Prior Authorization Group Description	**FARYDAK**
Drug Name	FARYDAK
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	History of recent myocardial infarction or unstable angina, QTcF greater than 450 msec or significant baseline ST-segment or T-wave abnormalities.
Required Medical Information	Patient must have multiple myeloma and received at least 2 prior regimens, including bortezomib and an immunomodulatory agent. Must be used in combination with bortezomib and dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 weeks
Other Criteria	For renewals: Patient must have clinical benefit. Patient must not have experienced unresolved severe or medically significant toxicity. Total treatment duration will not exceed 16 cycles (48 weeks).
Prior Authorization Group Description	**FIRAZYR**
Drug Name	FIRAZYR
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of hereditary angioedema. Firazyr will be used for acute attacks of angioedema. Patient has been advised to seek immediate medical attention in addition to treatment with Firazyr. Patient has been counseled to use no more than 3 doses in a 24 hour period.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**FLECTOR**
Drug Name	FLECTOR
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Application to non-intact skin from any etiology
Required Medical Information	Patient has acute pain due to minor strains, sprains, or contusions. Patient has been counseled to not wear the patch while bathing or showering.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**GILENYA**
Drug Name	GILENYA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Recent occurrence (within the last 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, class III or IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless a patient has a pacemaker. Baseline QTc interval greater than or equal to 500ms. Treatment with Class Ia or Class III anti-arrhythmic drugs.
Required Medical Information	Patient has a diagnosis of a relapsing form of multiple sclerosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**GILOTRIF**
Drug Name	GILOTRIF
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of previously untreated metastatic non-small cell lung cancer (NSCLC) with tumors expressing epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations. OR Patient has a diagnosis of metastatic squamous NSCLC and has been previously treated with platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**GLEEVEC**
Drug Name	IMATINIB MESYLATE
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following in an adult: A) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B) Ph+ acute lymphoblastic leukemia (ALL), C) Myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, D) Aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown, E) Hypereosinophilic syndrome or chronic eosinophilic leukemia, F) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, G) Gastrointestinal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy. Diagnosis of one of the following in a pediatric patient: A) Ph+ CML that is newly diagnosed in the chronic phase B) newly diagnosed Ph+ ALL.
Age Restrictions	18 years of age or younger - newly diagnosed CML in the chronic phase or newly diagnosed Ph+ ALL. 18 years of age or older for other indications.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**GONADOTROPIN**
Drug Name	GONADOTROPIN
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Not covered for a diagnosis of infertility.
Required Medical Information	Patient has a diagnosis of prepubertal cryptorchidism not due to anatomical obstruction or hypogonadotropic hypogonadism secondary to a pituitary deficiency in males.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**GRASTEK**
Drug Name	GRASTEK
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Severe, unstable, or uncontrolled asthma. A history of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. A history of esoinophilic esophagitis.
Required Medical Information	Will be used as immunotherapy for grass pollen-induced allergic rhinitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens.
Age Restrictions	Age 5 to 65 only
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Patient will be prescribed auto-injectable epinephrine. For renewals: patient must have a benefit from Grastek.

Prior Authorization Group Description	**GROWTH HORMONE**
Drug Name	HUMATROPE INJ 5MG, 6MG, 12MG, 24MG; GENOTROPIN INJ 0.4MG, 0.6MG, 0.8MG, 1MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG,
Tier	5
Drug Name	GENOTROPIN INJ 0.2MG, 5MG; NORDITROPIN INJ 5/1.5ML, 10/1.5ML; OMNITROPE INJ 5/1.5, 10/1.5ML; ZOMACTON INJ 5MG
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D including adult or childhood onset growth hormone deficiency (GHD), Turner syndrome (TS), Noonan syndrome (NS), small for gestational age (SGA), Prader-Willi syndrome (PWS), short stature homeobox-containing gene deficiency (SHOXD), chronic renal insufficiency (CRI).
Exclusion Criteria	Closed epiphyses in pediatric patients. Acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma or acute respiratory failure. Active malignancy. Active proliferative or severe non-proliferative diabetic retinopathy. For Prader-Willi Syndrome only: severe obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment.
Required Medical Information	For CRI: patient is not post-kidney transplant. For TS: diagnosis confirmed by karyotyping. For PWS: diagnosis confirmed by genetic testing. For pediatric GHD, CRI, SHOXD, and NS, patient must meet one of the following: 1) height more than 3 SDS below mean for age and gender 2) Height more than 2 SDS below mean with growth velocity more than 1 SDS below mean, or 3) Growth velocity over 1 year 2 SDS below mean. For adult GHD: must meet one of the following: 1) Failed 2 standard GH stimulation tests 2) Panhypopituitarism or 3 or more pituitary hormone deficiencies 3) Childhood-onset GHD with known mutations, embryopathic lesions, or irreversible structural lesions/damage 4) Low pre-treatment IGF-1 and failed 1 stimulation test prior to starting treatment.
Age Restrictions	For SGA: patient is more than 2 years old
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	For renewal of pediatric indications: final adult height has not been reached. For renewal of adult indications, patient has experienced an improvement or normalization of IGF-1 levels (not applicable to patients with panhypopituitarism).

Prior Authorization Group Name	**HARVONI**
Drug Name	HARVONI
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Information required for review: genotype, prior treatments, cirrhosis status, desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines as of the date of the request.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 or 24 weeks. 8 weeks per prescriber discretion.
Other Criteria	N/A
Prior Authorization Group Name	**HETLIOZ**
Drug Name	HETLIOZ
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of non-24-hour sleep-wake disorder.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**HRM-ANTIDIABETICS**
Drug Name	CHLOROPRAMIDE, GLYBURIDE, GLYBURIDE MICRONIZED, GLYBURIDE/METFORMIN
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The patient tried and failed to at least one of the following: glipizide, glipizide/metformin, glimepiride or has contraindications to all alternatives.
Age Restrictions	Applies to patients 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Patient will be monitored for hypoglycemia. Conservative dosing will be used to minimize hypoglycemic events.

Prior Authorization Group Description	**HRM-DIGOXIN**
Drug Name	LANOXIN 0.25mg
Tier	4
Drug Name	DIGITEK 0.25mg, DIGOX 0.25mg, DIGOXIN 0.25mg
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The patient has tried a lower dose (less than or equal to 0.125mg daily) or has contraindications to a lower dose.
Age Restrictions	Applies to patients 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	The patient has been counseled on and does not have signs and symptoms of toxicity.
Prior Authorization Group Description	**HRM-HYPNOTICS**
Drug Name	ESZOPICLONE, ZALEPLON, ZOLPIDEM
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The patient has tried and failed one of the following non-HRM formulary drugs: low-dose trazodone, Rozerem, Silenor OR a non-HRM formulary drug is not an acceptable alternative. Prescriber must acknowledge that the benefits of the HRM outweigh the potential risks. The prescriber attests that the lowest effective dose will be used to minimize side effects.
Age Restrictions	Applies to patients 65 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**HRM-MUSCLE RELAXANTS**
Drug Name	CYCLOBENZAPRINE
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The prescriber must attest that the medication benefits outweigh the potential risks.
Age Restrictions	Applies to patients 65 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**HRM-NITROFURANTOIN**
Drug Name	NITROFURANTOIN
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The prescriber has considered the risk for pulmonary and hepatic toxicity and acknowledges that the benefits outweigh the risks. The patient has tried and failed at least one of the following: trimethoprim, trimethoprim/sulfamethoxazole, ciprofloxacin or has contraindications to all alternatives.
Age Restrictions	Applies to patients 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Applies to patients that have greater than 90 days of therapy per year.

Prior Authorization Group Description	**IBRANCE**
Drug Name	IBRANCE
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer. Ibrance will be used with letrozole as initial endocrine based therapy in postmenopausal women OR with fulvestrant in women with disease progression following endocrine therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**ICLUSIG**
Drug Name	ICLUSIG
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has chronic myeloid leukemia (CML) and is T315I-positive, OR patient has T315I-positive Philadelphia chromosome positive acute lymphoblastic leukemia (ALL), OR patient has CML or Philadelphia chromosome positive ALL for whom no other tyrosine kinase inhibitor is indicated.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**IMBRUVICA**
Drug Name	IMBRUVICA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mantle cell lymphoma (MCL) and patient has received at least one prior therapy. Diagnosis of chronic lymphocytic leukemia (CLL) and patient has received at least one prior therapy. Diagnosis of CLL with 17p deletion. Diagnosis of Waldenstrom's macroglobulinemia (WM).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**INGREZZA**
Drug Name	INGREZZA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant monoamine oxidase inhibitor (MAOI) or tetrabenazine
Required Medical Information	Patient has been diagnosed with moderate to severe tardive dyskinesia including all of the following: involuntary athetoid or choreiform movements, history of treatment with dopamine receptor blocking agent, symptom duration lasting longer than 4-8 weeks. Patient has been evaluated by a treating neurologist or psychiatrist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	For renewal, patient must have improvement in symptoms.

Prior Authorization Group Description	**INLYTA**
Drug Name	INLYTA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced renal cell carcinoma (RCC). Patient has failed one prior systemic therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**INVEGA TRINZA**
Drug Name	INVEGA TRINZA
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient must have a diagnosis of schizophrenia. Patient must have been adequately treated with Invega Sustenna for at least 4 months. Invega Trinza will only be given once every 3 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**IRESSA**
Drug Name	IRESSA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has metastatic non-small cell lung cancer. The tumors have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations. Patient is using Iressa first line.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**IVIG**
Drug Name	BIVIGAM, FLEBOGAMMA DIF, GAMMAPLEX, HIZENTRA, OCTAGAM, PRIVIGEN
Tier	5
Drug Name	GAMASTAN S/D, GAMMAGARD LIQUID, GAMMAKED, GAMUNEX-C
Tier	4
Drug Name	GAMMAGARD S/D, CARIMUNE NANOFILTERED
Tier	3
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of hypersensitivity to immune globulin or any component of the preparation
Required Medical Information	For a diagnosis of ITP: patient must have a trial of corticosteroids unless platelet count is less than 20,000 cells/mm3 and bleeding has occurred. For a diagnosis of hypogammaglobulinemia associated with B-cell chronic lymphocytic leukemia: IgG level is less than 500 mg/dL or patient has a history of infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and despensed or administered for the individual.
Prior Authorization Group Description	**JAKAFI**
Drug Name	JAKAFI
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of intermediate or high-risk myelofibrosis (including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis). OR Patient has a diagnosis of polycythemia vera and has had an inadequate response to or was intolerant of hydroxyurea.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**JUXTAPID**
Drug Name	JUXTAPID
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	For initiation of treatment, moderate or severe hepatic impairment (eg, Child-Pugh B or C). For renewal, ALT or AST equal to or greater than 5 times the upper limit normal (ULN), or equal to greater than 3x ULN with signs or symptoms of liver toxicity or injury, increases in bilirubin greater than 2x ULN or active liver disease.
Required Medical Information	For initiation of therapy, 1. Patient has a diagnosis of homozygous familial hypercholesterolemia confirmed by one of the following: A. documented mutations in both alleles at LDL receptor, ApoB, PCSK9, or ARH adapter protein gene locus, B. documented skin fibroblast LDL receptor activity less than 20% of normal, OR C. the following criteria are met: a) untreated LDL-C greater than 500 mg/dL or unknown AND b) triglyceride level less than 350 mg/dL AND c) tendon or cutaneous xanthomas at age 10 or younger OR d) both parents with a history of LDL-C greater than 190 mg/dL, AND 2. Patient has tried and had an inadequate response to the maximum tolerated dose of a high potency statin and a PCSK9 inhibitor unless contraindicated. For renewal of therapy, 1. Patient meets all initial criteria AND 2. Current LDL-C is improved from the levels immediately prior to initiation of treatment with Juxtapid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**KALYDECO**
Drug Name	KALYDECO
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D including Cystic Fibrosis.
Exclusion Criteria	N/A
Required Medical Information	Statement from physician or lab results showing patient has cystic fibrosis with a CFTR gene mutation G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R OR patient has an R117H mutation in the CFTR gene. Patient is not homozygous for the F508del mutation in the CFTR gene.
Age Restrictions	Patient is at least 2 years old for granules and 6 years old for tablets.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**KISQALI**
Drug Name	KISQALI
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of hormone receptor positive, human epidermal growth factor receptor 2 negative advanced or metastatic breast cancer. Patient will be on letrozole with Kisqali. Kisqali is prescribed as initial endocrine-based therapy in a postmenopausal woman.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**KORLYM**
Drug Name	KORLYM
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Not covered if patient is pregnant. Maximum dose: 1200mg daily, not to exceed 20mg/kg/day. Patient requires concomitant treatment with long-term corticosteroids (e.g., immunosuppression for organ transplant). History of unexplained vaginal bleeding. Endometrial hyperplasia with atypia or endometrial carcinoma. Concomitantly taking simvastatin, lovastatin, or a CYP3A substrate with a narrow therapeutic range (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus)
Required Medical Information	Patient has a diagnosis of endogenous Cushing's syndrome and has type 2 diabetes mellitus or glucose intolerance. Patient has failed surgery or is not a candidate for surgery. Statement from physician verifying that non-hormonal contraception will be used during treatment and for one month after discontinuation of therapy unless the patient has had surgical sterilization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribing physician must be an endocrinologist.
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**KYNAMRO**
Drug Name	KYNAMRO
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	For initiation of treatment, moderate or severe hepatic impairment (eg, Child-Pugh B or C). For renewal, ALT or AST equal to or greater than 5 times the upper limit normal (ULN), or equal to greater than 3x ULN with signs or symptoms of liver toxicity or injury, increases in bilirubin greater than 2x ULN or active liver disease.
Required Medical Information	For initiation of therapy, all of the following requirements are met : 1)Patient has a diagnosis of homozygous familial hypercholesterolemia confirmed by one of the following: a) documented mutations in both alleles at LDL receptor, ApoB, PCSK9, or ARH adapter protein gene locus, b) documented skin fibroblast LDL receptor activity less than 20% of normal, OR c) the following criteria are met: i) untreated LDL-C greater than 500 mg/dL or unknown AND ii) triglyceride level less than 350 mg/dL AND iii) tendon or cutaneous xanthomas at age 10 or younger or both parents with a history of LDL-C greater than 190 mg/dL, AND 2) Patient has tried and had an inadequate response to the maximum tolerated dose of a high potency statin and a PCSK9 inhibitor unless contraindicated. For renewal of therapy, Patient meets all criteria for initiation of therapy AND current LDL-C is improved from levels immediately prior to initiation of treatment with Kynamro.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**LENVIMA**
Drug Name	LENVIMA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer. OR Patient has a diagnosis of advanced renal cell carcinoma (RCC) and has failed one prior anti-angiogenic therapy. Lenvima will be used in combination with everolimus when used for RCC.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**LETAIRIS**
Drug Name	LETAIRIS
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Patient has a diagnosis of pulmonary arterial hypertension (WHO Group I). For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, AND 2) Patient will use reliable contraception during treatment and for one month after stopping treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**LIDODERM**
Drug Name	LIDOCAINE PAD 5%
Tier	2
Covered Uses	All medically accepted indications not otherwise excluded from Part D including diabetic neuropathy and cancer-related neuropathic pain.
Exclusion Criteria	N/A
Required Medical Information	The patient has a diagnosis of post-herpetic neuralgia, diabetic neuropathy, or cancer-related neuropathic pain. The patch will only be applied to intact skin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**LONSURF**
Drug Name	LONSURF
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic colorectal cancer. Patient has been previously treated with a fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy (such as FOLFOX, FOLFIRI, FOLFOXIRI) AND an anti-VEGF biological therapy (such as Avastin). If patient is RAS wild-type, patient has been previously treated with an anti-EGFR therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**LYNPARZA**
Drug Name	LYNPARZA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced ovarian cancer. Patient has deleterious or suspected deleterious germline BRCA mutations. Patient has been treated with three or more prior lines of chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**MEKINIST**
Drug Name	MEKINIST
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has unresectable or metastatic melanoma with BRAF V600E or V600K mutations. Mekinist will be used as a single agent or with dabrafenib (Tafinlar). Patient has not received prior BRAF-inhibitor therapy (Zelboraf, Tafinlar).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**METHAMPHETAMINE**
Drug Name	METHAMPHETAMINE
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Not covered for a diagnosis of obesity.
Required Medical Information	Patient has a diagnosis of attention deficit disorder with hyperactivity.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**NEXAVAR**
Drug Name	NEXAVAR
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	For patients with squamous cell lung cancer, sorafenib will not be given in combination with carboplatin and paclitaxel.
Required Medical Information	Patient has a diagnosis of one of the following: unresectable hepatocellular carcinoma, advanced renal cell carcinoma, or locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**NINLARO**
Drug Name	NINLARO
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of multiple myeloma. Ixazomib will be used in combination with lenalidomide and dexamethasone. Patient has received at least one prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**NUEDEXTA**
Drug Name	NUEDEXTA
Tier	3
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Patient is currently using quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong the QT interval and are metabolized by CYP2D6 (examples: thioridazine and pimozide). Patient has a prolonged QT interval or congenital long QT syndrome (LQTS), or heart failure or a history suggestive of torsades de pointes (TdP). Patient has complete atrioventricular (AV) block without an implanted pacemaker or is at high risk of complete AV block.
Required Medical Information	Diagnosis of pseudobulbar affect (PBA)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**NUVIGIL**
Drug Name	NUVIGIL
Tier	4
Drug Name	ARMODAFINIL 50MG, 150MG, 200MG, 250MG
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy 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 Diagnosis of excessive sleepiness associated with shift work disorder.
Age Restrictions	17 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**ODOMZO**
Drug Name	ODOMZO
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of locally advanced basal cell carcinoma (BCC). BCC has either recurred following surgery or radiation therapy or patient was not a candidate for surgery or radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**OFEV**
Drug Name	OFEV
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The patient has a diagnosis of idiopathic pulmonary fibrosis. Liver function tests were performed prior to starting therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consulation with a pulmonologist
Coverage Duration	Plan year
Other Criteria	For renewal, the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage.

Prior Authorization Group Description	**OLYSIO**
Drug Name	OLYSIO
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Information required for review: genotype, prior treatments, cirrhosis status, desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines as of the date of the request.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 or 24 weeks per medical information provided
Other Criteria	N/A
Prior Authorization Group Description	**OPSUMIT**
Drug Name	OPSUMIT
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has pulmonary arterial hypertension (PAH), World Health Organization Group I disease. PAH was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). Liver function tests were performed prior to starting therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**ORENITRAM**
Drug Name	ORENITRAM 0.25MG, 1MG, 2.5MG
Tier	5
Drug Name	ORENITRAM 0.125MG
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Patient has a diagnosis of severe hepatic impairment (Child Pugh Class C).
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**ORKAMBI**
Drug Name	ORKAMBI
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has cystic fibrosis and is homozygous for the F508del mutation in the CFTR gene. Patient had baseline ALT, AST, and bilirubin assessed.
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**OTEZLA**
Drug Name	OTEZLA
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has diagnosis of active psoriatic arthritis OR moderate to severe plaque psoriasis and is a candidate for phototherapy or systemic therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	For renewals, patient has stable disease or has improved while on therapy.

Prior Authorization Group Description	**POMALYST**
Drug Name	POMALYST
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	For multiple myeloma: 1) Patient received prior therapy with Velcade (bortezomib) AND Revlimid (lenalidomide), 2) disease has progressed during or within 60 days of completion of last therapy 3) Will be used in combination with dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**PRALUENT**
Drug Name	PRALUENT
Tier	5
Covered Uses	All FDA-accepted indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease (ASCVD, defined as having at least one of the following: ACS, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin) and requires additional lowering of LDL cholesterol. Patient is on maximally tolerated statin therapy or has zero tolerance to statin therapy. Patient will be started on the 75mg dose. For a diagnosis of clinical atherosclerotic cardiovascular disease: patient has tried at least two statins (rosuvastatin, atorvastatin, simvastatin, pravastatin, lovastatin, or fluvastatin).
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**PROVIGIL**
Drug Name	MODAFINIL
Tier	2
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy 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 Diagnosis of excessive sleepiness associated with shift work disorder.
Age Restrictions	17 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**RAGWITEK**
Drug Name	RAGWITEK
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Severe, unstable, or uncontrolled asthma. A history of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. A history of esoinophilic esophagitis.
Required Medical Information	Will be used as immunotherapy for short ragweed pollen-induced allergic rhinitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen.
Age Restrictions	Age 18 to 65 only
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Patient will be prescribed auto-injectable epinephrine. For renewals: patient must have a benefit from Ragwitek.
Prior Authorization Group Description	**RELISTOR**
Drug Name	RELISTOR
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Patient with known or suspected mechanical GI obstruction and at increased risk of recurrent obstruction.
Required Medical Information	Patient has a diagnosis of opioid induced constipation with either chronic non cancer pain or advanced illness who are receiving palliative care, when response to laxative therapy has not been sufficient. Patient has had an inadequate response to Amitiza or Movantik.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**REMODULIN**
Drug Name	REMODULIN
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Congestive heart failure due to severe left ventricular systolic dysfunction
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiagram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH AND Patient has New York Heart Association (NYHA) Functional Class II-IV.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Part D if patient in long term care (defined by customer location code on claim) otherwise Part B
Prior Authorization Group Description	**REPATHA**
Drug Name	REPATHA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of heterozygous or homozygous familial hypercholesterolemia (HeFH or HoFH) or clinical atherosclerotic cardiovascular disease (ASCVD, defined as having at least one of the following: ACS, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin) and requires additional lowering of LDL cholesterol. Patient is on maximally tolerated statin therapy or has zero tolerance to statin therapy. For a diagnosis of clinical atherosclerotic cardiovascular disease: patient has tried at least two statins (rosuvastatin, atorvastatin, simvastatin, pravastatin, lovastatin, or fluvastatin).
Age Restrictions	13 years of age or older for HoFH, 18 years of age or older for other indications
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**RESPIRATORY PDE-5 INHIBITOR**
Drug Name	ADCIRCA, REVATIO
Tier	5
Drug Name	SILDENAFIL
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Receiving nitrate therapy (includes intermittent use)
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has (WHO Group I) PAH.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**REVLIMID**
Drug Name	REVLIMID
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of multiple myeloma and medication will be used in combination with dexamethasone. OR Diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5 q cytogenetic abnormality with or without additional cytogenetic abnormalities. OR Diagnosis of mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib. AND Patient is not using the medication for the treatment of chronic lymphocytic leukemia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**RUBRACA**
Drug Name	RUBRACA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced ovarian cancer with deleterious BRCA mutation. Patient has been treated with 2 or more chemotherapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**SOLARAZE**
Drug Name	DICLOFENAC SODIUM
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient must have a diagnosis of actinic keratosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**SOMATULINE**
Drug Name	SOMATULINE
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of either Acromegaly or gastroenteropancreatic neuroendocrine tumors (GEP-NETs). For acromegaly, patient has had an inadequate or partial response to surgery and/or radiotherapy or patient was not a candidate for surgery or radiotherapy. For GEP-NETs, tumors are unresectable, well- or moderately-differentiated, locally advanced or metastatic.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**SOVALDI**
Drug Name	SOVALDI
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Information required for review: genotype, prior treatments, cirrhosis status, desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines as of the date of the request.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12, 16, 24, or 48 weeks per medical information provided
Other Criteria	N/A

Prior Authorization Group Description	**SPRYCEL**
Drug Name	SPRYCEL
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Gastrointestinal stromal tumor (GIST)
Exclusion Criteria	N/A
Required Medical Information	Newly diagnosed adults with Philadelphia chromosome-positive chronic myelogenous leukemia (CML) in chronic phase. Adults with chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome-positive CML with resistance or intolerance to prior therapy including imatinib. Adults with diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (ALL) with resistance or intolerance to prior therapy. For patients with GIST, patient must have progressed on imatinib or sunitinib.
Age Restrictions	18 years or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**STELARA**
Drug Name	STELARA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of moderate to severe plaque psoriasis (affects more than 5% of body surface area or affects crucial areas such as hands, feet, or genitals) or active psoriatic arthritis. For psoriasis: patient must have had an inadequate response to either phototherapy (e.g., UVB, PUVA) or a traditional systemic agent (e.g., methotrexate, cyclosporine, acitretin), unless contraindicated or intolerant to such therapies. Patient was negative for latent TB infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	For renewals: patient has had stable disease or improved on therapy.

Prior Authorization Group Description	**STIVARGA**
Drug Name	STIVARGA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of: A) metastatic colon or rectal cancer AND patient has previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan -based therapy, an anti-vascular endothelial growth factor (VEGF) therapy, and, if KRAS wild type, an anti-epidermal growth factor receptor (EGFR) therapy or B) gastrointestinal stromal tumors that is locally advanced, unresectable or metastatic AND patient has tried and had an inadequate response, contraindication or intolerance to imatinib and sunitinib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**SUTENT**
Drug Name	SUTENT
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced/metastatic renal cell carcinoma. Diagnosis of gastrointestinal stromal tumor (GIST) after disease progression on or intolerance to imatinib. Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumors (pNET) in a patient with unresectable locally advanced or metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**TAFINLAR**
Drug Name	TAFINLAR
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of unresectable or metastatic melanoma AND will be used as monotherapy in patients with the BRAF V600E mutation OR dabrafenib will be used in combination with trametinib in patients with BRAF V600E or V600K mutations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**TAGRISSO**
Drug Name	TAGRISSO
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) T790M mutation-positive disease. Patient must have progressed on or after EGFR tyrosine kinase inhibitor (TKI) therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**TARCEVA**
Drug Name	TARCEVA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	For pancreatic cancer: Used first-line in locally advanced, unresectable, or metastatic cancer in combination with gemcitabine. For Non-small cell lung cancer: Not used in combination with platinum-based chemotherapy and used for: 1) Metastatic cancer, used first-line, tumors have EGFR exon 19 deletions or exon 21 substitution mutations. OR 2) Locally advanced or metastatic cancer, failed at least 1 prior regimen. OR 3) Locally advanced or metastatic cancer, used as maintenance after 4 cycles of platinum-based chemotherapy, no evidence of disease progression after the platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**TARGRETIN**
Drug Name	TARGRETIN
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	For gel: patient has a diagnosis of stage 1A or 1B cutaneous T-cell lymphoma that is refractory or persistent after treatment with other therapies or has not tolerated other therapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**TASIGNA**
Drug Name	TASIGNA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Uncorrected hypokalemia or hypomagnesemia, long QT syndrome. Use of concomitant drugs known to prolong the QT interval or strong CYP3A4 inhibitors.
Required Medical Information	Patient has a diagnosis of newly diagnosed Philadelphia chromosome positive CML in chronic phase OR a diagnosis of chronic phase or accelerated phase Philadelphia chromosome positive CML in patients that are resistant or intolerant to imatinib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**TECFIDERA**
Drug Name	TECFIDERA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of a relapsing form of multiple sclerosis. Patient must have a complete blood count within the past 6 months before initiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	To continue therapy, the patient must demonstrate stabilization or improvement while on Tecfidera.

Prior Authorization Group Description	**THALOMID**
Drug Name	THALOMID
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of: A) multiple myeloma that is newly diagnosed and is receiving concurrent dexamethasone B) acute treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum C) Maintenance therapy for prevention and suppression of the cutaneous manifestations of erythema nodosum leprosum recurrence. Thalidomide will not be used as monotherapy for erythema nodosum leprosum treatment if the member has moderate to severe neuritis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**TRACLEER**
Drug Name	TRACLEER
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy. Concomitant use with cyclosporine or glyburide. For initial therapy: alanine aminotransferase (ALT)/aspartate aminotransferase (AST) level greater than 3 times the upper limit of normal (ULN).
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group I) that was confirmed by right heart catheterization or Doppler echocardiagram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.). NYHA Functional Class II to IV symptoms. For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, and 2) Patient will use reliable contraception during treatment and for one month after stopping treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**TRANSMUCOSAL FENTANYL PRODUCTS**
Drug Name	ABSTRAL, FENTORA, LAZANDA, SUBSYS
Tier	5
Drug Name	FENTANYL CITRATE ORAL
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	A. Long-Acting opioid is being prescribed. B. The patient is opioid tolerant (patients are considered opioid tolerant if they have been taking at least 60mg of oral morphine per day, 25mcg of transdermal fentanyl/hr, 30mg of oral oxycodone daily, 8mg of oral hydromorphone daily, 25mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer).
Age Restrictions	16 years of age or older (fentanyl oral lozenge), 18 years of age or older all others.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**TYKERB**
Drug Name	TYKERB
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced or metastatic breast cancer with overexpression of HER2 AND Tykerb will be used with capecitabine AND patient has received prior therapy with an anthracycline, a taxane, and trastuzumab. OR Patient is postmenopausal with a diagnosis of hormone receptor positive metastatic breast cancer with overexpression of HER2 AND Tykerb will be used with letrozole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**UPTRAVI**
Drug Name	UPTRAVI
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group I) that was confirmed by right heart catheterization or Doppler echocardiagram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Other Criteria	N/A
Prior Authorization Group Description	**VENCLEXTA**
Drug Name	VENCLEXTA 100MG, STARTER PAK
Tier	5
Drug Name	VENCLEXTA 10MG, 50MG
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Must not be on a strong CYP3A inhibitor (such as ketoconazole, conivaptan, clarithromycin, indinavir, itraconazole, lopinavir, ritonavir, telaprevir, posaconazole, or voriconazole) at Venclexta initiation and during Venclexta ramp-up phase.
Required Medical Information	Patient has a diagnosis of chronic lymphocytic leukemia (CLL) with 17p deletion. Patient has received at least one prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**VOTRIENT**
Drug Name	VOTRIENT
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of advanced renal cell carcinoma or advanced soft tissue sarcoma. Patients with a diagnosis of soft tissue sarcoma must have received prior chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**XALKORI**
Drug Name	XALKORI
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC). The tumor is ROS1- or ALK-positive. Xalkori will be used as a single agent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**XENAZINE**
Drug Name	XENAZINE
Tier	5
Drug Name	TETRABENAZINE
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Tardive dyskinesia and Tourette's syndrome.
Exclusion Criteria	Actively suicidal or has untreated or inadequately treated depression. Impaired hepatic function. Concomitant monoamine oxidase inhibitor (MAOI) or use within 14 days of stopping MAOI. Concomitant reserpine or use within 20 days of stopping reserpine.
Required Medical Information	Diagnosis of chorea associated with Huntington's disease. If treating for tardive dyskinesia, require failure of at least one previous therapy (e.g., amantadine, benzodiazepines, haloperidol, atypical antipsychotics, etc.) or Gilles de la Tourette's syndrome with failure or least one previous therapy (e.g., antipsychotic agents, clonidine). Patients who require doses greater than 50 mg/day will be genotyped for CYP2D6 to determine whether the patient is a poor, intermediate or extensive metabolizer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	For renewal, patient must have a lack of disease progression or have improvement in symptoms.
Prior Authorization Group Description	**XEOMIN**
Drug Name	XEOMIN
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Infection at the site of injection
Required Medical Information	For blepharospasm: must have prior treatment with onabotulinumtoxinA (Botox)
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**XTANDI**
Drug Name	XTANDI
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic castration-resistant prostate cancer (CRPC). The patient has tried and had an inadequate response, contraindication or intolerance to Zytiga.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**XYREM**
Drug Name	XYREM
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Taking alcohol or sedative hypnotic agents while taking Xyrem.
Required Medical Information	Patient has a diagnosis of narcolepsy with either cataplexy or excessive daytime sleepiness. For patients with a diagnosis of excessive daytime sleepiness, patient has had a previous trial with or a contraindication, intolerance, or allergy to modafinil, armodafinil, methylphenidate, dextroamphetamine, or mixed amphetamine salts.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**ZEJULA**
Drug Name	ZEJULA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	NA
Required Medical Information	Patient has a diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer. Patuent had a complete or partial response to platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**ZELBORAF**
Drug Name	ZELBORAF
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of unresectable or metastatic melanoma. Patient has positive BRAF-V600E mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**ZEPATIER**
Drug Name	ZEPATIER
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Patient has moderate or severe hepatic impairment (Child-Pugh B or C). Patient is on OATP1B1/3 inhibitors, strong inducers of CYP3A or efavirenz.
Required Medical Information	Information required for review: genotype, prior treatments, cirrhosis status, desired treatment regimen, viral load, HIV status, liver transplant history, renal impairment status, NS5A polymorphism status. Requests will be reviewed against the most current edition of the American Association for the Study of Liver Diseases (AASLD) Infectious Diseases Society of America (IDSA) guidelines for Hepatitis C infection. Patients must be prescribed regimens recommended under these guidelines as of the date of the request.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 or 16 weeks per medical information provided
Other Criteria	N/A
Prior Authorization Group Description	**ZINBRYTA**
Drug Name	ZINBRYTA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Patient does not have hepatic disease or hepatic impairment, including an ALT or AST 2 times above the upper limit of normal. Patient does not have a history of autoimmune hepatitis or other autoimmune condition involving the liver.
Required Medical Information	Patient has a diagnosis of a relapsing form of multiple sclerosis (MS). Patient has had an inadequate response to two or more drugs for the treatment of MS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**ZOLINZA**
Drug Name	ZOLINZA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of cutaneous T-cell lymphoma with progressive, persistent or recurrent disease. Patient has received at least two prior systemic therapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**ZYDELIG**
Drug Name	ZYDELIG
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	For relapsed chronic lymphocytic leukemia, Zydelig is used in combination with rituximab. For relapsed follicular B-cell non-Hodgkin lymphoma and relapsed small lymphocytic lymphoma, patient has received at least two prior systemic therapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**ZYKADIA**
Drug Name	ZYKADIA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic non-small cell lung cancer has anaplastic lymphoma kinase (ALK)-positive disease. Patient had an inadequate response, progressed on, or had an intolerance or contraindication to Xalkori.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**ZYTIGA**
Drug Name	ZYTIGA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of metastatic castration-resistant prostate cancer (CRPC). Zytiga will be used in combination with prednisone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A