Baylor Scott and White Health Plan

SeniorCare (Cost)
SeniorCare Advantage (PPO)
SeniorCare Advantage (HMO)
Vital Traditions (HMO)

2018 Prior Authorization Criteria

ADCIRCA

MEDICATION(S)

ADCIRCA, TADALAFIL 20 MG TABLET

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

ADEMPAS

MEDICATION(S)

ADEMPAS

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

BERINERT

MEDICATION(S)

BERINERT

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Allergist, Immunologist, Hematologist or Dermatologist

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

CARBAGLU

MEDICATION(S)

CARBAGLU

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

CAYSTON

MEDICATION(S)

CAYSTON

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to pulmonary and infectious disease specialists

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

CINRYZE

MEDICATION(S)

CINRYZE

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Allergist, Immunologist, Hematologist or Dermatologist

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

CORLANOR

MEDICATION(S)

CORLANOR

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

Requires failure of or intolerance to maximized beta-blocker therapy.

COSENTYX

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Trial and failure, contraindication, or intolerance to Enbrel (etanercept) OR Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: Trial and failure, contraindication, or intolerance to Enbrel (etanercept) or Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: Trial and failure, contraindication, or intolerance to Enbrel (etanercept) or Humira (adalimumab), OR for continuation of prior Cosentyx therapy. All indications (Initial, reauth): Patient is not receiving Cosentyx in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)].

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Restricted to Dermatology and Rheumatology

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
N/A

DICLOFENAC 3% GEL

MEDICATION(S)

DICLOFENAC SODIUM 3% GEL

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

ENBREL

MEDICATION(S)
ENBREL, ENBREL MINI, ENBREL SURECLICK

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
If diagnosis is plaque psoriasis, must have moderate to severe plaque psoriasis affecting greater than 5% of the body surface area (BSA) or affecting crucial body areas such as the hands, feet, face or genitals.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Restricted to rheumatology and dermatology

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
If diagnosis is rheumatoid arthritis, must have failure or intolerance to methotrexate. If diagnosis is plaque psoriasis, must have failure of at least two of the following: potent topical corticosteroids, calcipotriene, tazarotene, phototherapy, acitretin, methotrexate, or cyclosporine.

ESBRIET

MEDICATION(S)

ESBRIET

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to Pulmonary

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

EXJADE

MEDICATION(S)

EXJADE

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

Patient must be 2 years of age or older.

PRESCRIBER RESTRICTION

Restricted to hematology and oncology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

FENTANYL TIRF

MEDICATION(S)

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

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Documentation of use to manage breakthrough pain in a patient with cancer who is already receiving opioid therapy and is opioid tolerant

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

Patients are considered opioid tolerant when taking morphine 60 mg/day or more, transdermal fentanyl 25 mcg/hr, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for 1 week or longer.

FERRIPROX

MEDICATION(S)
FERRIPROX

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Restricted to Hematology/Oncology

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
Therapeutic failure on, intolerance to, or contraindication to Exjade. Documentation of ANC greater than 1.5 x 1000000000 (10 to the 9th power) / L.

FIRAZYR

MEDICATION(S)

FIRAZYR

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

Must be 18 years or older

PRESCRIBER RESTRICTION

Allergist, Immunologist, Hematologist or Dermatologist

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

FORTEO

MEDICATION(S)
FORTEO

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Postmenopausal women who are at a high risk for fracture, or men with primary or hypogonadal osteoporosis who are at a high risk for fracture OR for the treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture. High risk for fracture defined as a history of osteoporosis-related fracture, Low bone density less than 2.5SD below normal. Additionally, requires treatment failure, contraindication or intolerance to at least one oral bisphosphonate.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
N/A

GATTEX

MEDICATION(S)
GATTEX

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Restricted to Gastroenterology

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
Documentation that member requires parenteral nutrition at least 3 times a week for the last 12 consecutive months.

GILOTRIF - FOR NEW STARTS ONLY

MEDICATION(S)

GILOTRIF

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to oncology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

GLEEVEC - FOR NEW STARTS ONLY

MEDICATION(S)

GLEEVEC, IMATINIB MESYLATE

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to oncology and hematology specialists

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

HARVONI

MEDICATION(S)
HARVONI

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1) Diagnosis of chronic hepatitis C (CHC) genotypes 1, 4, 5 or 6 2) Baseline HCV viral load (VL) 3) Treatment status of patient (treatment naive or treatment-experienced). If treatment-experienced, provide previous therapies 4) Documentation that patient does or does not have cirrhosis. If cirrhotic, documentation of compensated or decompensated status. 5) Documentation of whether patient has had a liver transplant

AGE RESTRICTION
Must be 12 years or older

PRESCRIBER RESTRICTION
Restricted to a Gastroenterologist, Hepatologist or Infectious Disease physician

COVERAGE DURATION
Criteria will be applied consistent with current AASLD/IDSA guidance

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance

HETLIOZ

MEDICATION(S)

HETLIOZ

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Must be prescribed by or in consultation with a sleep specialist or a neurologist

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

HUMIRA

MEDICATION(S)

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

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

If diagnosis is plaque psoriasis, must have moderate to severe plaque psoriasis affecting greater than 5% of the body surface area (BSA) or affecting crucial body areas such as the hands, feet, face or genitals.

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to rheumatology, dermatology, gastroenterology or ophthalmology.

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

If diagnosis is rheumatoid arthritis, must have failure or intolerance to methotrexate. If diagnosis is plaque psoriasis, must have failure of at least two of the following: potent topical corticosteroids, calcipotriene, tazarotene, phototherapy, acitretin, methotrexate, or cyclosporine.

ILARIS

MEDICATION(S)

ILARIS

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Rheumatologist, Immunologist or Dermatologist

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

IMBRUVICA - FOR NEW STARTS ONLY

MEDICATION(S)

IMBRUVICA

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to oncology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

JUXTAPID

MEDICATION(S)
JUXTAPID

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

EXCLUSION CRITERIA
Pregnancy

REQUIRED MEDICAL INFORMATION
Diagnosis of homozygous familial hypercholesterolemia (HoFH)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
Adequate trial (30 days of therapy), failure, contraindication or intolerance to at least one high dose statin therapy (atorvastatin 40-80 mg daily, or rosuvastatin 20-40mg daily).

KALYDECO

MEDICATION(S)

KALYDECO

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Coverage excluded if homozygous for the F508 del mutation in the CFTR gene

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to Pulmonary

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

KEVEYIS

MEDICATION(S)

KEVEYIS

COVERED USES

All medically accepted indications not otherwise excluded from Part D.

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year.

OTHER CRITERIA

N/A

KORLYM

MEDICATION(S)
KORLYM

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

EXCLUSION CRITERIA
Pregnancy

REQUIRED MEDICAL INFORMATION
Documentation of a negative pregnancy test within 14 days of initiating therapy in women of reproductive potential

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Restricted to Endocrinology

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
N/A

KYNAMRO

MEDICATION(S)
KYNAMRO

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Diagnosis of homozygous familial hypercholesterolemia (HoFH)

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
Adequate trial (30 days of therapy), failure, contraindication or intolerance to at least one high dose statin therapy (atorvastatin 40-80 mg daily, or rosuvastatin 20-40mg daily).

LIDOCAINE PATCH

MEDICATION(S)

LIDOCAINE 5% PATCH

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

LUMIZYME

MEDICATION(S)

LUMIZYME

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

MAVYRET

MEDICATION(S)

MAVYRET

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

1) Diagnosis of chronic hepatitis C
2) Treatment status of patient (treatment naive or treatment-experienced). If treatment-experienced, provide previous therapies.
3) Documentation that patient does or does not have cirrhosis. If cirrhotic, documentation of compensated or decompensated status.
4) Documentation of whether patient has had a liver transplant

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to a Gastroenterologist, Hepatologist or Infectious Disease physician

COVERAGE DURATION

Criteria will be applied consistent with current AASLD/IDSA guidance

OTHER CRITERIA

Criteria will be applied consistent with current AASLD/IDSA guidance

MEGESTROL ACETATE - FOR NEW STARTS ONLY

MEDICATION(S)

MEGESTROL 625 MG/5 ML SUSP, MEGESTROL ACET 40 MG/ML SUSP, MEGESTROL ACET 400 MG/10 ML

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

MEKINIST - FOR NEW STARTS ONLY

MEDICATION(S)

MEKINIST

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

A documented BRAF V600E or V600K mutation

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to oncology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

Mekinist, as a single agent, is not indicated for the treatment of patients who have received prior BRAF-inhibitor therapy (i.e. Zelboraf, Tafinlar).

MODAFINIL

MEDICATION(S)

MODAFINIL

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

MOZOBIL

MEDICATION(S)
MOZOBIL

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Requires diagnosis of non-Hodgin's lymphoma or multiple myeloma. Requires failure of standard stem cell mobilization using a colony stimulating factor (either G-CSF or GM-CSF) alone or in combination with chemotherapy.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Restricted to hematology and oncology

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
Requires use in combination with one of the following colony stimulating factors: Granulocyte Colony Stimulating Factor (G-CSF) or Granulocyte Macrophage Colony Stimulating Factor (GM-CSF)

MUSCLE RELAXANTS

MEDICATION(S)

CARISOPRODOL, CHLORZOXAZONE 500 MG TABLET, METHOCARBAMOL 500 MG TABLET, METHOCARBAMOL 750 MG TABLET, ORPHENADRINE ER 100 MG TABLET

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

Applies to members 65 years of age and older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

NATPARA

MEDICATION(S)

NATPARA

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

NORDITROPIN

MEDICATION(S)

NORDITROPIN FLEXPRO

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to endocrinology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

NORTHERA

MEDICATION(S)

NORTHERA

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to Neurology and Cardiology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

NOXAFIL

MEDICATION(S)

NOXAFIL 40 MG/ML SUSPENSION, NOXAFIL DR 100 MG TABLET

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

NUVIGIL (ARMODAFINIL)

MEDICATION(S)

ARMODAFINIL

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

OFEV

MEDICATION(S)

OFEV

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to Pulmonary

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

OPSUMIT

MEDICATION(S)

OPSUMIT

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

ORENCIA SYRINGE

MEDICATION(S)

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

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Trial and failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Orencia SC therapy, OR prior maintenance therapy of at least 4 weeks with Orencia IV. Patient is not receiving Orencia in combination with a biologic disease modifying antirheumatic drug (DMARD) [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Orencia in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to rheumatology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

ORKAMBI

MEDICATION(S)

ORKAMBI 100 MG-125 MG TABLET, ORKAMBI 200 MG-125 MG TABLET

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

Diagnosis of cystic fibrosis with documentation of homozygous F508del mutation in the CFTR gene, through an FDA-cleared CF mutation test.

AGE RESTRICTION

Approved for patients 6 years or older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Initial authorization for 4 months. Reauthorization approved for the duration of the contract year.

OTHER CRITERIA

For reauthorization: Documented response to therapy as defined as one of the following: a) Stable or improved FEV1, b) Documented clinical improvement.

PART D VS PART B

MEDICATION(S)

ACETYLCYSTEINE, ACYCLOVIR 1,000 MG/20 ML VIAL, ACYCLOVIR 500 MG/10 ML VIAL, ALBUTEROL 2.5 MG/0.5 ML SOL, ALBUTEROL 5 MG/ML SOLUTION, ALBUTEROL SUL 0.63 MG/3 ML SOL, ALBUTEROL SUL 1.25 MG/3 ML SOL, ALBUTEROL SUL 2.5 MG/3 ML SOLN, ALIMTA, AMBISOME, AMINOSYN II 10% IV SOLUTION, AMINOSYN II 15% IV SOLUTION, AMINOSYN II 8.5% IV SOLUTION, AMINOSYN II WITH ELECTROLYTES, AMINOSYN M, AMINOSYN WITH ELECTROLYTES, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-RF, AMPHOTERICIN B, APREPITANT, ARANESP, ATGAM, AVASTIN, AZACITIDINE, AZATHIOPRINE, BELEODAQ, BENLYSTA 120 MG VIAL, BENLYSTA 400 MG VIAL, BLEOMYCIN SULFATE, BORTEZOMIB, BUDESONIDE 0.25 MG/2 ML SUSP, BUDESONIDE 0.5 MG/2 ML SUSP, BUDESONIDE 1 MG/2 ML INH SUSP, CARIMUNE NF NANOFILTERED, CELLCEPT 200 MG/ML ORAL SUSP, CELLCEPT 250 MG CAPSULE, CELLCEPT 500 MG TABLET, CROMOLYN 20 MG/2 ML NEB SOLN, CYCLOPHOSPHAMIDE 25 MG CAPSULE, CYCLOPHOSPHAMIDE 50 MG CAPSULE, CYCLOSPORINE 100 MG CAPSULE, CYCLOSPORINE 25 MG CAPSULE, CYCLOSPORINE MODIFIED, DRONABINOL, EMEND 125 MG CAPSULE, EMEND 125 MG POWDER PACKET, EMEND 40 MG CAPSULE, EMEND 80 MG CAPSULE, EMEND TRIPACK, ENGERIX-B ADULT, ENGERIX-B PEDI 10 MCG/0.5 SYRN, ENVARSUS XR, ETOPOSIDE 1,000 MG/50 ML VIAL, ETOPOSIDE 100 MG/5 ML VIAL, ETOPOSIDE 500 MG/25 ML VIAL, FASLODEX, FREAMINE HBC, GAMMAGARD LIQUID, GAMMAGARD S-D, GAMUNEX-C, GANCICLOVIR, GANCICLOVIR SODIUM, GENGRAF, GRANISETRON HCL 1 MG TABLET, HEPATAMINE, HERCEPTIN, INTRALIPID, IPRATROPIUM BR 0.02% SOLN, IPRATROPIUM-ALBUTEROL, KADCYLA, KEYTRUDA, LEUCOVORIN CALCIUM 100 MG VIAL, LEUCOVORIN CALCIUM 200 MG VIAL, LEUCOVORIN CALCIUM 350 MG VIAL, LEUCOVORIN CALCIUM 50 MG VIAL, LEUCOVORIN CALCIUM 500 MG VL, LEUKINE, LEVALBUTEROL CONCENTRATE, LEVALBUTEROL HCL, LUPRON DEPOT, LUPRON DEPOT-PED, MITOXANTRONE HCL, MYCOPHENOLATE 200 MG/ML SUSP, MYCOPHENOLATE 250 MG CAPSULE, MYCOPHENOLATE 500 MG TABLET, MYCOPHENOLIC ACID, MYFORTIC, NEBUPENT, NEORAL, NEULASTA, NEUPOGEN, NULOJIX, ONDANSETRON 4 MG/5 ML SOLUTION, ONDANSETRON HCL 24 MG TABLET, ONDANSETRON HCL 4 MG TABLET, ONDANSETRON HCL 8 MG TABLET, ONDANSETRON ODT, OPDIVO, PACLITAXEL, PAMIDRONATE DISODIUM, PRIVIGEN, PROCRIT, PROGRAF, PROLEUKIN, PROLIA, PULMOZYME, RAPAMUNE, RECOMBIVAX HB 10 MCG/ML SYR, RECOMBIVAX HB 10 MCG/ML VIAL, RECOMBIVAX HB 40 MCG/ML VIAL, RECOMBIVAX HB 5 MCG/0.5 ML SYR, REMICADE, RITUXAN, SANDOSTATIN LAR DEPOT, SIROLIMUS, SOMATULINE DEPOT, SYNRIBO, TACROLIMUS 0.5 MG CAPSULE, TACROLIMUS 1 MG CAPSULE, TACROLIMUS 5 MG CAPSULE, TOBI, TOPOTECAN HCL, TRISENOX, TYSABRI, TYVASO, TYVASO INSTITUTIONAL START KIT, TYVASO REFILL KIT, TYVASO STARTER

KIT, VELCADE, VENTAVIS, XGEVA, YERVOY, ZOLEDRONIC ACID 4 MG VIAL, ZOLEDRONIC ACID 4 MG/5 ML VIAL, ZOLEDRONIC ACID 5 MG/100 ML, ZOMETA 4 MG/100 ML INJECTION, ZORTRESS

DETAILS

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

RAVICTI

MEDICATION(S)

RAVICTI

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

REPATHA

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

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Low-density lipoprotein cholesterol (LDL-C) levels. For initiation of treatment, relevant chart notes documenting medical rationale are required. For continuation of therapy, ongoing documentation of successful response to the medication may be necessary.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Restricted to cardiology, endocrinology or a board certified lipidologist

COVERAGE DURATION
Initial authorization for 4 months. Reauthorization approved for the duration of the contract year.

OTHER CRITERIA
1. For all indications must have documentation of one of the following:
a) Current use of high-intensity statin therapy for at least 3 months, defined as atorvastatin 40-80 mg daily or rosuvastatin 20-40 mg daily, OR
b) FDA labeled contraindication to statin therapy, OR
c) Documented statin intolerance to lowest average starting dose of all formulary statins. Intolerance is defined as intolerable bilateral muscle side effects or biomarker changes (such as elevations of creatinine kinase) that decrease or resolve after discontinuation of therapy with statin.
AND
2. Must meet listed criteria below for each specific diagnosis:
a) For familial hypercholesterolemia (FH), confirmed diagnosis by one of the following:
i) Genetic mutation in one of the following genes: LDLR, APOB, or PCSK9, OR

ii) WHO MedPed score of 6 or higher OR
iii) LDL-C greater than 330 mg/dl, OR
iv) LDL-C greater than 190 mg/dl and two of the following:
1) Presence of tendon xanthomas in patient or in first- or second-degree relatives,
2) History of premature atherosclerotic cardiovascular disease
(ASCVD) in men less than 55 years or women less than 60 years,
3) First-degree relative with premature ASCVD (men less than 55 years and women less than 60 years),

b.) For atherosclerotic cardiovascular disease (ASCVD), documentation of one of the following LDL-C level and cardiovascular risk combinations. LDL-C levels must be taken after at least 3 months of continuous therapy with statin outlined in criterion 1 above:
i) LDL-C greater than 70 mg/dl and history of clinical ASCVD, defined as one of the following: NSTEMI, myocardial infarction, unstable angina, coronary revascularization, or clinically signification multi-vessel coronary heart disease.

RETIN-A MICRO

MEDICATION(S)

RETIN-A MICRO PUMP 0.08% GEL

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Excluded if prescribed for cosmetic use

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

SEDATIVES

MEDICATION(S)

ESZOPICLONE, ZALEPLON, ZOLPIDEM TARTRATE 10 MG TABLET, ZOLPIDEM TARTRATE 5 MG TABLET, ZOLPIDEM TARTRATE ER

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

Only applies to members 65 years of age and older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

Prior authorization and quantity limit applies only to members 65 years of age and older who will be evaluated for appropriate use of high risk medication. Zolpidem and Zaleplon: For requests for greater than 90 days cumulative use within the past 365 days, will require failure of, contraindication to, or intolerance to Rozerem and Silenor. Eszopiclone: Requires failure of, contraindication to, or intolerance to Rozerem and Silenor.

SIGNIFOR

MEDICATION(S)

SIGNIFOR

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to Endocrinology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

SIGNIFOR LAR

MEDICATION(S)

SIGNIFOR LAR 20 MG KIT, SIGNIFOR LAR 20 MG VIAL, SIGNIFOR LAR 40 MG KIT, SIGNIFOR LAR 40 MG VIAL, SIGNIFOR LAR 60 MG KIT, SIGNIFOR LAR 60 MG VIAL

COVERED USES

All FDA approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to Endocrinology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

SILDENAFIL

MEDICATION(S)

REVATIO 10 MG/ML ORAL SUSP, SILDENAFIL, SILDENAFIL 10 MG/12.5 ML VIAL

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

SOVALDI

MEDICATION(S)
SOVALDI

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
1) Documented diagnosis of chronic hepatitis C (CHC) with one of the following genotypes (GT): 1,2, 3, 4, 5 or 6 2)Treatment status of patient (treatment naïve or treatment-experienced). If treatment-experienced, provide previous therapies. 3) Documentation that patient does or does not have cirrhosis. If cirrhotic, documentation of compensated or decompensated status. 4) Documentation of whether patient has had a liver transplant

AGE RESTRICTION
Must be 12 years or older

PRESCRIBER RESTRICTION
Restricted to a Hepatologist, Gastroenterologist or Infectious Disease physician

COVERAGE DURATION
Criteria will be applied consistent with current AASLD/IDSA guidance

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance

SYNAGIS

MEDICATION(S)

SYNAGIS

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

Must be less than 2 years of age

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

6 months

OTHER CRITERIA

N/A

TAFINLAR - FOR NEW STARTS ONLY

MEDICATION(S)

TAFINLAR

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

A documented positive BRAF V600E or V600K mutation

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to oncology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

Tafinlar should not be used in patients with wild-type BRAF melanoma due to the potential risk of tumor promotion in these patients.

TARCEVA - FOR NEW STARTS ONLY

MEDICATION(S)

TARCEVA

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to oncology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

TAZORAC

MEDICATION(S)

TAZAROTENE, TAZORAC 0.05% CREAM, TAZORAC 0.05% GEL, TAZORAC 0.1% GEL

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Excluded if prescribed for cosmetic use

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

TREMFYA

MEDICATION(S)
TREMFYA

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
Restricted to Dermatology

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
One of the following: Trial and failure, contraindication, or intolerance to Enbrel (etanercept) OR Humira (adalimumab) AND 2) Trial and failure, contraindication, or intolerance to Cosentyx (secukinumab), OR for continuation of prior Tremfya therapy. Patient is not receiving Tremfya in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi golimumab)].

TRETINOIN

MEDICATION(S)

TRETINOIN 0.01% GEL, TRETINOIN 0.025% CREAM, TRETINOIN 0.025% GEL, TRETINOIN 0.05% CREAM, TRETINOIN 0.1% CREAM, TRETINOIN MICROSPHERE

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

Excluded if prescribed for cosmetic use

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

TRICYCLIC ANTIDEPRESSANTS - FOR NEW STARTS ONLY

MEDICATION(S)

AMITRIPTYLINE HCL, CLOMIPRAMINE HCL, DOXEPIN 10 MG CAPSULE, DOXEPIN 10 MG/ML ORAL CONC, DOXEPIN 100 MG CAPSULE, DOXEPIN 150 MG CAPSULE, DOXEPIN 25 MG CAPSULE, DOXEPIN 50 MG CAPSULE, DOXEPIN 75 MG CAPSULE, IMIPRAMINE HCL, TRIMIPRAMINE MALEATE

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

Applies to members 65 years of age and older

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

Prior authorization applies to members 65 years of age and older who will be evaluated for appropriate use of high risk medication. Requires trial of one formulary alternative including notrtiptyline or desipramine unless nortriptyline or desipramine are not indicated for the condition being treated.

TYMLOS

MEDICATION(S)
TYMLOS

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
For postmenopausal women who are at a high risk for fracture. High risk for fracture defined as a history of osteoporosis-related fracture, low bone density less than 2.5 SD below normal. Additionally, requires treatment failure, contraindication or intolerance to at least one oral bisphosphonate.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
N/A

UPTRAVI

MEDICATION(S)
UPTRAVI

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
Patient must have World Health Organization (WHO) group 1 classification of pulmonary arterial hypertension.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
History of inadequate response, contraindication, or intolerance to a PDE5 inhibitor (ie, Adcirca, Revatio) or Adempas (riociguat), OR History of inadequate response, contraindication, or intolerance to an endothelin receptor antagonist [e.g. Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)].

VPRIV

MEDICATION(S)

VPRIV

COVERED USES

All FDA-approved indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

XALKORI - FOR NEW STARTS ONLY

MEDICATION(S)

XALKORI

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to oncology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

XIFAXAN

MEDICATION(S)
XIFAXAN

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
If diagnosis is hepatic encephalopathy, requires ONE of the following criteria be met: 1) Encephalopathy with admission to the hospital while on lactulose, 2) Encephalopathy with uncontrolled diarrhea, 3) Encephalopathy with intolerance to lactulose, or 4) Encephalopathy not improving on lactulose alone.

XOLAIR

MEDICATION(S)
XOLAIR

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

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
If diagnosis is asthma, requires the following: 1) Serum IgE level prior to initiation 2) Expected dose of Xolair 3) Poor control of asthma as demonstrated by at least one of the following: one hospital admission in the prior 6 months, or 2 emergency room visits in the prior 6 months, or 2 months of daily oral corticosteroids use without significant tapering or other events which are felt to indicate poor control.

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Duration of the contract year

OTHER CRITERIA
If diagnosis is asthma, requires patient be on combined inhaled corticosteroid and long-acting bronchodilator therapy.

ZELBORAF - FOR NEW STARTS ONLY

MEDICATION(S)

ZELBORAF

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A

ZYKADIA - FOR NEW STARTS ONLY

MEDICATION(S)

ZYKADIA

COVERED USES

All medically accepted indications not otherwise excluded from Part D

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

Restricted to oncology

COVERAGE DURATION

Duration of the contract year

OTHER CRITERIA

N/A