ANDROID

Products Affected

- ANDROID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

BLINCYTO

Products Affected

- BLINCYTO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	Known hypersensitivity to blinatumomab or to any component of the product formulation.
Required Medical Information	Appropriate diagnosis [used for relapsed or refractory Philadelphia chromosome-negative (Phnegative), B-cell precursor acute lymphoblastic leukemia (ALL)], used as monotherapy, and at least one prior ALL therapy has been ineffective.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial - 60 days. Renewal - 90 days
Other Criteria	Renewal: Remission with initial induction (60 day) therapy.

BOSULIF

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Appropriate diagnosis [used for relapsed or refractory Philadelphia chromosome-negative (Phnegative), B-cell precursor acute lymphoblastic leukemia (ALL)], used as monotherapy, and at least one prior ALL therapy has been ineffective.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

CIALIS

Products Affected

- CIALIS ORAL TABLET 2.5 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician and prior trial and failure of at least one alpha blocker and one alpha reductase inhibitor
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

DIAZEPAM RECTAL GEL

Products Affected

- DIASTAT PEDIATRIC
- *diazepam gel 10 mg, 20 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	Treatment for Status Epilepticus
Required Medical Information	Appropriate diagnosis [used as an adjunctive treatment for Partial seizures or Generalized tonicclonic seizures in refractory patients to control bouts of increased seizure activity].
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

ESBRIET

Products Affected

- ERWINAZE INJECTION
- ESBRIET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Appropriate diagnosis (idopathic pulmonary fibrosis [IPF]), monitoring (hepatiac function/LFTs).
Age Restrictions	
Prescriber Restrictions	Pulmonologist
Coverage Duration	365 days
Other Criteria	

ESRD THERAPY

Products Affected

- PROCRIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Hemogloblin less than 10 g/dl for patients receiving Cancer Chemotherapy and Hemoglobin less than 12 and Hematocrit less than 33 for other approved FDA indications in addition to supporting statement of diagnosis from physician
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	

FARYDAK

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Appropriate diagnosis (used for multiple myeloma in combination with bortezomib and dexamethasone, and an inadequate response to at least 2 prior regimens, including bortezomib and an immunomodulatory agent (i.e. thalidomide, lenalidomide, or pomalidomide).
Age Restrictions	
Prescriber Restrictions	Oncologist, hematologist
Coverage Duration	365 days
Other Criteria	

FENTANYL

Products Affected

- FENTORA BUCCAL TABLET 200 MCG, 400 MCG, 600 MCG, 800 MCG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

- FULYZAQ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Diagnosis of non-infectious diarrhea and HIV, member must be on antiretroviral therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician in patients with EGFR exon 19 deletions or exon 21 (L858R) substitution as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

GROWTH HORMONE

Products Affected

- HUMATROPE INJECTION SOLUTION RECONSTITUTED 12 MG, 24 MG
- NUTROPIN AQ NUSPIN 10
- NUTROPIN AQ NUSPIN 20
- NUTROPIN AQ NUSPIN 5
- NUTROPIN AQ PEN
- SAIZEN
- SAIZEN CLICK.EASY

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

HARVONI

Products Affected

- HARVONI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Must submit documentation of chronic hepatitis C genotype (confirmed by HCV RNA level within the last 6 months) and subtype. Must submit laboratory results within 6 weeks of initiating therapy including: 1) CBC w Platelets, 2) AST/ALT, 3)Total Bilirubin, 4)Serum Albumin, 5)PT/INR, 6)Serum Creatinine, and 7)GFR.
Age Restrictions	Patient must be age 18 or over
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist.
Coverage Duration	24 weeks: treatment-experienced with cirrhosis, 12 weeks: All others
Other Criteria	

HRM

Products Affected

- ARBINOXA ORAL SOLUTION
- *digoxin oral tablet*
- *guanfacine hcl er*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, AND Monitoring plan for adverse side effects, AND Anticipated treatment course/duration, AND If formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to the alternative(s).
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication.
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Appropriate diagnosis (used in combination with letrozole for the treatment of postmenopausal women with estrogen receptor (ER)- positive, human epidermal growth factor receptor 2 (HER2)- negative advanced breast cancer)
Age Restrictions	
Prescriber Restrictions	Oncologist
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	

IMBRUVICA

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

KALYDECO

Products Affected

- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

KANUMA

Products Affected

- KANUMA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	Hypersensitivity to sebelipase alfa or any component of the formulation
Required Medical Information	Must have a documented diagnosis of Lysosomal acid lipase (LAL) deficiency
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	Pregnancy
Required Medical Information	Supporting statement of diagnosis and relevant medical information from physician.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

LEMTRADA

Products Affected

- LEMTRADA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	Human immunodeficiency virus (HIV) positive
Required Medical Information	Appropriate diagnosis (used for relapsing form of multiple sclerosis (relapsing-remitting or secondary progressive multiple sclerosis) with treatment failure with at least two covered disease modifying therapies for multiple sclerosis (e.g., Betaseron, Copaxone, Rebif). Treatment failure is defined as meeting at least two of the three following (a, b, or c): a.At least two relapses within the past 12 months b.CNS lesion progression as measured by MRI c. Worsening disability (e.g., decreased mobility, decreased ability toperform activities of daily living due to disease progression, or EDSS greater than 3.5).
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	365 days
Other Criteria	

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	Hypersensitivity to trifluridine/tipiracil or any of the other components of the formulation
Required Medical Information	1.Must have a documented diagnosis of metastatic colorectal cancer AND 2.Must have tried and failed a chemotherapy regimen consisting of a fluoropyrimidine-based, oxaliplatin-based, irinotecan-based chemotherapy, or an anti-VEGF biological therapy AND 3.Must try and fail an anti-EGFR therapy if RAS wild-type
Age Restrictions	18 years of age or older
Prescriber Restrictions	Must be prescribed by, or in conjunction, with an oncologist or hematologist.
Coverage Duration	12 months
Other Criteria	

LYNPARZA

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Appropriate diagnosis and testing for BRCA mutation (deleterious or suspected deleterious germline BRCA mutated (as detected by an FDA approved test) advanced ovarian cancer that has been treated with 3 or more prior lines of chemotherapy).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

MODAFINIL

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Hypoparathyroidism caused by calcium-sensing receptor mutations. Acute post-surgical hypoparathyroidism.
Age Restrictions	Appropriate diagnosis and labs (used for hypocalcemia secondary to hypoparathyroidism and hypocalcemia is not corrected by calcium supplements and active forms of vitamin D alone. Serum calcium concentration greater than 7.5 mg/dL, and serum 25-hydroxyvitamin D concentration above the lower limit of normal laboratory reference range. Concurrently using a calcium supplement and active form of vitamin D.
Prescriber Restrictions	18 years of age or older
Coverage Duration	365 days
Other Criteria	

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	Hypersensitivity to mepolizumab or any component of the formulation
Required Medical Information	Must have a documented diagnosis of severe asthma with an eosinophilic phenotype AND Must not be used for the relieve of acute bronchospasm or status asthmaticus AND Must have a baseline absolute blood eosinophil count ? 150 cells/microL at initiation of therapy or ? 300 cells/microL within the last 12 months AND 4. The member must still be symptomatic despite being compliant to a trial of a combination of at least a medium dose inhaled corticosteroid with either a long acting beta agonist (LABA), leukotriene modifier, or theophylline
Age Restrictions	12 years of age or older
Prescriber Restrictions	Must be prescribed by, or in conjunction with, an allergist, pulmonologist or immunologist.
Coverage Duration	6 months
Other Criteria	

ONCOLOGY AGENTS

Products Affected

- ALECENSA
- COTELLIC
- DARZALEX
- EMPLICITI
- NINLARO
- ODOMZO
- PORTRAZZA
- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	Contraindications to the use of any requested ingredients, medication is being used for experimental or investigational use or patient is enrolled in a clinical trial.
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in conjunction, with an oncologist or hematologist.
Coverage Duration	3 months
Other Criteria	

OPDIVO

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Appropriate diagnosis [unresectable or metastatic malignant melanoma and disease progression following ipilimumab (Yervoy) and a BRAF inhibitor (if BRAF V600 mutation-positive), OR metastatic squamous non-small cell lung cancer (NSCLC) with disease progression on or after platinum-based chemotherapy].
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Initial Therapy: Must have 1. diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test AND 2. Baseline FEV1 greater than or equal to 40% AND 3. Baseline liver function tests (ALT/AST and bilirubin) provided AND 4. If less than 18 years of age, baseline ophthalmological exam completed Continuation of therapy: 1. Documentation patient is tolerating and responding to medication (i.e. improved FEV1, weight gain, decreased exacerbations, etc.) AND 2. Adherence to therapy is confirmed (supported by documentation from patient's chart notes or electronic claim history) AND 3. Liver function tests (ALT/AST and bilirubin) provided with each renewal during first year of treatment and annually thereafter AND 4. ALT or AST does not exceed 5 times the upper limit of normal AND 5. ALT or AST does not exceed 3 times upper limit of normal with bilirubin greater than 2 times upper limit of normal.
Age Restrictions	Must be greater than or equal to 12 years of age.
Prescriber Restrictions	Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation.
Coverage Duration	365 days
Other Criteria	

PPACA BREAST CANCER PREVENTION

Products Affected

- *raloxifene hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Covered for asymptomatic women without a prior diagnosis of breast cancer who are at increased risk for the disease.
Age Restrictions	Covered for adults age 35 years and older.
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

PPACA COLORECTAL CANCER SCREENING

Products Affected

- COLYTE WITH FLAVOR PACKS
- GAVILYTE-C
- GAVILYTE-G
- GAVILYTE-N WITH FLAVOR PACK
- GOLYTELY
- NULYTELY WITH FLAVOR PACKS
- SUPREP BOWEL PREP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Covered when used as bowel preparation for colonoscopy or sigmoidoscopy procedures.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

REGRANEX

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Diabetic Neuropathic Ulcers: Diabetic patient with ulcer wound. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Diabetic Neuropathic Ulcers: Maximum 5 months
Other Criteria	

SAMSCA

Products Affected

- SAMSCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis and relevant medical information from physician.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

SILDENAFIL

Products Affected

- *sildenafil citrate intravenous**
- *sildenafil citrate oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

SOVALDI

Products Affected

- SOVALDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Must have genotype 1,2,3,4,5, or 6.
Age Restrictions	Patient must be age 18 or over.
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist.
Coverage Duration	12 weeks:genotype 1,2,or4_24 wks:genotype 3 OR no interferon_48 wks:liver cancer awaiting transplant
Other Criteria	For genotypes 2,3, and 4, patient must be taking ribavirin with Sovaldi.

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

UNITUXIN

Products Affected

- UNITUXIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Appropriate diagnosis (used for high-risk neuroblastoma in combination with 13-cis-retinoic acid (i.e. isotretinoin), granulocyte-macrophage colony-stimulating factor (i.e. sargramostim), and interleukin-2 (aldesleukin), with at least a partial response to first-line multiagent, multimodality therapy.
Age Restrictions	
Prescriber Restrictions	Oncologist, hematologist
Coverage Duration	365 days
Other Criteria	

VICTRELIS

Products Affected

- VICTRELIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician that includes diagnosis, viral load, genotype, and labs indicating status of liver function as compensated liver disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	44 weeks
Other Criteria	

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician that establishes the cancer as anaplastic lymphoma kinase (ALK)-positive
Age Restrictions	
Prescriber Restrictions	must be prescribed by an oncologist
Coverage Duration	365 days
Other Criteria	

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	
Required Medical Information	Supporting statement of diagnosis from the physician and prior trial and failure of docetaxel
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 days
Other Criteria	

YONDELIS

Products Affected

- YONDELIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by the plan.
Exclusion Criteria	Hypersensitivity to trabectedin or any component of the formulation
Required Medical Information	1.Must have a documented diagnosis of unresectable or metastatic soft tissue sarcoma (liposarcoma or leiomyosarcoma) AND 2.Must have tried and failed a chemotherapy regimen consisting of an anthracycline-containing regimen
Age Restrictions	18 years of age or older.
Prescriber Restrictions	Must be prescribed by, or in conjunction, with an oncologist or hematologist.
Coverage Duration	12 months
Other Criteria	

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