJECTION SOLUTION 4 MG/2ML, 4 MG/2ML (2ML SYRINGE)
- Ondansetron HCl Oral SOLUTION 4 MG/5ML
- Oxaliplatin Intravenous SOLUTION 100 MG/20ML
- PACLitaxel Intravenous CONCENTRATE 300 MG/50ML
- Paricalcitol Intravenous SOLUTION 2 MCG/ML
- Paricalcitol Oral CAPSULE 1 MCG, 2 MCG, 4 MCG
- Plenamine Intravenous SOLUTION 15 %
- Premasol Intravenous SOLUTION 6 %

- Privigen Intravenous SOLUTION 20 GM/200ML
- Procalamine Intravenous SOLUTION 3 %
- Prograf Intravenous SOLUTION 5 MG/ML
- Prosol Intravenous SOLUTION 20 %
- Pulmozyme INHALATION SOLUTION 1 MG/ML
- RabAvert Intramuscular SUSPENSION RECONSTITUTED
- Rapamune ORAL SOLUTION 1 MG/ML
- Recombivax HB INJECTION SUSPENSION 10 MCG/ML, 10 MCG/ML (1ML SYRINGE), 40 MCG/ML, 5 MCG/0.5ML
- SandIMMUNE ORAL CAPSULE 100 MG, 25 MG
- SandIMMUNE ORAL SOLUTION 100 MG/ML
- Sirolimus ORAL TABLET 0.5 MG, 1 MG, 2 MG
- Tacrolimus ORAL CAPSULE 0.5 MG, 1 MG, 5 MG
- Tazicef INJECTION SOLUTION RECONSTITUTED 2 GM
- Tecentriq Intravenous SOLUTION 1200 MG/20ML
- Tetanus-Diphtheria Toxoids Td Intramuscular SUSPENSION 2-2 LF/0.5ML
- Thiotepa Injection SOLUTION RECONSTITUTED 15 MG
- Thymoglobulin Intravenous SOLUTION RECONSTITUTED 25 MG
- Tobramycin INHALATION NEBULIZATION SOLUTION 300 MG/5ML
- Toposar Intravenous SOLUTION 1 GM/50ML
- Topotecan HCl Intravenous SOLUTION RECONSTITUTED 4 MG
- Torisel Intravenous SOLUTION 25 MG/ML
- Travasol Intravenous SOLUTION 10 %
- Treanda Intravenous SOLUTION RECONSTITUTED 100 MG
- Uvadex INJECTION SOLUTION 20 MCG/ML
- Vectibix Intravenous SOLUTION 100 MG/5ML
- Ventavis INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML
- VinBLAStine Sulfate Intravenous SOLUTION 1 MG/ML
- VinCRIStine Sulfate Intravenous SOLUTION 1 MG/ML
- Vinorelbine Tartrate Intravenous SOLUTION 50 MG/5ML
- Zortress ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG

Details

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

HEALTH CHOICE GENERATIONS (PDP)
2017 Prior Authorization Criteria

Alphabetical Listing