ACTEMRA (BCBS RI)

Products Affected

- Actemra INJ 162MG/0.9ML, 200MG/10ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis).
Required Medical Information	Diagnosis of one of the following: A) moderate to severe rheumatoid arthritis and patient had inadequate response to, intolerance to, or contraindication to one or more non-biologic disease-modifying anti-rheumatic drugs for at least 3 consecutive months, or B) systemic juvenile idiopathic arthritis and patient had inadequate response or intolerance to at least one oral systemic agent (i.e. NSAID, corticosteroid) C) Polyarticular Juvenile Idiopathic Arthritis AND Patient has had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs for at least 3 consecutive months
Age Restrictions	RA - 18 years of age or older. sJIA and pJIA - 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has been tested for TB and latent TB has been ruled out or is being treated. Approvable under Part D only if patient is in a long term care facility OR the medication is not being administered with an infusion pump.

ACTIQ (S)

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Management of acute or post-operative pain, including headache/migraine, dental pain, or use in the emergency room. Opioid non-tolerant patients.
Required Medical Information	Patient meets the following: A) Diagnosis of cancer and use is for breakthrough cancer pain, B) patient is opioid tolerant and taking at least 60 mg morphine/day, at least 25 mcg transdermal fentanyl/hour, at least 30 mg of oxycodone daily, at least 8 mg oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer, C) other formulary short-acting strong narcotic analgesic alternatives (other than fentanyl) have been ineffective, not tolerated, or contraindicated, D) prescriber is registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy Access program
Age Restrictions	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Not covered for members enrolled in a Medicare approved hospice program

ADAGEN (S)

Products Affected

- Adagen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe thrombocytopenia
Required Medical Information	Diagnosis of adenosine deaminase (ADA) deficiency in a patient with severe combined immunodeficiency disease (SCID) AND patient is not a suitable candidate for, or who has failed, bone marrow transplantation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ADCIRCA (S)

Products Affected

- Adcirca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Receiving nitrate therapy (includes intermittent use)
Required Medical Information	Diagnosis o f 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 AND Patient has New York Heart Association (NYHA) Functional Class II or III.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	N/A

ADEMPAS (S)

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form. Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline). Pregnancy.
Required Medical Information	Diagnosis of pulmonary arterial hypertension WHO group I with New York Heart Association Functional Class II or III AND diagnosis was confirmed by right heart catheterization OR Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) AND patient has perisistent or recurrent disease after surgical treatment (e.g., pulmnary endarterectomy) or has CTEPH that is inoperable AND female patients are enrolled in the ADEMPAS REMS program
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.)

AFINITOR (S)

Products Affected

- Afinitor

PA Criteria	Criteria Details
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 and patient has failed therapy (disease progressed) with Sutent or Nexavar OR Diagnosis of pancreatic neuroendocrine tumors (pNET) that are unresectable, locally advanced or metastatic OR Diagnosis of renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery OR Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin OR Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection.
Age Restrictions	18 years of age or older for RCC, pNET, and renal angiomyolipoma with TSC. 1 year of age or older for SEGA
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

AFINITOR DISPERZ (S)

Products Affected

- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC) that requires therapeutic intervention but is not a candidate for curative surgical resection.
Age Restrictions	1 year of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ALDURAZYME (S)

Products Affected

- Aldurazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Hurler or Hurler-Scheie form of Mucopolysaccharidosis I (MPS I) or Diagnosis of Scheie form of MPS I with moderate to severe symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

AMPYRA (S)

Products Affected

- Ampyra

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute). Patient currently using any other forms of 4-aminopyridine.
Required Medical Information	Diagnosis of multiple sclerosis AND patient is ambulatory (able to walk at least 25 feet) AND patient has walking impairment
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial - 1 month. Renewal - 12 months
Other Criteria	For renewal, walking speed has improved from baseline.

ANADROL-50 (S)

Products Affected

- Anadrol-50

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	• Patient has a diagnosis of refractory anemia caused by deficient red cell production AND • Treatment will not replace other measures such as transfusion, iron supplementation, immunosuppressive therapy, corticosteroids, or erythropoiesis-stimulating agents
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ARANESP (S)

Products Affected

- Aranesp Albumin Free INJ 100MCG/0.5ML, 100MCG/ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 25MCG/0.42ML, 25MCG/ML, 300MCG/0.6ML, 300MCG/ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	uncontrolled hypertension. Pure red cell aplasia that begins after ESA treatment.
Required Medical Information	Pre-treatment hemoglobin level less than 10 g/dL AND Patient has adequate iron stores prior to initiation of therapy defined as ferritin more than 100 mcg/L or serum transferrin saturation greater than 20% AND other causes of anemia such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic disease (such as sickle cell anemia, thalassemia, and porphyria) have been ruled out AND Diagnosis of one of the following: A) Anemia due to chronic kidney disease (CKD) with or without hemodialysis, OR B) Anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy and two additional months of chemotherapy is anticipated.
Age Restrictions	N/A
Prescriber Restrictions	CKD - prescribed by a nephrologist or hematologist. Non-myeloid malignancies - prescribed by an oncologist/hematologist
Coverage Duration	Initial: 3 months. Renewal: CKD-12 months, Non-myeloid malignancies - 4 months

Other Criteria	For renewal of CKD, for dialysis patients: Hb less than 11 g/dL or physician will decrease or interrupt dose and for non-dialysis patients: Hb less than 10 g/dL or physician will decrease or interrupt dose. For renewal of non-myeloid malignancies: Concurrent myelosuppressive chemotherapy and Hb is 12g/dL or less and there is measurable response after eight weeks (defined as an increase in Hb 1 g/dL or more or a reduction in red blood cell transfusion requirements). Excluded for ESRD patients on dialysis.

ARCALYST (S)

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cryopyrin-associated period syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS).
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with or recommendation of, an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist
Coverage Duration	12 months
Other Criteria	Approve doses based on FDA labeling

AUBAGIO (S)

Products Affected

- Aubagio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. First clinical episode with MRI features consistent with multiple sclerosis.
Exclusion Criteria	Severe hepatic impairment. Current treatment with leflunomide. Patients who are pregnant or women of childbearing potential not using reliable contraception.
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting MS or progressive-relapsing MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced no or a decrease in the number of multiple sclerosis flare-ups.

AVONEX (S)

Products Affected

- Avonex

PA Criteria	Criteria Details
Covered Uses	All-FDA approved indication not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, disease has not progressed and has responded to therapy.

BARACLUDE (S)

Products Affected

- Baraclude

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic hepatitis B AND patient has evidence of viral replication AND Patient has evidence of persistent elevations in serum aminotransferase (ALT or AST) or histologically active disease AND patient is receiving anti-retroviral therapy if the patient has HIV co-infection
Age Restrictions	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient must be HBeAg negative OR HBeAg positive, but has not seroconverted OR HBeAg positive and seroconverted to anti-Hbe with detectable HBV DNA levels OR HbeAg positive and seroconverted to anti-Hbe with undetectable levels of HBV DNA levels for less than 12 months

BENZODIAZEPINES (S)

Products Affected

- Alprazolam ORAL TABS
- Alprazolam Er TB24 0.5MG
- Alprazolam Intensol
- Alprazolam Odt
- Alprazolam Xr ORAL TB24 1MG, 2MG, 3MG
- Chlordiazepoxide Hcl
- Clonazepam ORAL TABS
- Clonazepam Odt
- Clorazepate Dipotassium
- Diazepam ORAL TABS
- Diazepam RECTAL GEL
- Diazepam SOLN
- Diazepam Intensol
- Estazolam
- Flurazepam Hcl
- Lorazepam ORAL TABS
- Lorazepam Intensol
- Onfi
- Oxazepam
- Temazepam
- Triazolam

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute closed-angle glaucoma (with the exception of oxazepam). For lorazepam injection only: sleep apnea syndrome or severe respiratory insufficiency except in those patients receiving lorazepam for amnestic effects while being mechanically ventilated.
Required Medical Information	Verify the medication is being used for an FDA-approved diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Not covered for members enrolled in a Medicare approved hospice program

BETASERON (S)

Products Affected

- Betaseron

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indication not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, disease has not progressed and has responded to therapy.

BETHKIS (S)

Products Affected

- Bethkis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cystic fibrosis AND patient has evidence of P. aeruginosa in the lungs
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations). For inhalation solution only (does not apply to TOBI Podhaler): Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

BONIVA IV (BCBS RI)

Products Affected

- Boniva INJ
- Ibandronate Sodium INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient is a postmenopausal female with osteoporosis AND Patient has a documented trial and failure of an oral bisphosphonate, where failure is defined as new fractures in compliant patient on therapy for at least 6 months, failure to produce a clinically significant change in biochemical markers of bone turnover, or a significant loss of bone mineral density on follow-up scans after 12-24 months of therapy OR documented contraindication or intolerance to oral bisphosphonate therapy or is unable to comply with appropriate administration recommendations for oral bisphosphonate therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient had an objective response to therapy. Approvable under Part D only if patient is in a long term care facility OR the medication is not being administered with an infusion pump.

BOSULIF (S)

Products Affected

- Bosulif

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Philadelphia chromosome-positive chronic myelogenous leukemia AND disease is resistant or intolerant to prior therapy (such as Gleevec, Sprycel, or Tasigna)
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

BOTOX (S)

Products Affected

- Botox INJ 100UNIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Infection at the proposed injection site. Cosmetic use (e.g., wrinkles).
Required Medical Information	Diagnosis of one of the following: A) strabismus, OR B) blepharospasm associated with dystonia, OR C) Urinary incontinence and condition is associated with a neurologic condition and Patient tried and had an inadequate response to at least one antimuscarinic agent, unless contraindicated or intolerant to antimuscarinics (e.g., narrow angle glaucoma) and patient does not have a urinary tract infection and patient is routinely performing clean intermittent self-catheterization (CIC) or is willing/able to perform CIC, OR D) Chronic migraine and medication will be used as prophylaxis and experiences headaches on 15 or more days per month lasting four hours or longer and patient has tried and had an inadequate response with at least two first-line therapies from two different therapeutic classes (i.e. antiepileptics, beta-blockers, triptans, and tricyclic antidepressants) OR E) Cervical dystonia (including spasmodic torticollis) F) Overactive bladder and has symptoms (e.g., urge urinary incontinence, urgency, and frequency) and patient has tried and had an inadequate response to at least one antimuscarinic agent, unless contraindicated or intolerant to anti-muscarinics (e.g., narrow angle glaucoma) OR F) Axillary hyperhidrosis and patient's condition significantly interferes with patient's daily activities and Condition is refractory to treatment with topical aluminum chloride OR G) Upper limb spasticity
Age Restrictions	12 years of age or older - strabismus or blepharospasm
Prescriber Restrictions	Urinary incontinence - prescribed by or in consultation with an urologist
Coverage Duration	12 months
Other Criteria	N/A

BUTRANS (S)

Products Affected

- Butrans

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Significant respiratory depression or severe bronchial asthma. Known or suspected paralytic ileus.
Required Medical Information	Patient is not in hospice care AND Patient has a diagnosis of moderate to severe chronic pain requiring continuous, around-the-clock opioid analgesic for an extended period of time AND patient tried and failed, is unable to tolerate, or has a contraindication to at least one therapy from each of the following two drug categories: NSAIDs and generic extended-release opioid product and/or opioid combination product, unless the patient has documented swallowing difficulties AND the medication will not be used for one of the following: management of acute pain or requires opioid analgesia for a short period of time (management of post-operative pain, including use after outpatient or day surgeries), management of mild pain, or management of intermittent pain (e.g., use on an as needed basis).
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Not covered for members enrolled in a Medicare approved hospice program

CAPRELSA (S)

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Congenital long QT syndrome
Required Medical Information	Diagnosis of symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CAYSTON (S)

Products Affected

- Cayston

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cystic fibrosis AND patient has evidence of P. aeruginosa in the lungs
Age Restrictions	7 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations)

CELEBREX (S)

Products Affected

- Celebrex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Hypersensitivity to celecoxib or sulfonamide drugs. History of asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. Treatment of peri-operative pain in the setting of coronary artery bypass graft surgery.
Required Medical Information	Patient has failed previous treatment or has an intolerance to at least one of the following: NSAIDs or salicylate OR patient is currently receiving treatment with any of the following: anticoagulants/antiplatelet drugs (i.e. warfarin, heparin, LMWH, Pradaxa, Plavix, etc.), antiulcer agents (i.e. proton pump inhibitors, histamine-2-receptor antagonists, or misoprostol), chronic use of oral corticosteroids, or methotrexate OR patient has a history of peptic ulcer disease or history of gastrointestinal bleed
Age Restrictions	PA applies to patients younger than 65 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CEREZYME (S)

Products Affected

- Cerezyme INJ 200UNIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of type 1 Gaucher disease
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CIALIS 2.5 MG, 5 MG (S)

Products Affected

- Cialis ORAL TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of nitrates. Diagnosis of erectile dysfunction without signs and symptoms of BPH.
Required Medical Information	Diagnosis of benign prostatic hyperplasia (BPH) and patient has experienced intolerance to or treatment failure with an alpha-blocker (e.g., doxazosin, prazosin, tamsulosin) or a 5-alpha reductase inhibitor (e.g., dutasteride, finasteride)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CIMZIA (S)

Products Affected

- Cimzia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis)
Required Medical Information	Diagnosis of moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs for at least 3 consecutive months OR Diagnosis of moderate to severe Crohn's disease and patient had an inadequate response to, is intolerant to, or is contraindicated to conventional therapy with one or more of the following: corticosteroids (i.e. prednisone, methylprednisolone) or non-biologic DMARDs (i.e. azathioprine, methotrexate, mercaptopurine, etc.)
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has been tested for TB and latent TB has been ruled out or is being treated. Dosing as per the FDA labeling.

COMETRIQ (S)

Products Affected

- Cometriq

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Gastrointestinal perforation. Fistula. Severe hemorrhage.
Required Medical Information	Diagnosis of progressive, metastatic medullary thyroid cancer
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

COPAXONE (S)

Products Affected

- Copaxone INJ 20MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of relapsing-remitting multiple sclerosis OR diagnosis of first clinical episode with MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient does not have progressive disease and responding to therapy.

CYSTARAN (S)

Products Affected

- Cystaran

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The member has a diagnosis of cystinosis and has corneal cystine crystal accumulation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

DALIRESP (S)

Products Affected

- Daliresp

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate to severe liver impairment (Child-Pugh B or C)
Required Medical Information	Diagnosis of severe chronic obstructive pulmonary disease (COPD) (defined as FEV1 less than or equal to 50% of predicted and FEV1/forced vital capacity [FVC] less than 0.7) associated with chronic bronchitis AND history of COPD exacerbations which requires the use of systemic corticosteroids, antibiotics, or hospital admission AND Medication will be used with a long-acting inhaled bronchodilator (i.e. long-acting anticholinergic, or long-acting beta agonist in combination with inhaled corticosteroid) or patient is at high-risk of COPD exacerbation and is not a candidate for long-acting inhaled bronchodilator therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

DIFFERIN (S)

Products Affected

- Adapalene
- Differin GEL 0.3%
- Differin LOTN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Acne rosacea. Actinic keratoses (solar keratoses). Flat warts (verucca plana/juveniles). Hyperkeratosis disorder (i.e. epidermolytic hyperkeratosis, lenticularis perstans [Flegel's disease], palmoplantar hyperatosis, keratosis follicularis [Darier's disease]). Ichthyosis (i.e. congenital, lamellar, vulgaris, or X-linked)
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mild to moderate acne vulgaris (including comedonal, cystic, and nodular) OR Diagnosis of acne rosacea and patient has experienced treatment failure of or intolerance to sulfacetamide, metronidazole, or azelaic acid OR patient is receiving treatment for actinic keratosis (or solar keratoses) with multiple lesions on the face OR Diagnosis of flat warts (verucca plana/jeveniles) OR Diagnosis of hyperkeratosis disorder (i.e. epidermolytic hyperkeratosis, lenticularis perstans [Flegel's disease], palmoplantar hyperatosis, keratosis follicularis [Darier's disease] OR Diagnosis of ichthyosis (i.e. congenital, lamellar, vulgaris, or X-linked)
Age Restrictions	PA applies to patients older than 40 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, medication has been effective in treating the patient's condition.

EGRIFTA (S)

Products Affected

- Egrifta INJ 2MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnant. Active malignancy (newly diagnosed or recurrent).
Required Medical Information	Diagnosis of excess abdominal fat secondary to HIV infection with lipodystrophy AND Patient has been receiving antiretroviral therapy AND waist circumference greater than 37.4 inches (men) or greater than 37 inches (women) AND waist-to-hip ratio greater than 0.94 (men) or greater than 0.88 (women)
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	For renewal, documentation that the patient has experienced a reduction from baseline in visceral adipose tissue as measured by waist circumference.

ELELYSO (S)

Products Affected

- Elelyso

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of type 1 Gaucher disease
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ELIGARD (S)

Products Affected

- Eligard

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced or metastatic prostate cancer
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

EMSAM (S)

Products Affected

- Emsam

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pheochromocytoma. Patient is taking or will take any of the following: SSRIs, SNRIs, tricyclic antidepressants (TCAs), bupropion, buspirone, meperidine, tramadol, methadone, pentazocine, dextromethorphan, St. John's wort, mirtazapine, cyclobenzaprine, oral selegiline, other MAOIs, oxcarbazepine, carbamazepine, and/or sympathomimetic amines
Required Medical Information	Diagnosis of major depressive disorder AND Patient had adequate trial with at least 2 generic oral antidepressants from differing classes (at least one should be from the following list: selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors, mirtazapine, or bupropion unless contraindicated), unless unable to take any oral medication AND Patient had an adequate washout period (for patients previously on agents requiring a washout period) AND Patients exceeding doses over 6mg/24 hours will be on a tyramine restricted diet (i.e. avoid aged/spoiled/fermented meat and cheese, tap beer, fava beans, or any foods with high amounts of tyramine)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, the patient has improved or stabilized on Emsam.

ENBREL (S)

Products Affected

- Enbrel
- Enbrel Sureclick

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis)
Required Medical Information	Diagnosis of moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs for at least 3 consecutive months OR Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis and patient had an inadequate response, intolerance or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) for at least 3 consecutive months OR Diagnosis of psoriatic arthritis and patient had an inadequate response, intolerance, or contraindication to methotrexate OR Diagnosis of ankylosing spondylitis and patient had an inadequate response, intolerance or contraindication to one or more NSAIDs OR Diagnosis of moderate to severe chronic plaque psoriasis (affecting more than 5% of body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) and patient had an inadequate response, intolerance or contraindication to conventional therapy with at least one of the following: phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA] for at least one continuous month or one or more oral systemic treatments (i.e. methotrexate, cyclosporine, acitretin, sulfasalazine) for at least 3 consecutive months.
Age Restrictions	2 years of age or older for JIA. 18 years of age or older for all other indications
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has been tested for TB and latent TB has been ruled out or is being treated. Dosing as per FDA approved labeling.

EPIDUO (S)

Products Affected

- Epiduo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Acne rosacea. Actinic keratoses (solar keratoses). Flat warts (verucca plana/juveniles). Hyperkeratosis disorder (i.e. epidermolytic hyperkeratosis, lenticularis perstans [Flegel's disease], palmoplantar hyperatosis, keratosis follicularis [Darier's disease]). Ichthyosis (i.e. congenital, lamellar, vulgaris, or X-linked)
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mild to moderate acne vulgaris (including comedonal, cystic, and nodular) OR Diagnosis of acne rosacea and patient has experienced treatment failure of or intolerance to sulfacetamide, metronidazole, or azelaic acid OR patient is receiving treatment for actinic keratosis (or solar keratoses) with multiple lesions on the face OR Diagnosis of flat warts (verucca plana/jeveniles) OR Diagnosis of hyperkeratosis disorder (i.e. epidermolytic hyperkeratosis, lenticularis perstans [Flegel's disease], palmoplantar hyperatosis, keratosis follicularis [Darier's disease] OR Diagnosis of ichthyosis (i.e. congenital, lamellar, vulgaris, or X-linked)
Age Restrictions	PA applies to patients older than 40 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, medication has been effective in treating the patient's condition.

EPOETIN ALFA (S)

Products Affected

- Epogen
- Procrit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	uncontrolled hypertension. Pure red cell aplasia that begins after ESA treatment.
Required Medical Information	Pre-treatment hemoglobin level less than 10 g/dL AND Patient has adequate iron stores prior to initiation of therapy defined as ferritin more than 100 mcg/L or serum transferrin saturation greater than 20% AND other causes of anemia such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic disease (such as sickle cell anemia, thalassemia, and porphyria) have been ruled out AND Diagnosis of one of the following: A) Anemia due to chronic kidney disease (CKD) with or without hemodialysis, OR B) Anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy and two additional months of chemotherapy is anticipated, C)Treatment of anemic in a patient at high risk for perioperative blood loss from elective, noncardiac, nonvascular surgery to reduce the need for allogeneic blood transfusion, D) Anemia in zidovudine-treated HIV infection with serum erythropoietin levels 500 mUnits/mL or less and zidovudine doses 4,200 mg/week or less.
Age Restrictions	N/A
Prescriber Restrictions	CKD - prescribed by a nephrologist or hematologist. Non-myeloid malignancies - prescribed by an oncologist/hematologist. Surgery - Prescribed by a surgeon. HIV - Prescribed by an infectious disease specialist.
Coverage Duration	Initial: 3 months. Renewal: CKD-12 months, Non-myeloid cancers, HIV-4 months. Surgery-3 months

Other Criteria	For renewal of CKD, for dialysis patients: Hb less than 11 g/dL or physician will decrease or interrupt dose and for non-dialysis patients: Hb less than 10 g/dL or physician will decrease or interrupt dose. For renewal of non-myeloid malignancies: Concurrent myelosuppressive chemotherapy and Hb is 12g/dL or less and there is measurable response after eight weeks (defined as an increase in Hb 1 g/dL or more or a reduction in red blood cell transfusion requirements). For renewal of zidovudine-treated HIV, Hb is 12g/dL or less AND Zidovudine dose remains 4,200 mg/week or less and there is a measurable response after eight weeks (defined as an increase in Hb or a reduction in RBC transfusion requirements or documented dose escalation [up to max of 300 units/kg/dose]). ESRD patients on dialysis excluded.

ERIVEDGE (S)

Products Affected

- Erivedge

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic basal cell carcinoma OR Diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ERWINAZE (S)

Products Affected

- Erwinaze

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Member has experienced any of the following with prior asparaginase therapy: serious hypersensitivity reactions, including anaphylaxis, serious pancreatitis, serious thrombosis, serious hemorrhagic events
Required Medical Information	Diagnosis of acute lymphoblastic leukemia AND Patient has a hypersensitivity to E. coli-derived asparaginase
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

EXALGO (S)

Products Affected

- Exalgo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Significant respiratory depression. Acute or severe bronchial asthma. Hypercarbia. Known or suspected paralytic ileus. Patients who have had surgical procedures or underlying disease that would result in narrowing of the gastrointestinal tract. Gastrointestinal obstruction. Known allergy to sulfite-containing medications.
Required Medical Information	Patient is not under hospice care AND Diagnosis of moderate to severe pain requiring continuous, around-the-clock opioid analgesic for an extended period of time AND patient is opioid tolerant AND Tried and failed, is unable to tolerate, or has contraindications to at least one generic extended-release opioid product.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Not covered for members enrolled in a Medicare approved hospice program

FABRAZYME (S)

Products Affected

- Fabrazyme INJ 35MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Fabry disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

FENTANYL (S)

Products Affected

- Abstral
- Fentora
- Lazanda
- Subsys SUBLINGUAL LIQD 100MCG, 1600MCG, 200MCG, 400MCG, 600MCG, 800MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Management of acute or post-operative pain, including headache/migraine, dental pain, or use in the emergency room. Opioid non-tolerant patients.
Required Medical Information	Patient meets the following: A) Diagnosis of cancer and use is for breakthrough cancer pain, B) patient is opioid tolerant and taking at least 60 mg morphine/day, at least 25 mcg transdermal fentanyl/hour, at least 30 mg of oxycodone daily, at least 8 mg oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer, C) other formulary short-acting strong narcotic analgesic alternatives (other than fentanyl) have been ineffective, not tolerated, or contraindicated, D) prescriber is registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy Access program
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Not covered for members enrolled in a Medicare approved hospice program

FERRIPROX (S)

Products Affected

- Ferriprox

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of transfusional iron overload due to thalassemia syndromes AND patient has failed prior chelation therapy with Desferal or Exjade (failure is defined as a serum ferritin level greater than 2,500 mcg/L) or patient has a contraindication or intolerance to Desferal or Exjade AND Patient has an absolute neutrophil count greater than 1.5 x 109/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced at least a 20% reduction in serum ferritin levels and has an absolute neutrophil count greater than 0.5 x 109/L

FIRMAGON (S)

Products Affected

- Firmagon

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced or metastatic prostate cancer
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

FLECTOR (S)

Products Affected

- Flector

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Known hypersensitivity to diclofenac. Previously experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. Use for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery. Application to non-intact or damaged skin resulting from any etiology (e.g., exudative dermatitis, eczema, infected lesion, burns or wounds).
Required Medical Information	Patient is receiving treatment for acute pain due to minor strains, sprains and contusions AND patient had experienced treatment failure with at least 2 prescription strength oral NSAIDs or patient has a documented swallowing disorder.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A

FLOLAN (S)

Products Affected

- Epoprostenol Sodium

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	• Patient has a diagnosis of PAH (WHO Group I) WHO/NYHA Class IV patients OR • Patient has a diagnosis of PAH (WHO Group I) WHO/NYHA Class II-III patients who do not respond adequately to, are unable to tolerate, or are not candidates for endothelin receptor antagonists (e.g. TRACLEER [bosentan] or LETAIRIS [ambrisentan]) and phosphodiesterase-5 (PDE-5) inhibitors (e.g. REVATIO [sildenafil], ADCIRCA [tadalafil]).
Age Restrictions	N/A
Prescriber Restrictions	Prescription is written by a pulmonologist or cardiologist or documentation of consultation with pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	N/A

FORTEO (S)

Products Affected

- Forteo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of one of the following: a) osteoporosis in a postmenopausal female, b) primary or hypogonadal osteoporosis in a male, or c) osteoporosis associated with sustained systemic glucocorticoid therapy AND patient is considered to be at high-risk for fracture by meeting one or more of the following: A) history of osteoporotic fracture, B) multiple risk factors for facture (including older age, female gender, prior osteoporotic fracture, low body mass index, rheumatoid arthritis, smoker, alcohol intake more than 3 drinks/day, parental history of hip fracture, oral glucocorticoid therapy or patient ever took prednisone at a dose of 5 mg or higher), or C) documented trial and failure of bisphosphonate, or D) documented contraindication or intolerance to bisphosphonate therapy. Patient has not received more than 2 years of therapy with Forteo.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve doses based on FDA labeling

GATTEX (S)

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary, pancreatic), colorectal cancer, or small bowel cancer
Required Medical Information	Diagnosis of short bowel syndrome AND patient is receiving specialized nutritional support (i.e. parenteral nutrition)
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient has a reduced need for parenteral support (20% reduction) after at least 6 months of therapy.

GAZYVA (S)

Products Affected

- Gazyva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Absolute Contraindication
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approvable under Part D only if patient is in a long term care facility OR the medication is not being administered with an infusion pump.

GILENYA (S)

Products Affected

- Gilenya

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. First clinical episode with MRI features consistent with multiple sclerosis.
Exclusion Criteria	Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500 ms. Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (quinidine, procainamide, amiodarone, sotalol).
Required Medical Information	Diagnosis of a relapsing form of multiple sclerosis or diagnosis of first clinical episode with MRI features consistent with MS AND Patient will be observed for signs and symptoms of bradycardia in a controlled setting for at least 6 hours after the first dose
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	For renewal, the patient has experienced a reduction in the number of MS relapses, improvement in object symptoms scores, or has not had MRI progression.

GILOTRIF (S)

Products Affected

- Gilotrif

PA Criteria	Criteria Details
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 AND patient has a known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution as detected by an FDA approved test or Clinical Laboratory Improvement Amendments-approved facility AND the medication will be used first-line
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

GLEEVEC (S)

Products Affected

- Gleevec

PA Criteria	Criteria Details
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: A) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B) Ph+ acute lymphoblastic leukemia (ALL), C) 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, D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, E) hypereosinophilic syndrome or chronic eosinophilic leukemia, F) myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, G) aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutation or with c-KIT mutational status unknown
Age Restrictions	1 year of age or older - 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	12 months
Other Criteria	N/A

GRALISE (S)

Products Affected

- Gralise

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of post-herpetic neuralgia and patient has tried and failed a dose of at least 1800 mg of generic gabapentin or patient has experienced intolerance to generic gabapentin
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

GROWTH HORMONE (S)

Products Affected

- Genotropin
- Genotropin Miniquick
- Humatrope INJ 12MG, 24MG, 6MG
- Humatrope Combo Pack
- Norditropin Flexpro
- Norditropin Nordiflex Pen INJ 30MG/3ML
- Nutropin INJ 10MG
- Nutropin Aq
- Nutropin Aq Pen INJ 20MG/2ML
- Omnitrope INJ 5MG/1.5ML
- Saizen INJ 5MG
- Saizen Click.easy
- Tev-tropin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Growth hormone deficiency (GHD). Small for gestational age (SGA). Chronic renal insufficiency (CRI). Short stature homeobox-containing gene (SHOX) deficiency. Noonan syndrome. Prader-Willi Syndrome (PWS). Turner Syndrome. Adult- or childhood-onset GHD.
Exclusion Criteria	Closed epiphyses. 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 PWS only: sever obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment.

Required Medical Information	Diagnosis of pediatric indication: A) GHD and bone age at least 1 year or 2 standard deviations (SD) delayed compared with chronological age and 2 stim tests with peak GH secretion below 10 ng/mL or IGF-1/IGFBP3 level more than 2 SDS below mean if CNS pathology, h/o irradiation, or proven genetic cause, B) SGA and birth weight or length 2 or more SDS below mean for gestational age and fails to manifest catch up growth by age 2 (height 2 or more SDS below mean for age and gender), C) CRI and nutritional status has been optimized, metabolic abnormalities have been corrected, and patient has not had renal transplant D) SHOX deficiency or Noonan syndrome E) PWS confirmed by genetic testing, F) Turner Syndrome confirmed by chromosome analysis. For GHD, CRI, SHOX deficiency, Noonan syndrome, and PWS one of the following: height more than 3 SDS below mean for age and gender, or height more than 2 SDS below mean with GV more than 1 SDS below mean, or GV over 1 year 2 SDS below mean. OR Diagnosis of an adult indication: A) childhood- or adult-onset GHD confirmed by 2 standard GH stim tests (provide assay): 1 test must be insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L). If contraindicated, use a standardized stim test (i.e. arginine plus GH releasing hormone [preferred], glucagon, arginine), B) GHD with at least 1 other pituitary hormone deficiency and failed at least 1 GH stim test (ITT preferred), C) GHD with panhypopituitarism (3 or more pituitary hormone deficiencies), D) GHD with irreversible hypothalamic-pituitary structural lesions due to tumors, surgery or radiation of pituitary or hypothalamus region AND a subnormal IGF-1 (after at least 1 month off GH therapy) AND Objective evidence of GHD complications, such as: low bone density, increased visceral fat mass, or cardiovascular complications AND Completed linear growth (GV less than 2 cm/year) AND GH has been discontinued for at least 1 month (if previously receiving GH).
Age Restrictions	SGA more than 2 years of age
Prescriber Restrictions	Pediatric endocrinologist for pediatric indications. Endocrinologist for adult indications.
Coverage Duration	12 months
Other Criteria	For renewal of pediatric indications, final adult height has not been reached as determined by the fifth percentile of adult height and growth velocity is more than 2 cm/year. For renewal of adult indications, patient has experienced an improvement or normalization of IGF-1 levels (not a requirement in patients with panhypopituitarism).

H.P. ACTHAR GEL (BCBS RI)

Products Affected

- Acthar Hp

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Infantile spasms, MS, psoriatic arthritis, rheumatoid arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, SLE, systemic dermatomyositis, severe erythema multiforme, Stevens-Johnson Syndrome, serum sickness, severe acute & chronic allergic and inflammatory processes involving the eye and its adnexa such as: keratitis, irtis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation, symptomatic sarcoidosis, to induce a diuresis or a remisison of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus
Age Restrictions	2 years of age or your for diagnosis of IS, 18 years of age or older in MS
Prescriber Restrictions	N/A
Coverage Duration	IS-plan year, Collagen diseases - 6 months. Others- 1 month
Other Criteria	For rheumatic disorders: Failure of 12 week course of corticosteroid and concomitant therapy with a 3 month course of biologic DMARD. For MS: Failure of 3 to 5 day course of corticosteroid and concomitant use of a 3 month course of an immunomodulator

HEPSERA (S)

Products Affected

- Adefovir Dipivoxil
- Hepsera

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic hepatitis B AND patient has evidence of viral replication AND Patient has evidence of persistent elevations in serum aminotransferase (ALT or AST) or histologically active disease
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient must be HBeAg negative OR HBeAg positive, but has not seroconverted OR HBeAg positive and seroconverted to anti-Hbe with detectable HBV DNA levels OR HbeAg positive and seroconverted to anti-Hbe with undetectable levels of HBV DNA levels for less than 12 months

HORIZANT (S)

Products Affected

- Horizant

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of moderate to severe primary restless leg syndrome and patient has experienced treatment failure or is intolerant to ropinirole or pramipexole OR Patient has a diagnosis of post-herpetic neuralgia and patient tried and failed a dose of at least 1800 mg of generic gabapentin or patient has experienced intolerance to generic gabapentin
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient had a measurable response to therapy (e.g. decrease in symptoms onset or severity, improved sleep for RLS or decreased pain severity for PHN)

HRM - ANALGESICS

Products Affected

- Meperidine Hcl INJ 25MG/ML, 50MG/ML
- Meperidine Hcl ORAL SOLN
- Meperitab
- Pentazocine/acetaminophen
- Pentazocine/naloxone Hcl
- Talwin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Mild pain: acetaminophen, codeine. Moderate to severe pain: short-term NSAIDs, tramadol, tramadol/APAP, morphine sulfate, hydrocodone/APAP, oxycodone, oxycodone/APAP, fentanyl. Neuropathic pain: duloxetine, pregabalin, gabapentin, desipramine, nortriptyline, topical agents (capsaicin, topical lidocaine). Not covered for members enrolled in a Medicare approved hospice program

HRM - ANTIDEPRESSANTS

Products Affected

- Amitriptyline Hcl ORAL TABS
- Chlordiazepoxide/amitriptyline
- Clomipramine Hcl ORAL CAPS
- Doxepin Hcl CONC
- Doxepin Hcl ORAL CAPS
- Imipramine Hcl ORAL TABS
- Imipramine Pamoate
- Perphenazine/amitriptyline
- Trimipramine Maleate ORAL CAPS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Applies to New Starts only.TCA: nortriptyline, desipramine, low-dose doxepin, trazodone. Derpession: SSRI, SNRI, mirtazapine, bupropion. duloxetine, pregabalin, gabapentin. Insomnia: ramelteon (8 mg/d), low-dose doxepin (= 6mg/d).

HRM - ANTIEMETIC DRUGS

Products Affected

- Diphenhydramine Hcl CAPS 50MG
- Diphenhydramine Hcl INJ
- Hydroxyzine Hcl INJ
- Hydroxyzine Hcl ORAL SOLN
- Hydroxyzine Hcl ORAL TABS
- Hydroxyzine Pamoate ORAL CAPS
- Metoclopramide Hcl INJ
- Phenadoz
- Promethazine Hcl INJ
- Promethazine Hcl ORAL TABS
- Promethazine Hcl RECTAL SUPP 12.5MG, 25MG
- Promethazine Hcl SYRP
- Promethegan
- Trimethobenzamide Hcl CAPS
- Trimethobenzamide Hcl INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Not covered for members enrolled in a Medicare approved hospice program.

HRM - ANTIHISTAMINES

Products Affected

- Carbinoxamine Maleate SOLN
- Carbinoxamine Maleate TABS
- Clemastine Fumarate SYRP
- Clemastine Fumarate TABS 2.68MG
- Cyproheptadine Hcl SYRP
- Cyproheptadine Hcl TABS
- Promethazine Vc

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - ANTIHYPERTENSIVE AGENTS

Products Affected

- Guanfacine Hcl
- Reserpine TABS 0.25MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Low dose thiazide or a second generation calcium channel blocker OR ACE inhibitor, ARB, beta-blocker or combination product based on specific chronic conditions

HRM - ANTIPARKINSON AGENTS

Products Affected

- Benztropine Mesylate INJ
- Benztropine Mesylate ORAL TABS
- Trihexyphenidyl Hcl

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - ANXIOLYTICS

Products Affected

- Meprobamate

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Anxiety: SSRI, SNRI, buspirone. Insomnia: ramelteon (8 mg/d), low-dose doxepin (= 6mg/d). Not covered for members enrolled in a Medicare approved hospice program.

HRM - CALCIUM CHANNEL BLOCKERS, DIHYDROPYRIDINE

Products Affected

- Nifedipine ORAL CAPS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	extended-release nifedipine, nicardipine, amlodipine

HRM - ORAL AND TRANSDERMAL ESTROGENS AND PROGESTINS

Products Affected

- Alora
- Cenestin
- Climara Pro
- Combipatch
- Delestrogen INJ 10MG/ML
- Divigel GEL 1MG/GM
- Enjuvia
- Estradiol ORAL TABS
- Estradiol TRANSDERMAL PTWK
- Estradiol Valerate INJ
- Estradiol/norethindrone Acetate
- Estropipate ORAL TABS
- Jinteli
- Menest
- Menostar
- Prefest
- Premarin ORAL TABS
- Prempro
- Vivelle-dot

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - PLATELET INHIBITORS

Products Affected

- Ticlopidine Hcl

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	clopidogrel, dipyridamole with aspirin

HRM - SEDATIVE HYPNOTIC AGENTS

Products Affected

- Zaleplon
- Zolpidem Tartrate
- Zolpidem Tartrate Er

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) when used longer than 90 days and wishes to proceed with the originally prescribed medication AND intended duration of therapy will be verified.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - SKELETAL MUSCLE RELAXANTS

Products Affected

- Amrix
- Carisoprodol TABS 350MG
- Carisoprodol/aspirin
- Carisoprodol/aspirin/codeine
- Chlorzoxazone TABS
- Cyclobenzaprine Hcl ORAL TABS
- Methocarbamol ORAL TABS
- Orphenadrine Citrate INJ
- Orphenadrine Citrate Er

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - SULFONYLUREAS

Products Affected

- Chlorpropamide
- Glyburide ORAL TABS
- Glyburide Micronized
- Glyburide/metformin Hcl

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	glimepiride, glipizide

HRM - VASODILATORS

Products Affected

- Dipyridamole ORAL TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	clopidogrel, dipyridamole with aspirin

HUMIRA (S)

Products Affected

- Humira
- Humira Pen-crohns Diseasestarter

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis)
Required Medical Information	Diagnosis of moderate to severe rheumatoid arthritis and inadequate response, intolerance, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) (e.g., hydroxychloroquine [HCQ], sulfasalazine, methotrexate [MTX], leflunomide, azathioprine, cyclosporine) for at least 3 consecutive months OR Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis and inadequate response, intolerance or contraindication to one or more non-biologic DMARDs (e.g., HCQ, sulfasalazine, MTX, leflunomide, azathioprine, cyclosporine) for at least 3 consecutive months OR Diagnosis of psoriatic arthritis and inadequate response, intolerance, or contraindication to MTX OR Diagnosis of ankylosing spondylitis and inadequate response, intolerance or contraindication to one or more NSAIDs OR Diagnosis of moderate to severe chronic plaque psoriasis (affecting more than 5% of body surface area or crucial body areas such as the hands, feet, face, or genitals) and inadequate response, intolerance or contraindication to at least one of the following: phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA] for at least one continuous month or one or more oral systemic treatments (e.g., MTX, cyclosporine, acitretin, sulfasalazine) for at least 3 consecutive months OR Diagnosis of moderate to severe Crohn's disease and inadequate response, intolerance, or contraindication to two or more of the following: corticosteroids (e.g., prednisone, methylprednisolone) or non-biologic DMARDs (e.g., azathioprine, MTX, mercaptopurine) OR Diagnosis of moderate to severe ulcerative colitis and inadequate response, intolerance or contraindication to two or more of the following: corticosteroids (e.g., prednisone, methylprednisolone), 5-ASA (i.e. mesalamine, sulfasalazine, balsalazide, olsalazine) or non-biologic DMARDs (azathioprine, MTX, mercaptopurine).
Age Restrictions	4 years of age or older for JIA. 18 years of age or older for all other indications

Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has been tested for TB and latent TB has been ruled out or is being treated as per guidelines. Dosing as per FDA approved labeling

ICLUSIG (S)

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Chronic myelogenous leukemia in patients with the T315I mutation.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic myelogenous leukemia (CML) and patient has tried and failed or has an intolerance to two first-line tyrosine kinase inhibitors OR Diagnosis of CML and the patient has a known T315I mutation OR Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia and the patient has tried and failed or had an intolerance to two previous tyrosine kinase inhibitors.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ILARIS (S)

Products Affected

- Ilaris

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cryopyrin-associated period syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS) OR Diagnosis of active systemic juvenile idiopathic arthritis (sJIA) AND patient has tried and had an inadequate response, contraindication or intolerance to corticosteroids (e.g., prednisone, methylprednisolone) or methotrexate
Age Restrictions	For CAPS: 4 years of age or older. For sJIA: 2 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with or recommendation of, an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist
Coverage Duration	12 months
Other Criteria	Approve doses based on FDA labeling

IMBRUVICA (S)

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mantle cell lymphoma AND paitent has relapsed or is refractory to at least one prior therapy for the treatment of MCL
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

INCIVEK (S)

Products Affected

- Incivek

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnant. Unwilling to comply with required contraception methods. Co-administration with alfuzosin, cisapride, dihydroergotamine, drosperinone, ergonovine, ergotamine, lovastatin, methylergonovine, midazolam (oral), pimozide, rifampin, sildenafil (Revatio), simvastatin, St. John's wort, tadalafil (Adcirca), triazolam
Required Medical Information	Diagnosis of chronic hepatitis C genotype 1 with compensated liver disease AND medication will be used with ribavirin and peginterferon alfa AND Has not previously failed a treatment regimen with a hepatitis C protease inhibitor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial - 8 weeks. Renewal - 4 weeks
Other Criteria	For renewal, patient continue to receive concurrent therapy with ribavirin and peginterferon alfa AND viral load at week 4 is 1,000 IU/mL or less, the patient has not experienced a serious skin reaction while on therapy.

INCRELEX (S)

Products Affected

- Increlex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Closed epiphyses. Active or suspected malignancy.
Required Medical Information	Diagnosis of severe primary IGF-1 deficiency, defined as height standard deviation score (SDS) less than or equal to -3.0 AND basal IGF-1 SDS less than or equal to -3.0 AND normal or elevated growth hormone OR Diagnosis of growth hormone deletion with development of neutralizing antibodies to growth hormone AND othercauses of IGF-1 deficiency (e.g., hypothyroidism, nutritional deficiencies, pituitary disorders, etc.) have been ruled out or corrected prior to initiating therapy.
Age Restrictions	N/A
Prescriber Restrictions	Pediatric endocrinologist
Coverage Duration	12 months
Other Criteria	For renewal, Patient had a minimum growth rate of at least 2 cm/year.

INFERGEN (S)

Products Affected

- Infergen INJ 15MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled depression. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon and ribavirin.
Required Medical Information	Diagnosis of chronic hepatitis C with compensated liver disease AND patient will be receiving combination therapy with ribavirin, unless ribavirin is contraindicated AND Infergen will not be used as part of triple therapy with a protease inhibitor AND Patient has a clinical reason for not using peginterferon
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	48 weeks
Other Criteria	N/A

INHALED TOBRAMYCIN (S)

Products Affected

- Tobi
- Tobi Podhaler
- Tobramycin NEBU

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cystic fibrosis AND patient has evidence of P. aeruginosa in the lungs
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations). For inhalation solution only (does not apply to TOBI Podhaler): Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

INLYTA (S)

Products Affected

- Inlyta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced renal cell carcinoma AND patient failed one or more systemic therapies for renal cell carcinoma (e.g., sunitinib-, bevacizumab-, temsirolimus-, or cytokine-containing regimens)
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

IVIG (S)

Products Affected

- Carimune Nanofiltered INJ 3GM
- Gammagard Liquid
- Gamunex-c INJ 1GM/10ML
- Hizentra
- Privigen INJ 20GM/200ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of hypersensitivity (including anaphylaxis or severe systemic reaction) to immune globulin or any component of the preparation. Selective IgA deficiency and history of hypersensitivity to immunoglobulin. For IV administration only: Patient will not take the medication at the minimum concentration available and the minimum infusion rate practicable if they have one of the following conditions: Pre-existing renal insufficiency, diabetes mellitus, volume depletion, sepsis, paraproteinemia, age over 65 years, receiving known nephrotoxic drugs.
Required Medical Information	Medication will be given intravenously and the patient has one of the following: A) idiopathic thrombocytopenic purpura (ITP), B) Kawasaki syndrome, C) hypogammaglobulinemia and/or recurrent bacterial infection associated with B-cell chronic lymphocytic leukemia, D) chronic inflammatory demyelinating polyneuropathy (CIDP), E) multifocal motor neuropathy (MMN). OR Medication will be given by the subcutaneous route or intravenous route and patient has a diagnosis of one of the following types of primary immunodeficiency (PI): hypogammaglobulinemia, congenital agammaglobulinemia (X-linked agammaglobulinemia), Common variable immunodeficiency, X-linked immunodeficiency with hyperimmunoglobulin M, severe combined immunodeficiency, Wiskott-Aldrich syndrome
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	ITP, Kawasaki - 2 months, Other - 12 months.
Other Criteria	Non-LTC members: Part B if the drug is being administered with an infusion pump. Part D for all other administration techniques. LTC members - always Part D

JAKAFI (S)

Products Affected

- Jakafi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of myelofibrosis (primary, post-poycythemia vera or post-essential thrombocythemia) AND patient has two or more of the following: age older than 65 years, white blood cell count greater than 25 x 109/L, hemoglobin less than 10 g/dL, peripheral blasts more than 1%, constitutional symptoms (e.g., night sweats, fevers, unintentional weight loss, debilitating fatigue)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

JUXTAPID (S)

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests. Pregnancy. Concomitant use with strong or moderate CYP3A4 inhibitors.
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia AND Medication will be used as adjunct to a low-fat diet and other lipid-lowering treatments AND Patient has tried and had an inadequate response or intolerance to statins
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	For renewal, patient has responded to therapy with a decrease in LDL levels.

KADCYLA (BCBS RI)

Products Affected

- Kadcyla INJ 100MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of HER2-positive metastatic breast cancer and the member has been previously treated with trastuzumab and a taxane
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Prescriber has assessed the patient's hepatic function and left ventricular ejection fraction prior to initiation of therapy. Female patients of child-bearing potential had pregnancy status verified prior to the initiation of Kadcyla and have been advised of the risk of fetal harm and the need for contraception. Approvable under Part D only if patient is in a long term care facility OR the medication is not being administered with an infusion pump.

KALYDECO (S)

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cystic fibrosis AND Patient has a known G551D mutation on at least one allele in the cystic fibrosis transmembrane conductance regulator gene documented by an FDA-cleared cystic fibrosis-mutation test that includes measurement of the G551D mutation
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced benefit from therapy (i.e. improvement in pulmonary lung function [FEV1], decreased number of pulmonary exacerbations)

KINERET (S)

Products Affected

- Kineret

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis)
Required Medical Information	Diagnosis of moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)for at least 3 consecutive months OR Diagnosis of cryopyrin-associated periodic syndrome (CAPS) with neonatal-onset multisystem inflammatory disease (NOMID)
Age Restrictions	18 years of age or older for rheumatoid arthritis
Prescriber Restrictions	For CAPS, diagnosed by, or upon consultation with or recommendation of, an immunologist, allergist, dermatologist, rheumatologist, neurologist or other medical specialist
Coverage Duration	12 months
Other Criteria	Patient has been tested for TB and latent TB has been ruled out or is being treated. Dosing as per the FDA labeling for rheumatoid arthritis.

KORLYM (S)

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy. Patient requires concomitant treatment with systemic corticosteroids for serious medical conditions/illnesses (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 index (e.g., cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, or tacrolimus)
Required Medical Information	Diagnosis of endogenous Cushing's syndrome AND diagnosis of type 2 diabetes mellitus or glucose intolerance AND Patient has hyperglycemia secondary to hypercortisolism AND patient has failed or is not a candidate for surgery
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, Patient had a positive response to therapy with Korlym

KUVAN (S)

Products Affected

- Kuvan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of phenylketonuria (PKU) and patient is and will be maintained on a phenylalanine-restricted diet
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 2 months. Renewal: 12 months.
Other Criteria	For initial approval, Patient will have phenylalanine levels measured one week after starting therapy and periodically for up to two months of therapy to determine response. For renewal, patient has been determined to be a responder to therapy (i.e. phenylalanine levels have decreased by at least 30% from baseline) and phenylalanine levels will be measured periodically during therapy.

KYNAMRO (S)

Products Affected

- Kynamro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests.
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia AND Medication will be used as adjunct to a low-fat diet and other lipid-lowering treatments AND Patient has tried and had an inadequate response or intolerance to statins
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	For renewal, patient has responded to therapy with a decrease in LDL levels.

LETAIRIS (S)

Products Affected

- Letairis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis o f 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 AND Patient has New York Heart Association (NYHA) Functional Class II or III AND pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with two forms of reliable contraception in female patients of reproductive potential.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	N/A

LEUKINE (S)

Products Affected

- Leukine

PA Criteria	Criteria Details
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: A) Patient has undergone allogeneic or autologous bone marrow transplant (BMT) and engraftment is delayed or failed and Patient does not have excessive leukemic myeloid blasts in bone marrow/peripheral blood (more than 10%) OR B) Patient is undergoing autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis OR C) Medication will be used for myeloid reconstitution after an autologous or allogeneic BMT OR D) Patient has acute myeloid leukemia and administration will be after completion of induction chemotherapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

LINZESS (S)

Products Affected

- Linzess

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Mechanical gastrointestinal obstruction.
Required Medical Information	Diagnosis of irritable bowel syndrome-constipation for at least 12 non-consecutive weeks and patient has tried and failed increasing fluid and fiber intake and patient has tried and failed or has an intolerance to osmotic laxatives, stimulant laxatives or probiotics OR Diagnosis of chronic idiopathic constipation for at least 3 months and patient has tried and failed increasing fluid and fiber intake and patient has tried and failed or has an intolerance to osmotic laxatives, stimulant laxatives or stool softeners.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial - 4 months. Renewal - 12 months
Other Criteria	For renewal, the patient has experienced an increase in the number of bowel movements.

LUMIZYME (S)

Products Affected

- Myozyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of infantile-onset Pompe disease (GAA) deficiency.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

LUPANETA (S)

Products Affected

- Lupaneta Pack

PA Criteria	Criteria Details
Covered Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	N/A

LUPRON DEPOT (S)

Products Affected

- Leuprolide Acetate INJ
- Lupron Depot INJ 22.5MG, 3.75MG, 30MG, 45MG, 7.5MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy in patients with child-bearing potential. Breastfeeding. Undiagnosed abnormal vaginal bleeding.
Required Medical Information	Diagnosis of one of the following: A) advanced or metastatic prostate cancer (7.5 mg 1-month, 22.5 mg 3-month, 30 mg 4-month, & 45 mg 6-month depots only), B) Endometriosis (3.75 mg 1-month & 11.25 mg 3-month depots only) and for initial, patient has had an inadequate pain control response or patient has an intolerance or contraindication to one of the following: Danazol OR Combination [estrogen/progesterone] Oral Contraceptives OR Progestins and for retreatment course, Patient is experiencing recurrence of symptoms after an initial course of therapy with leuprolide acetate and Norethindrone acetate 5 mg daily will be co-administered, or C) Anemia due to uterine Leiomyomata (Fibroids) (3.75 mg 1-month &11.25 mg 3-month depots only) and Patient is preoperative and Patient has tried and had an inadequate response to monotherapy with iron and Patient will be receiving concomitant iron therapy while on leuprolide.
Age Restrictions	Uterine fibroids - 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Endometriosis - 6 months, Uterine fibroids - 3 months, Prostate cancer - 12 months.
Other Criteria	For endometriosis and uterine fibroids, patient will be using nonhormonal contraception during and for 12 weeks after therapy.

LUPRON DEPOT- PED (S)

Products Affected

- Lupron Depot-ped INJ 11.25MG, 11.25MG, 15MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of central precocious puberty and patient had early onset of secondary sexual characteristics (male: earlier than 9 years of age. female: earlier than 8 years of age) and advanced bone age of at least one year compared with chronological age and has undergone gonadotropin-releasing hormone agonist (GnRHa) testing with peak luteinizing hormone (LH) level above pre-pubertal range or random LH level in pubertal range and Patient had the following diagnostic evaluations to rule out tumors, when suspected: diagnostic imaging of the brain (MRI or CT scan), Pelvic/testicular/adrenal ultrasound, Human chorionic gonadotropin levels, Adrenal steroids to rule out congenital adrenal hyperplasia
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pediatric endocrinologist
Coverage Duration	12 months
Other Criteria	For renewal of CPP, LH levels have been suppressed to pre-pubertal levels and consideration for discontinuation of therapy when the patient is 11 years of age for girls and 12 years of age for boys.

MARINOL (S)

Products Affected

- Dronabinol

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chemotherapy-induced nausea and vomiting AND patient has tried and failed conventional antiemetic treatments (e.g., aprepitant/fosaprepitant, dexamethasone, t-hydroxytriptamine-3 serotonin receptor antagonists, butyrophenones, phenothiazines, metoclopramide) OR Patient has a diagnosis of anorexia associated with weight loss due to AIDS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Part B if related to cancer treatment and is a full replacement for IV antiemetic within 48 hrs of cancer treatment. Part D if related to cancer treatment after the 48-hour period, or for any other medically accepted diagnosis.

MEKINIST (S)

Products Affected

- Mekinist

PA Criteria	Criteria Details
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, positive BRAF V600E or V600K mutation as detected by an FDA-approved test (THxID-BRAF Kit) or Clinical Laboratory Improvement Amendments (CLIA)-approved facility, and the patient has not received prior BRAF-inhibitor therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

MOZOBIL (S)

Products Affected

- Mozobil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnant. Breast feeding.
Required Medical Information	Patient is to undergo autologous stem cell transplantation for the treatment of non-Hodgkin's lymphoma or multiple myeloma AND Patient will concomitantly receive a daily dose of a granulocyte colony-stimulating factor (G-CSF) for 4 days prior to the first evening dose of Mozobil and on each day prior to apheresis while using Mozobil.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 days
Other Criteria	N/A

MYOZYME (S)

Products Affected

- Lumizyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of late (non-infantile) onset Pompe disease (GAA) deficiency and the patient does not have evidence of cardiac hypertrophy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NAGLAZYME (S)

Products Affected

- Naglazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Mucopolysaccharidosis VI (MPS VI or Maroteaux-Lamy syndrome).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NEULASTA (S)

Products Affected

- Neulasta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For use as primary prophylaxis of febrile neutropenia (FN) in one of the following patients: A) Patient has a 20% or higher risk of FN based on chemotherapy regimen OR B) Patient has a less than 20% risk of developing FN based on chemotherapy regimen AND at least one of the following risk factors are present: 65 years or older, Poor performance status, Poor nutritional status, Previous episodes of febrile neutropenia, Extensive prior treatment including large radiation ports, Cytopenias due to bone marrow involvement by tumor, Administration of combined chemoradiotherapy, Presence of open wounds or active infections, Other serious comorbidities (including renal or liver dysfunction notably elevated bilirubin), or C) Patient is receiving a dose-dense chemotherapy regimen in breast cancer, small cell lung cancer, or non-Hodgkin's lymphoma
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NEUPOGEN (S)

Products Affected

- Neupogen INJ 300MCG/0.5ML, 480MCG/0.8ML, 480MCG/1.6ML

PA Criteria	Criteria Details
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: A) congenital, cyclic, or idiopathic neutropenia, B) severe febrile neutropenia (FN) with the following: Has not received prophylactic pegfilgrastim and Used as adjunct to appropriate antibiotics in high-risk patients and any one of the following: 65 years or older, Uncontrolled primary disease, Pneumonia, Hypotension and multiorgan dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalization when developed fever, Prior FN, Severe (ANC less than 100/mcL) or anticipated prolonged (more than 10 days) neutropenia, C) Autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis, D) Undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT, E) Acute myeloid leukemia and will be given after completion of induction or consolidation chemotherapy, F) Acute lymphoblastic leukemia and will be given after completion of the first few days of chemotherapy of the initial induction or first post-remission course, G) Myelodysplastic syndrome with severe neutropenia and recurrent infection, H) Receiving radiation therapy, not on chemotherapy, and expected to have prolonged delays in treatment due to neutropenia, I) Neutropenia associated with HIV infection and antiretroviral therapy, J) Aplastic anemia, K)Primary prophylaxis of FN in one of the following patients: 20% or higher risk of FN based on chemotherapy regimen OR Less than 20% risk of FN based on chemotherapy regimen with one of the following: 65 years or older, Poor performance status, Poor nutritional status, Previous FN, Extensive prior treatment including large radiation ports, Cytopenias due to bone marrow involvement by tumor, Administration of combined chemoradiotherapy, Presence of open wounds or active infections, Other serious comorbidities (including renal or liver dysfunction) or Receiving dose-dense chemotherapy regimen in breast or small cell lung cancer or non-Hodgkin’s lymphoma.
Age Restrictions	N/A

Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NEXAVAR (S)

Products Affected

- Nexavar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	squamous cell lung cancer being treated with carboplatin and paclitaxel.
Required Medical Information	Diagnosis of unresectable hepatocellular carcinoma or Diagnosis of advanced renal cell carcinoma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NPLATE (S)

Products Affected

- Nplate INJ 250MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	• Patient has a diagnosis of relapsed/refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) for greater than 6 months AND • Patient's baseline platelet count is less than 50,000/mcL AND • Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding AND • Patient had an insufficient response, intolerance, or contraindication to corticosteroids, immune globulin OR • Patient had an inadequate response or contraindication to a splenectomy
Age Restrictions	Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Renewal criteria: patient's platelet count has increased to a level sufficient to avoid clinically important bleeding after at least 4 weeks of therapy at the maximum weekly dose (10 mcg/kg)

NUVIGIL (S)

Products Affected

- Nuvigil

PA Criteria	Criteria Details
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	OSA/hypopnea syndrome - 6 months (initial), 12 months (renewal). Other diagnoses - 12 months.
Other Criteria	N/A

OLYSIO (S)

Products Affected

- Olysio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Pregnant. Unwilling to comply with required contraception methods. Men with female partners who are pregnant.
Required Medical Information	Diagnosis of chronic hepatitis C genotype 1 virus infection with compensated liver disease AND A) medication will be used with ribavirin and peginterferon alfa AND patients with genotype 1a HCV infection have been screened for NS3 Q80K polymorphism and the patient does not have the polymorphism or B) medication will be used with Sovaldi with or without ribavirin AND the patient is treatment-naïve AND the patient is ineligible (e.g., labeled contraindication to peginterferon or patient has a concomitant condition that precludes the use of peginterferon) for an interferon-based regimen
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	With PEG/RBV: Initial - 8 weeks. Renewal - 4 weeks. With Sovaldi: 12 wks
Other Criteria	For renewal with PEG/RBV, patient continues to receive concurrent therapy with ribavirin and peginterferon alfa AND viral load at week 4 is less than 25 IU/mL.

OPSUMIT (S)

Products Affected

- Opsumit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy.
Required Medical Information	Diagnosis of pulmonary arterial hypertension WHO group I with New York Heart Association Functional Class II or III AND diagnosis was confirmed by right heart catheterization AND female patients are enrolled in the OPSUMIT REMS program
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.)

ORENCIA (S)

Products Affected

- Orencia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis)
Required Medical Information	Diagnosis of moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)for at least 3 consecutive months OR Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis and patient had an inadequate response, intolerance or contraindication to one or more non-biologic DMARDs for at least 3 consecutive months and patient had an inadequate response to one or more tumor necrosis factor inhibitors
Age Restrictions	6 years of age or older for JIA. 18 years of age or older for rheumatoid arthritis
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has been tested for TB and latent TB has been ruled out or is being treated. Dosing as per FDA approved labeling.

OXANDRIN (S)

Products Affected

- Oxandrolone ORAL TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Breast or prostate cancer in men. Breast cancer in women with hypercalcemia. Pregnancy. Nephrosis or nephrotic phase of nephritis. Hypercalcemia.
Required Medical Information	Patient is receiving treatment as an adjunct therapy to promote weight gain and has one of the following: Extensive surgery, Chronic infections, Severe trauma, Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons and Patient has had an inadequate response, intolerance, or contraindication to nutritional supplements and a nutritional consult was performed OR Oxandrin (oxandrolone) will be used to counterbalance protein catabolism associated with chronic corticosteroid administration OR Patient has bone pain associated with osteoporosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Osteoporosis bone pain: 1 month. Other diagnoses: 3 months
Other Criteria	For renewal, patient has experienced an objective improvement (i.e. weight gain, increase in lead body mass, or reduction in muscle pain/weakness)

PEGASYS (S)

Products Affected

- Pegasys
- Pegasys Proclick INJ 135MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled depression. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon and ribavirin.
Required Medical Information	Diagnosis of hepatitis C with compensated liver disease and patient will be receiving one of the following: A) Combination therapy with an HCV protease inhibitor and ribavirin and Patient has HCV genotype 1 OR B) Combination therapy with ribavirin only and if patient has HCV genotype 1, the patient has a contraindication to HCV protease inhibitors OR Monotherapy when ribavirin is contraindicated OR Diagnosis of chronic hepatitis B and evidence of hepatitis B viral replication and patient has been serum hepatitis B surface antigen (HBsAg)-positive for at least 6 months.
Age Restrictions	HCV: 18 years of age or older if used as triple therapy, otherwise 5 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	HBV - 12 months. HCV: Initial - 16 weeks. Renewal - duration based on FDA approved labeling.
Other Criteria	For renewal of HCV, approval is based on the requirements outlined in the FDA-approved labeling, including viral load, presence of cirrhosis , and response to prior therapy.

PEGINTRON (S)

Products Affected

- Peg-intron INJ 50MCG/0.5ML
- Peg-intron Redipen
- Peg-intron Redipen Pak 4 INJ 120MCG/0.5ML, 150MCG/0.5ML, 80MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled depression. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon and ribavirin.
Required Medical Information	Diagnosis of hepatitis C with compensated liver disease and patient will be receiving one of the following: A) Combination therapy with an HCV protease inhibitor and ribavirin and Patient has HCV genotype 1 OR B) Combination therapy with ribavirin only and if patient has HCV genotype 1, the patient has a contraindication to HCV protease inhibitors OR Monotherapy when ribavirin is contraindicated.
Age Restrictions	HCV: 18 years of age or older if used as triple therapy, otherwise 3 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial - 16 weeks. Renewal - duration based on FDA approved labeling
Other Criteria	For renewal, approval is based on the requirements outlined in the FDA-approved labeling, including viral load, presence of cirrhosis , and response to prior therapy.

PERJETA (BCBS RI)

Products Affected

- Perjeta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of HER2-positive metastatic breast cancer AND medication is being used in combination with trastuzumab and docetaxel AND Patient has not received prior anti-HER2 therapy (e.g., trastuzumab) or chemotherapy for metastatic disease AND pregnancy status will be verified prior to initiation of therapy AND females of reproductive potential will be advised of the risks of embryo-fetal death and birth defects, and the need for effective contraception during and after pertuzumab treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approvable under Part D only if patient is in a long term care facility OR the medication is not being administered with an infusion pump.

POMALYST (S)

Products Affected

- Pomalyst

PA Criteria	Criteria Details
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 and the patient has received two prior therapies, including Revlimid and Velcade unless the patient has a contraindication or intolerance to Revlimid or Velcade and the patient has demonstrated disease progression on or within 60 days of completion of last therapy AND the prescriber, pharmacist, and patient are enrolled in the Pomalyst REMS program
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 month
Other Criteria	N/A

PROCYSBI (S)

Products Affected

- Procysbi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of nephropathic cystinosis AND Patient has tried and failed, or had an intolerance to, therapy with Cystagon (immediate-release cysteamine bitartrate)
Age Restrictions	6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

PROLIA (BCBS RI)

Products Affected

- Prolia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient is at high risk for fracture defined as one of the following: Personal history of low-trauma fractures as an adult, History of osteoporotic fracture in a first degree relative, Concurrent use of systemic corticosteroids (avg dose more than 5 mg of prednisone per day), Concurrent cigarette smoking, Low body weight less than 127 pounds, Low bone mineral density (T-score of -2.5 or lower) AND Diagnosis of one of the following: Patient is female and is receiving adjuvant aromatase inhibitor therapy for breast cancer, Patient is male and is receiving androgen deprivation therapy for non-metastatic prostate cancer, Patient is a male or postmenopausal female with a diagnosis of osteoporosis AND Patient has a documented trial and failure with a bisphosphonate (failure is defined as new fractures in compliant patients) or contraindication or intolerance to bisphosphonate therapy or is unable to comply with appropriate administration recommendations for oral or injectable bisphosphonate therapy AND Patient is concomitantly taking calcium 1000 mg daily and at least 400 IU vitamin D daily AND Patient will have pre-existing hypocalcemia and vitamin D deficiency corrected prior to administration of the medication
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Calcium, mineral, and vitamin D levels will be monitored periodically during treatment. Approvable under Part D only if patient is in a long term care facility OR the medication is not being administered with an infusion pump.

PROMACTA (S)

Products Affected

- Promacta

PA Criteria	Criteria Details
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: A) Relapsed/refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) for greater than 6 months AND Baseline platelet count is less than 50,000/mcL AND Degree of thrombocytopenia and clinical condition increase the risk of bleeding AND Patient had an insufficient response, intolerance, contraindication to corticosteroids or immune globulin or inadequate response or contraindication to splenectomy, B)Chronic hepatitis C and patient has thrombocytopenia defined as platelets less than 90,000/mcL for initiation (pre-treatment) of interferon therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	ITP - 12 months. Hep C - 9 weeks (initial), 24 weeks (renewal)
Other Criteria	For renewal of ITP, after at least 4 weeks of therapy at the maximum weekly dose (10 mcg/kg) the platelet count increased to a sufficient level to avoid clinically important bleeding. For renewal of Hepatitis C, platelets less than 75,000/mcL for maintenance of optimal interferon-based therapy.

PROVIGIL (S)

Products Affected

- Modafinil

PA Criteria	Criteria Details
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	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	OSA/hypopnea syndrome - 6 months (initial), 12 months (renewal). Other diagnoses - 12 months.
Other Criteria	N/A

PULMOZYME (S)

Products Affected

- Pulmozyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cystic fibrosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations). Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

QUALAQUIN (S)

Products Affected

- Qualaquin
- Quinine Sulfate CAPS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Prolongation of QT interval. Glucose-6-phosphate dehydrogenase deficiency. Myasthenia gravis. Known hypersensitivity to mefloquine or quinidine. Optic neuritis.
Required Medical Information	Patient is being treated for uncomplicated Plasmodium falciparum malaria
Age Restrictions	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	One month
Other Criteria	Dosing will be approved per the FDA labeling.

RAVICTI (S)

Products Affected

- Ravicti

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	acute hyperammonemia. N-acetylglutamate synthase (NAGS) deficiency
Required Medical Information	Diagnosis of urea cycle disorder involving deficiencies of carbamoyl phosphate syntehtase (CPS), ornithine transcarbamoylase (OTC), or argininosuccinic acid synthetase (AAS) confirmed via enzymatic, biochemical, or genetic testing AND protein-restricted diet alone or amino acid supplements alone has been ineffective AND patient has tried and had an inadequate response, is intolerant, or has a contraindication to Buphenyl AND patient will maintain a protein-restricted diet while on therapy.
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

REBIF (S)

Products Affected

- Rebif
- Rebif Titration Pack

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, disease has not progressed and has responded to therapy.

RECLAST (BCBS RI)

Products Affected

- Zoledronic Acid INJ 5MG/100ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indication not otherwise excluded from Part D.
Exclusion Criteria	Creatinine clearance less than 35 mL/min or evidence of acute renal impairment. Hypocalcemia (corrected calcium level less than 8.0 mg/dL). Patient is currently receiving Zometa.
Required Medical Information	Supplementation with calcium and vitamin D AND Diagnosis of one of the following: A) Postmenopausal female with osteoporosis diagnosed by BMD (T-score -2.5 or below) or by history of fracture, B) Patient will receive medication for prevention of osteoporosis AND patient is a postmenopausal female with one of the following risk factors for fracture: Low BMD (T-score -1.5 or below), Low body weight (less than 57.6 kg or 127 pounds), Smoking, Alcohol use (3 or more drinks/day), Family history of osteoporosis, Early menopause, Age 65 years or older, Equivalent dose of 7.5 mg prednisone or more/day for a minimum of 3 months, C) Male with osteoporosis diagnosed by BMD (T-score -2.5 or below) or by history of fracture, D) Patient is male and will receive medication for prevention of osteoporosis AND patient requires an equivalent dose of 7.5 mg prednisone or more/day for a minimum of 3 months, E) Premenopausal female with a history of fracture AND Patient requires the use of glucocorticoids for at least 3 months or requires an equivalent dose of 7.5 mg prednisone or more/day, F) Premenopausal female who requires an equivalent dose of 7.5 mg prednisone or more/day for a minimum of 12 months G) Diagnosis of Paget's disease of bone with any one of the following: Serum alkaline phosphatase two times or more higher than the upper limit of the age-specific normal reference range, Symptomatic disease (i.e. bone pain, headache with skull involvement, back pain due to radiculopathy or arthropathy, fissure fractures), At risk for complications from the disease (e.g., those with active disease near neurovascular structures or major joints) AND For osteoporosis indications, Patient has tried and had inadequate response to oral bisphosphonates, unless patient has a contraindication/intolerance to oral bisphosphonate.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	12 months
Other Criteria	Approve doses based on FDA labeling. Approvable under Part D only if patient is in a long term care facility OR the medication is not being administered with an infusion pump.

RELISTOR (S)

Products Affected

- Relistor INJ 12MG/0.6ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Known or suspected mechanical gastrointestinal obstruction. On renewal, patient does not have severe or persistent diarrhea.
Required Medical Information	Diagnosis of opioid-induced constipation AND Patient has used opioid medication for a minimum of 2 weeks AND Patient is experiencing fewer than 3 bowel movements in a week or no bowel movement for longer than 2 days AND Patient is diagnosed with an advanced illness (e.g., incurable cancer, end-stage chronic obstructive pulmonary disease/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS, etc.) AND Patient is receiving palliative care AND Patient has tried and had an insufficient response to laxative (e.g., lubiprostone) therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 months
Other Criteria	For renewal, the patient has responded to therapy (i.e. increase in bowel movements)

REMICADE (BCBS RI)

Products Affected

- Remicade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis). Moderate to severe heart failure in patients receiving doses greater than 5 mg/kg.
Required Medical Information	Diagnosis of moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)for at least 3 consecutive months and patient will be on concomitant methotrexate OR Diagnosis of ankylosing spondylitis and patient had an inadequate response, intolerance or contraindication to one or more NSAIDs OR Diagnosis of severe chronic plaque psoriasis (affecting more than 10% of body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) and patient had an inadequate response, intolerance or contraindication to conventional therapy with at least one of the following: phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA] for at least one continuous month or one or more oral systemic treatments for at least 3 consecutive months OR Diagnosis of moderate to severe Crohn's disease and patient had an inadequate response, intolerance, or contraindication to conventional therapy with two or more of the following: corticosteroids or non-biologic DMARDs OR Diagnosis of fistulizing Crohn's disease OR Diagnosis of moderate to severe ulcerative colitis and patient had an inadequate response, intolerance or contraindication to conventional therapy with two or more of the following: corticosteroids, 5-ASA (i.e. mesalamine, sulfasalazine, balsalazide, olsalazine) or non-biologic DMARDs OR Diagnosis of psoriatic arthritis and patient had an inadequate response, intolerance or contraindication to methotrexate.
Age Restrictions	6 years of age or older for UC or Crohn's disease (non-fistulizing). 18 years of age or older for all other indications, including fistulizing Crohn's disease
Prescriber Restrictions	N/A
Coverage Duration	12 months

Other Criteria	Patient has been tested for TB and latent TB has been ruled out or is being treated. Approvable under Part D only if patient is in a long term care facility OR the medication is not being administered with an infusion pump.

REMODULIN (S)

Products Affected

- Remodulin

PA Criteria	Criteria Details
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 o f 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 AND Patient has New York Heart Association (NYHA) Functional Class II-IV.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

REVATIO (S)

Products Affected

- Revatio INJ
- Sildenafil Citrate TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Receiving nitrate therapy (includes intermittent use)
Required Medical Information	Diagnosis o f 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 AND Patient has New York Heart Association (NYHA) Functional Class II or III.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	N/A

REVLIMID (S)

Products Affected

- Revlimid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of multiple myeloma and patient has received at least one prior therapy 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 5q cytogenetic abnormality with or without additional cytogenetic abnormalities OR Diagnosis of mantle cell lymphoma and patient's disease has relapsed or progressed after trying at least two prior therapies (Velcade and one of the following: bendamustine, cladribine, fludarabine, rituximab) AND patient is enrolled in the RevAssist Program
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

SANDOSTATIN (S)

Products Affected

- Octreotide Acetate

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acromegaly and patient had an inadequate response or cannot be treated with surgical resection, pituitary irradiation, and/or bromocriptine mesylate at maximally tolerated doses OR Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea and flushing episodes OR Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal of acromegaly, IGF-1 level has normalized or improved. For renewal of metastatic carcinoid tumor, patient has improvement in diarrhea and flushing episodes. For renewal of vasoactive intestinal peptide tumor, improvement in diarrhea episodes.

SANDOSTATIN LAR (S)

Products Affected

- Sandostatin Lar Depot

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acromegaly and patient had an inadequate response or cannot be treated with surgical resection, pituitary irradiation, and/or bromocriptine mesylate at maximally tolerated doses OR Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea and flushing episodes OR Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea AND Patient received at least two weeks of Sandostatin Injection and has tolerate therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal of acromegaly, IGF-1 level has normalized or improved. For renewal of metastatic carcinoid tumor, patient has improvement in diarrhea and flushing episodes. For renewal of vasoactive intestinal peptide tumor, improvement in diarrhea episodes.

SAVELLA (S)

Products Affected

- Savella
- Savella Titration Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Use of monoamine oxidase inhibitors concomitantly or within 14 days. Uncontrolled narrow-angle glaucoma. End-stage renal disease.
Required Medical Information	Diagnosis of fibromyalgia AND patient had a previous trial (of at least 30 days) with or has a contraindication, intolerance, or allergy to one of the following agents used for the treatment of fibromyalgia: tricyclic antidepressant, SNRI, SSRI, gabapentin, or cyclobenzaprine.
Age Restrictions	17 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal patient had an objective response to therapy.

SEROSTIM (S)

Products Affected

- Serostim

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	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.
Required Medical Information	Diagnosis of AIDS-wasting syndrome or cachexia (defined as unintentional weight loss of at least 10% of baseline weight) AND Treatment failure with or intolerance to dronabinol or megestrol AND Patient is currently receiving treatment with antiretrovirals
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	For renewal, patient has experienced an increase in body weight and/or improvement in lead body mass AND wasting is still evident

SIGNIFOR (S)

Products Affected

- Signifor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of (pituitary) Cushing's disease AND pituitary surgery is not an option or has not been curative
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient had a clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease

SIMPONI (S)

Products Affected

- Simponi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis)
Required Medical Information	Diagnosis of moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)for at least 3 consecutive months and patient will be on concomitant methotrexate OR Diagnosis of psoriatic arthritis and patient had an inadequate response, intolerance, or contraindication to methotrexate OR Diagnosis of ankylosing spondylitis and patient had an inadequate response, intolerance or contraindication to one or more NSAIDs OR Diagnosis of ulcerative colitis and patient has had inadequate responses to, is intolerant to, or is contraindicated to conventional therapy with two or more of the following: Corticosteroids (i.e. prednisone, methylprednisolone), 5-ASAs (i.e. mesalamine, sulfasalazine, balsalazide, olsalazine), or Non-biologic DMARDs
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has been tested for TB and latent TB has been ruled out or is being treated. Dosing as per FDA approved labeling.

SIMPONI ARIA (S)

Products Affected

- Simponi Aria

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis)
Required Medical Information	Diagnosis of moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)for at least 3 consecutive months and patient will be on concomitant methotrexate
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient has been tested for TB and latent TB has been ruled out or is being treated. Dosing as per FDA approved labeling.

SIMVASTATIN (S)

Products Affected

- Simvastatin TABS 80MG
- Vytorin TABS 10MG; 80MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active liver disease. Pregnancy. Nursing. Patient is taking or initiating therapy with any of the following: verapamil, diltiazem, amiodarone, dronedarone, amlodipine, ranolazine, strong CYP3A4 inhibitors (i.e., itraconazole, ketoconazole, posaconazole, HIV protease inhibitors, erythromycin, clarithromycin, telithromycin, and nefazodone), gemfibrozil, cyclosporine, and danazol.
Required Medical Information	Patient has been taking simvastatin 80 mg chronically (12 months or more) without evidence of muscle toxicity AND, if patient is of Chinese descent, they are not concurrently receiving lipid-modifying doses (at least 1 gram/day) of niacin-containing products
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

SOMATULINE DEPOT (S)

Products Affected

- Somatuline Depot

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acromegaly AND Inadequate response to surgery and/or radiation therapy or patient cannot be treated with surgery and/or radiotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient's IGF-1 levels has normalized or improved.

SOMAVERT (S)

Products Affected

- Somavert

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acromegaly AND Inadequate response to surgery and/or radiation therapy and/or other medical therapies (such as dopamine agonists and/or somatostatin analogues) or patient is not a candidate for any of those treatment options.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, Patient has experienced a decrease or normalization of insulin-like growth factor-1 (IGF-1) levels.

SOVALDI (S)

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Pregnant. Unwilling to comply with required contraception methods. Men with female partners who are pregnant.
Required Medical Information	Diagnosis of chronic hepatitis C AND A) medication will be used with ribavirin and peginterferon alfa and has genotype 1 or 4 infection, B) medication will be used with ribavirin and patient meets one of the following: a) Genotype 2 or 3 infection, b) Genotype 1 and patient is ineligible for an interferon-based regimen (e.g., labeled contraindication to peginterferon or patient has a concomitant condition that precludes the use of peginterferon) or c) Hepatocellular carcinoma and meets Milan criteria for liver transplant (i.e. a single HCC nodule with a maximum size of 5 cm or as many as 3 nodules with the largest not exceeding 3 cm and no macrovascular invasion) OR C) Medication will be used with simeprevir with or without ribavirin and the patient has genotype 1 infection and patient is treatment-naive and ineligible for an interferon-based regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 wk: G1 triple tx, G2, G4, w/ Olysio. 24 wk: G1 dual tx, G3. 16 wk: G2 non-responder. 48 wk: HCC
Other Criteria	N/A

SPRYCEL (S)

Products Affected

- Sprycel

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. GIST.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) that is newly diagnosed in the chronic phase OR Ph+ CML with resistance of intolerance to prior therapy OR Diagnosis of Ph+ acute lymphoblastic leukemia OR Gastrointestinal stromal tumors (GIST) after disease progression on Gleevec (imatinib) or Sutent (sunitinib)
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

STELARA (S)

Products Affected

- Stelara

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis [TB])
Required Medical Information	Diagnosis of moderate to severe plaque psoriasis (affecting more than 5% of the body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) AND patient tried and had an inadequate response, is intolerant of, or is contraindicated to conventional therapy with at least one of the following: phototherapy (including but not limited to, psoralen with ultraviolet-a [PUVA] and/or retinoids [rePUVA]) for at least one continuous month or oral systemic treatment (e.g., methotrexate, cyclosporine, acitretin) for at least 3 consecutive months AND Patient has been tested for latent TB infection and latent TB has been ruled out or is being treated.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Dosing as per FDA approved labeling.

STIVARGA (S)

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of: A) metastatic colorectal 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 Gleevec or Sutent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Hepatic function will be monitored prior to and during treatment and, if patient has elevated liver function tests of hepatocellular necrosis, therapy will be interrupted and then reduced or discontinued.

SUBOXONE (S)

Products Affected

- Buprenorphine Hcl/naloxone Hcl
- Suboxone SUBLINGUAL FILM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of opioid dependence AND Prescription is a part of an overall treatment program (e.g., self-help groups, counseling, provide ongoing care, vocational training) AND Patient is not receiving any other opioids written by a different prescriber AND Patient is not pregnant.
Age Restrictions	16 years of age or older
Prescriber Restrictions	Prescriber is certified through SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Suboxone and provide registration number
Coverage Duration	Initial - 3 months. Renewal - 9 months
Other Criteria	For renewal, patient meets all initial criteria and prescriber is evaluating random urine drug screens and assessing the patient's progress (e.g., relapse, progress/accomplishment of treatment goals) and patient is not pregnant.

SUBUTEX (S)

Products Affected

- Buprenorphine Hcl SUBLINGUAL SUBL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of opioid dependence AND Prescription is a part of an overall treatment program (e.g., self-help groups, counseling, provide ongoing care, vocational training) AND Patient is not receiving any other opioids written by a different prescriber
Age Restrictions	16 years of age or older
Prescriber Restrictions	Prescriber is certified through SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Suboxone and provide registration number
Coverage Duration	Initial - 3 months (pregnant) or 1 month (not pregnant). Renewal - 9 months
Other Criteria	For renewal, patient meets all initial criteria and prescriber is evaluating random urine drug screens and assessing the patient's progress (e.g., relapse, progress/accomplishment of treatment goals)

SUTENT (S)

Products Affected

- Sutent

PA Criteria	Criteria Details
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 OR Diagnosis of gastrointestinal stromal tumors after disease progression on or intolerance to Gleevec OR Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumors in a patient with unresectable locally advanced or metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

SYLATRON (S)

Products Affected

- Sylatron

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	autoimmune hepatitis. Hepatic decompensation (Child-Pugh score greater than 6 [Class B or C])
Required Medical Information	Patient is being treated adjuvantly for melanoma with microscopic or gross nodal involvement within 84 days of definitive surgical resection including complete lymphadenectomy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

SYNAGIS (S)

Products Affected

- Synagis INJ 50MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient will use palivizumab for immunoprophylaxis of respiratory syncytial virus (RSV) during the peak months of infection in the patient's geographic region AND Patient meets one of the following criteria: A) Infants born at 28 weeks, six days gestation or earlier and who are younger than 12 months of age at the start of the RSV season OR B) Infants born at 29 to 31 weeks, six days gestation and who are younger than six months of age at the start of the RSV season OR C) Infants born at 32 to 34 weeks, six days gestation and who are younger than three months of age at the start of RSV season with at least one of the following risk factors may be dosed until 90 days of age: Child care attendance or Sibling younger than five years of age living in the same household (who is not a multiple birth younger than one year of age) OR D) Infants and children younger than one year of age at the start of RSV season with either congenital abnormalities of the airway or neuromuscular disease that compromises handling of respiratory secretions OR E) Infants and children younger than two years of age with hemodynamically significant congenital heart disease and who have at least one of the following criteria: Receiving medication to control congestive heart failure, Has moderate to severe pulmonary hypertension, or Has cyanotic heart disease OR F) Infants and children younger than two years of age who have received medical therapy (oxygen, bronchodilator, diuretic, or corticosteroid therapy) for chronic lung disease within six months of the start of the RSV season
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months

Other Criteria	Approve 3 doses based on patient body weight in infants born at 32 to 34 weeks, six days gestation and who are younger than three months of age at the start of RSV season with at least one risk factor. Approve 5 doses based on patient body weight for all other indications.

SYNRIBO (S)

Products Affected

- Synribo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of chronic myelogenous leukemia AND patient has tried and failed or has a contraindication or intolerance to 2 tyrosine kinase inhibitors
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TACLONEX (S)

Products Affected

- Taclonex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of stable psoriasis vulgaris (plaque psoriasis) AND Patient tried adequate therapy (at least two weeks) with at least one of the following agents: medium to high potency topical steroid (unless contraindicated/intolerant without concurrent vitamin D analog use) or vitamin D analogs (unless contraindicated/intolerant without concurrent steroid use) or tazarotene (unless contraindicated/intolerant to its use)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, has the patient responded to therapy (e.g., patient's symptoms have improved)

TAFINLAR (S)

Products Affected

- Tafinlar

PA Criteria	Criteria Details
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 and a positive BRAF V600E mutation as detected by an FDA-approved test (THxID-BRAF Kit) or Clinical Laboratory Improvement Amendments (CLIA)-approved facility.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TARCEVA (S)

Products Affected

- Tarceva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer and Tarceva will be used in combination with gemcitabine OR Diagnosis of locally advanced or metastatic (stage III or IV) non-small cell lung cancer with one of the following: A) failure with at least one prior chemotherapy regimen and Tarceva will be used as monotherapy, or B) no evidence of disease progression after four cycles of first-line platinum-based chemotherapy and Tarceva will be used as maintenance treatment and Tarceva will be used as monotherapy, or C) Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility .
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TARGRETIN (S)

Products Affected

- Targretin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cutaneous T-cell lymphoma (CTCL) and patient is not a candidate for or had an inadequate response, is intolerant to, or has a contraindication to at least one prior systemic therapy for cutaneous manifestations of CTCL
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Female patients of child-bearing potential have a documented negative pregnancy test one week prior to the initiation of therapy.

TASIGNA (S)

Products Affected

- Tasigna

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Long QT syndrome. Uncorrected hypokalemia. Uncorrected hypomagnesemia. Concomitant use with a drug known to prolong the QT interval or strong cytochrome P450 3A4 inhibitors
Required Medical Information	Diagnosis of newly diagnosed Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) in the chronic phase OR Diagnosis of Ph+ CML with resistance or intolerance to prior therapy.
Age Restrictions	18 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TAZORAC (S)

Products Affected

- Tazorac

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indication not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy.
Required Medical Information	Diagnosis of acne vulgaris and patient has tried an adequate trial (at least two weeks) with at least one other topical acne product (e.g., benzoyl peroxide, salicylic acid, clindamycin, erythromycin, adapalene, azelaic acid, and/or tretinoin) OR Diagnosis of stable moderate to severe plaque psoriasis and 20% or less body surface area involvement and patient has a contraindication or tried adequate trial (at least 2 weeks) with at least one other topical psoriasis product (e.g., medium to high potency corticosteroid and/or vitamin D analogs) AND females of child-bearing potential are using adequate birth control measures during therapy.
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TECFIDERA (S)

Products Affected

- Tecfidera
- Tecfidera Starter Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting MS or progressive-relapsing MS, or secondary-progresive MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, Patient had an objective response to therapy (ie no or slowed progression of disease)

TESTOSTERONE (S)

Products Affected

- Androderm TRANSDERMAL PT24 2MG/24HR, 4MG/24HR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Carcinoma of the breast. Known or suspected carcinoma of the prostate.
Required Medical Information	Diagnosis of hypogonadism (primary or hypogonadotropic) AND patient is male AND patient's serum testosterone (total or free) value and the laboratory reference value range reported by laboratory service AND diagnosis has been confirmed by a low-for-age serum testosterone (total or free) level defined by the normal laboratory reference value
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TOPICAL RETINOIDS (S)

Products Affected

- Avita
- Retin-a Micro
- Tretinoin EXTERNAL CREA
- Tretinoin EXTERNAL GEL
- Tretinoin Microsphere
- Tretinoin Microsphere Pump GEL 0.1%
- Tretin-x CREA 0.075%
- Tretin-x EXTERNAL KIT 0; 0; 0; 0; 0; 0.025%, 0; 0; 0; 0; 0; 0.05%, 0; 0; 0; 0; 0; 0.1%
- Ziana

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mild to moderate acne vulgaris (including comedonal, cystic, and nodular).
Age Restrictions	PA applies to patients older than 26 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, medication has been effective in treating the patient's condition.

TRACLEER (S)

Products Affected

- Tracleer

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Receiving concomitant cyclosporine A or glyburide therapy. Aminotransferase elevations are accompanied by signs or symptoms of liver dysfunction or injury or increases in bilirubin at least 2 times the upper limit of normal.
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 AND Patient has New York Heart Association (NYHA) Functional Class II-IV AND pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with two forms of reliable contraception in female patients of reproductive potential.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	Liver aminotransferases will be measured prior to initiation of treatment and then monthly.

TRELSTAR (S)

Products Affected

- Trelstar Depot Mixject
- Trelstar La Mixject
- Trelstar Mixject

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of advanced or metastatic prostate cancer
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TYKERB (S)

Products Affected

- Tykerb

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of breast cancer with tumors that overexpress human epidermal growth factor receptor 2 (HER2) AND a) the medication will be used in combination with Xeloda in a patient with advanced or metastatic disease and the patient has received prior therapy including an anthracycline, a taxane, and trastuzumab or b) The medication will be used in combination with Femara for the treatment of a postmenopausal woman with hormone receptor-positive metastatic disease for whom hormonal therapy is indicated.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TYSABRI (S)

Products Affected

- Tysabri

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of progressive multifocal leukoencephalopathy.
Required Medical Information	Diagnosis of relapsing form of multiple sclerosis and medication will be used as monotherapy and patient had an inadequate response, intolerance, or contraindication to conventional therapy with one of the following: An interferon beta product, Copaxone, Gilenya OR Diagnosis of moderate to severe active Crohn's disease and medication will not be used in combination with immunosuppressants or inhibitors of tumor necrosis factor-alfa and patient had an inadequate response, intolerance, or contraindication to any of the following: Humira, Remicade, or Cimzia.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient and physician are registered in the TOUCH prescribing program.

TYVASO (S)

Products Affected

- Tyvaso
- Tyvaso Refill
- Tyvaso Starter

PA Criteria	Criteria Details
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 o f 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 AND Patient has New York Heart Association (NYHA) Functional Class III.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

TYZEKA (S)

Products Affected

- Tyzeka

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Co-administration with pegylated interferon alfa-2a
Required Medical Information	Diagnosis of chronic hepatitis B AND patient has evidence of viral replication AND Patient has evidence of persistent elevations in serum aminotransferase (ALT or AST) or histologically active disease AND In hepatitis B e antigen (HBeAg)-positive patients, the patient has hepatitis B virus (HBV) deoxyribonucleic acid (DNA) less than 9 log10 copies/mL and ALT greater than or equal to two times the upper limit of normal OR in HBeAg-negative patients, the patient has HBV DNA less than 7 log10 copies/mL
Age Restrictions	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, patient must be HBeAg negative OR HBeAg positive, but has not seroconverted OR HBeAg positive and seroconverted to anti-Hbe with detectable HBV DNA levels OR HbeAg positive and seroconverted to anti-Hbe with undetectable levels of HBV DNA levels for less than 12 months

VALCHLOR (S)

Products Affected

- Valchlor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Absolute Contraindication
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

VELETRI (S)

Products Affected

- Veletri INJ 1.5MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	• Patient has a diagnosis of PAH (WHO Group I) WHO/NYHA Class IV patients OR • Patient has a diagnosis of PAH (WHO Group I) WHO/NYHA Class II-III patients who do not respond adequately to, are unable to tolerate, or are not candidates for endothelin receptor antagonists (e.g. TRACLEER [bosentan] or LETAIRIS [ambrisentan]) and phosphodiesterase-5 (PDE-5) inhibitors (e.g. REVATIO [sildenafil], ADCIRCA [tadalafil]).
Age Restrictions	N/A
Prescriber Restrictions	Prescription is written by a pulmonologist or cardiologist or documentation of consultation with pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	N/A

VENTAVIS (S)

Products Affected

- Ventavis

PA Criteria	Criteria Details
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 o f 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 AND Patient has New York Heart Association (NYHA) Functional Class III or IV.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

VICTRELIS(S)

Products Affected

- Victrelis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnant. Unwilling to comply with required contraception methods. Co-administration with alfuzosin, carbamazepine, cisapride, dihydroergotamine, drosperinone, ergonovine, ergotamine, lovastatin, methylergonovine, midazolam (oral), phenobarbital, phenytoin, pimozide, rifampin, sildenafil (Revatio), simvastatin, St. John's wort, tadalafil (Adcirca), triazolam.
Required Medical Information	Diagnosis of chronic hepatitis C genotype 1 with compensated liver disease AND medication will be used with ribavirin and peginterferon alfa AND Has not previously failed a treatment regimen with a hepatitis C protease inhibitor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial - 12 weeks. Renewal - duration based on FDA approved labeling
Other Criteria	For renewal, approval is based on the requirements outlined in the FDA-approved labeling, including viral load, presence of cirrhosis , and response to prior therapy and confirm that the patient is continuing to receive concurrent therapy with ribavirin and peginterferon alfa.

VOTRIENT (S)

Products Affected

- Votrient

PA Criteria	Criteria Details
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 OR Diagnosis of advanced soft tissue sarcoma and patient received at least one prior chemotherapy (e.g., doxorubicin, dacarbazine, ifosfamide, epirubicin, gemicitabine, docetaxel, or vinorelbine).
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

VPRIV (S)

Products Affected

- Vpriv

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of type 1 Gaucher disease
Age Restrictions	4 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

XALKORI (S)

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of locally advanced or metastatic (stage III or IV) non-small cell lung cancer AND patient has non-squamous cell histology AND Patient has alkaline phosphatase (ALK)-positive disease as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

XENAZINE (S)

Products Affected

- Xenazine

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Actively suicidal. Untreated or inadequately treated depression. Impaired hepatic function. Concomitant use of monoamine oxidase inhibitors. Concomitant use of reserpine or within 20 days of discontinuing reserpine.
Required Medical Information	Diagnosis of chorea associated with Huntington's disease AND any medication possibly contributing to the underlying symptoms of chorea has been discontinued (e.g., antipsychotics, metoclopramide, amphetamines, methylphenidate, dopamine agonists, etc.) unless cessation would be detrimental to the underlying condition AND patient has been genotypes to CYP2D6 to determine whether the patient is a poor, intermediate or extensive metabolizer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Dosing will be approved per the FDA labeling based on CYP2D6 testing.

XEOMIN (S)

Products Affected

- Xeomin INJ 50UNIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Hypersensitivity to human albumin or sucrose. Presence of infection at the proposed injection site(s).
Required Medical Information	Diagnosis of blepharospasm OR cervical dystonia (spasmodic torticollis)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

XGEVA (BCBS RI)

Products Affected

- Xgeva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Hypocalcemia (calcium less than 8.0 mg/dL).
Required Medical Information	Diagnosis of a solid tumor (e.g., breast cancer, castrate-resistant prostate cancer, thyroid carcinoma, kidney, or non-small cell lung cancer) and patient has bone metastases and Medication will be used for the prevention of skeletal-related events (e.g., spinal cord compression, hypercalcemia, bone pain or lesions requiring radiation or surgery) OR Patient has a diagnosis of giant cell tumor of bone and Tumor is unresectable or surgical resection is likely to result in severe morbidity AND patient will receive supplementation with calcium and vitamin D.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

XOLAIR (S)

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of moderate to severe persistent allergic asthma AND Evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. radioallergosorbent test) for a specific IgE or in vitro reactivity to a perennial aeroallergen AND Pretreatment serum IgE levels greater than 30 and less than 700 IU/mL AND Symptoms are not adequately controlled with high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) for at least 3 months
Age Restrictions	12 years of age or older
Prescriber Restrictions	Asthma specialist (i.e., allergist, immunologist, or pulmonologist)
Coverage Duration	6 months
Other Criteria	For renewal, patient has experienced an objective response to therapy, defined as one or more of the following: Reduction in number of asthma exacerbations from baseline (i.e. asthma exacerbation requiring treatment with systemic corticosteroids or doubling of ICS dose from baseline), Improvement in forced expiratory volume in 1 second (FEV1) from baseline, Decreased use of rescue medications from baseline.

XTANDI (S)

Products Affected

- Xtandi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic castration-resistant prostate cancer AND patient is male AND patient had prior chemotherapy that included docetaxel AND the patient has tried and had an inadequate response, contraindication or intolerance to Zytiga.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

XYREM (S)

Products Affected

- Xyrem

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant treatment with sedative hypnotic agents. Succinic semialdehyde dehydrogenase deficiency.
Required Medical Information	Diagnosis of narcolepsy with excessive daytime sleepiness, cataplexy or both and for patients with excessive daytime sleepiness, patient has had a previous trial with or has a contraindication, intolerance, or allergy to Provigil or Nuvigil.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For renewal, the patient had a positive response to the medication (increased sleep quality for patients with narcolepsy)

ZALTRAP (S)

Products Affected

- Zaltrap INJ 100MG/4ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	severe hemorrhage, development of gastrointestinal perforation, compromised wound healing
Required Medical Information	Diagnosis of metastatic colorectal cancer AND will be used in combination with 5-fluorouracil, leucovorin, and irinotecan (FOLFIRI) AND disease is resistant to or has progressed following an oxaliplatin-containing regimen
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient will be monitored for signs and symptoms of gastrointestinal bleeding and other severe bleeding. Therapy will be suspended for at least 4 weeks prior to elective surgery and not resumed for at least 4 weeks following major surgery and until the wound is fully healed.

ZAVESCA (S)

Products Affected

- Zavesca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	pregnancy
Required Medical Information	Diagnosis of mild to moderate type 1 Gaucher disease and patient is not a candidate for enzyme replacement therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patients have been advised of the risk of fetal harm and the need for contraception.

ZELBORAF (S)

Products Affected

- Zelboraf

PA Criteria	Criteria Details
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 and patient has positive BRAF-V600E mutation documented by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ZOLINZA (S)

Products Affected

- Zolinza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of cutaneous T-cell lymphoma AND progressive, persistent or recurrent disease on or following 2 systemic therapies (e.g., bexarotene, romidepsin) or patient is not a candidate for other systemic therapies AND patient does not have severe hepatic impairment.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

ZOMETA (S)

Products Affected

- Zoledronic Acid INJ 4MG/5ML
- Zometa INJ 4MG/100ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Current treatment with Reclast.
Required Medical Information	Diagnosis of hypercalcemia of malignancy and has a corrected calcium greater than or equal to 12 mg/dL OR Diagnosis of multiple myeloma and associated bone disease (e.g., osteolytic bone lesions, bone metastases, osteopenia, etc.) OR Diagnosis of a solid tumor (e.g., breast cancer, prostate cancer that has progressed after at least one hormonal therapy (i.e. antiandrogen [bicalutamide, flutamide, nilutamide], LHRH agonist [leuprolide, goserelin], LHRH antagonists [degarelix]), kidney cancer, non-small cell lung cancer, or thyroid cancer) and patient has bone metastases and medication will be used in conjunction with standard antineoplastic therapy and medication is used for the prevention of skeletal-related events (e.g. spinal cord compression, hypercalcemia, bone pain or lesions requiring radiation or surgery) AND Patient will be supplemented with calcium and vitamin D AND Patient has tried and had an inadequate response or has a contraindication/intolerance to pamidronate
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ZORBTIVE (S)

Products Affected

- Zorbtive

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	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.
Required Medical Information	Diagnosis of short bowel syndrome AND patient is receiving specialized nutritional support (i.e. parenteral nutrition)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 weeks
Other Criteria	N/A

ZYTIGA (S)

Products Affected

- Zytiga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic prostate cancer AND Patient has castration-resistant disease (defined by tumor growth/disease progression, rise in PsA levels, new metastases) AND Zytiga will be used in combination with prednisone
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- Abraxane
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium
- Adriamycin INJ 2MG/ML
- Albuterol Sulfate INHALATION NEBU
- Alimta INJ 500MG
- Aloxi
- Amifostine
- Aminophylline INJ
- Aminosyn INJ 148MEQ/L; 1280MG/100ML; 980MG/100ML; 1280MG/100ML; 300MG/100ML; 720MG/100ML; 940MG/100ML; 720MG/100ML; 400MG/100ML; 440MG/100ML; 5.4MEQ/L; 860MG/100ML; 420MG/100ML; 520MG/100ML; 160MG/100ML; 44MG/100ML; 800MG/100ML, 50.3MEQ/L; 695MG/100ML; 713MG/100ML; 490MG/100ML; 517MG/100ML; 350MG/100ML; 210MG/100ML; 462MG/100ML; 700MG/100ML; 735MG/100ML; 120MG/100ML; 209MG/100ML; 505MG/100ML; 371MG/100ML; 31.3MEQ/L; 280MG/100ML; 140MG/100ML; 189MG/100ML; 350MG/100ML, 51MEQ/L; 448MG/100ML; 343MG/100ML; 448MG/100ML; 105MG/100ML; 252MG/100ML; 329MG/100ML; 252MG/100ML; 140MG/100ML; 154MG/100ML; 300MG/100ML; 147MG/100ML; 182MG/100ML; 56MG/100ML; 31MG/100ML; 280MG/100ML, 90MEQ/L; 1100MG/100ML; 850MG/100ML; 35MEQ/L; 1100MG/100ML; 260MG/100ML; 620MG/100ML; 810MG/100ML; 624MG/100ML; 340MG/100ML; 380MG/100ML; 5.4MEQ/L; 750MG/100ML; 370MG/100ML; 460MG/100ML; 150MG/100ML; 44MG/100ML; 680MG/100ML

- Aminosyn II INJ 50.3MEQ/L; 695MG/100ML; 713MG/100ML; 490MG/100ML; 517MG/100ML; 350MG/100ML; 210MG/100ML; 462MG/100ML; 700MG/100ML; 735MG/100ML; 120MG/100ML; 209MG/100ML; 505MG/100ML; 371MG/100ML; 31.3MEQ/L; 280MG/100ML; 140MG/100ML; 189MG/100ML; 350MG/100ML, 61.1MEQ/L; 844MG/100ML; 865MG/100ML; 595MG/100ML; 627MG/100ML; 425MG/100ML; 255MG/100ML; 561MG/100ML; 850MG/100ML; 893MG/100ML; 146MG/100ML; 253MG/100ML; 614MG/100ML; 450MG/100ML; 33.3MEQ/L; 340MG/100ML; 170MG/100ML; 230MG/100ML; 425MG/100ML, 71.8MEQ/L; 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 45.3MEQ/L; 400MG/100ML; 200MG/100ML; 270MG/100ML; 500MG/100ML
- Aminosyn II 4.25/dextrose25% INJ 30.6MEQ/L; 422MG/100ML; 432MG/100ML; 298MG/100ML; 25%; 314MG/100ML; 212MG/100ML; 128MG/100ML; 280MG/100ML; 425MG/100ML; 446MG/100ML; 73MG/100ML; 126MG/100ML; 307MG/100ML; 225MG/100ML; 19MEQ/L; 170MG/100ML; 85MG/100ML; 115MG/100ML; 212MG/100ML
- Aminosyn II 8.5%/electrolytes
- Aminosyn-hbc
- Aminosyn-hf
- Aminosyn-pf
- Aminosyn-pf 7%
- Amiodarone Hcl INJ 50MG/ML
- Amphotericin B INJ
- Ampicillin Sodium INJ 10GM, 125MG, 1GM
- Ampicillin-sulbactam
- Anzemet ORAL TABS
- Aralast Np INJ 400MG
- Arranon
- Arzerra INJ 100MG/5ML
- Astagraf XL
- Atgam
- Avastin INJ 100MG/4ML
- Avelox INJ
- Azacitidine
- Azactam In Iso-osmotic Dextrose
- Azasan
- Azathioprine TABS
- Azathioprine Sodium
- Azithromycin INJ 500MG
- Bicnu
- Bleomycin Sulfate INJ 30UNIT
- Brovana
- Budesonide INHALATION SUSP
- Busulfex
- Calcitriol INJ 1MCG/ML
- Calcitriol ORAL CAPS
- Calcitriol ORAL SOLN
- Carboplatin INJ 150MG/15ML
- Cefazolin Sodium INJ 10GM, 1GM, 1GM; 5%, 500MG
- Cefotaxime Sodium INJ 10GM, 500MG
- Cefoxitin Sodium INJ 10GM, 1GM, 2GM
- Ceftazidime INJ 1GM, 2GM, 6GM
- Ceftriaxone Sodium INJ
- Cefuroxime Sodium INJ 1.5GM, 7.5GM, 750MG
- Cefuroxime/dextrose
- Cellcept
- Cellcept Intravenous
- Chlorothiazide Sodium
- Cidofovir
- Ciprofloxacin INJ 400MG/40ML
- Ciprofloxacin I.v.-in D5w

- Cisplatin INJ 100MG/100ML
- Cladribine
- Clindamycin Phosphate Add-vantage
- Clindamycin Phosphate In D5w
- Clinimix 2.75%/dextrose 5%
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 20%
- Clinimix 4.25%/dextrose 25%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 5%/dextrose 25%
- Clinisol Sf 15%
- Clolar
- Colistimethate Sodium INJ
- Cosmegen
- Coumadin INJ
- Cromolyn Sodium NEBU
- Cubicin
- Cyclophosphamide ORAL TABS
- Cyclosporine INJ
- Cyclosporine ORAL CAPS
- Cyclosporine Modified
- Cytarabine INJ 500MG
- Cytarabine Aqueous
- Dacarbazine INJ 200MG
- Dacogen
- Dactinomycin
- Daunorubicin Hcl INJ 5MG/ML
- Decitabine
- Dexrazoxane INJ 500MG
- Dextrose 10% Flex Container
- Dextrose 10%/nacl 0.2%
- Dextrose 10%/nacl 0.45%
- Dextrose 2.5%/sodium Chloride 0.45%
- Dextrose 5%
- Dextrose 5% /electrolyte #48 Viaflex
- Dextrose 5%/nacl 0.2%
- Dextrose 5%/nacl 0.225%
- Dextrose 5%/nacl 0.33%
- Dextrose 5%/nacl 0.45%
- Dextrose 5%/nacl 0.9%
- Dextrose 5%/potassium Chloride 0.15%
- Diltiazem Hcl INJ 100MG, 50MG/10ML
- Docefrez
- Docetaxel INJ 140MG/7ML, 80MG/4ML, 80MG/8ML
- Doxercalciferol ORAL CAPS
- Doxil
- Doxorubicin Hcl INJ 2MG/ML
- Doxycycline Hyclate INJ
- Duramorph
- Elitek INJ 1.5MG
- Ellence INJ 200MG/100ML
- Emend ORAL CAPS
- Engerix-b
- Epirubicin Hcl INJ 50MG/25ML
- Eraxis INJ 100MG
- Erbitux INJ 100MG/50ML
- Erythrocin Lactobionate INJ 500MG
- Esomeprazole Sodium
- Etopophos
- Etoposide INJ 500MG/25ML
- Famotidine INJ
- Famotidine Premixed
- Fluconazole In Dextrose INJ 56MG/ML; 400MG/200ML
- Fludarabine Phosphate INJ 50MG
- Fluorouracil INJ 2.5GM/50ML
- Fortaz INJ 1GM, 1GM/50ML; 5%, 2GM/50ML; 5%
- Foscarnet Sodium
- Freamine Hbc 6.9%
- Ganciclovir INJ
- Gemcitabine Hcl INJ 1GM
- Gengraf
- Gentamicin Sulfate INJ
- Gentamicin Sulfate/0.9% Sodium Chloride INJ 0.9MG/ML; 0.9%, 1.4MG/ML; 0.9%, 1.6MG/ML; 0.9%, 1MG/ML; 0.9%
- Granisetron Hcl INJ 0.1MG/ML, 1MG/ML
- Granisetron Hcl TABS

- Halaven
- Hecoria
- Hectorol
- Heparin Sodium INJ 10000UNIT/ML, 1000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 2500UNIT/ML, 5000UNIT/ML
- Heparin Sodium/d5w
- Hepatamine
- Hepatasol
- Herceptin
- Idarubicin Hcl INJ 10MG/10ML
- Ifex INJ 3GM
- Ifosfamide INJ 1GM
- Ifosfamide/mesna INJ 1GM; 1GM
- Imipenem/cilastatin
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 2.25%; 20%
- Ionosol-b/dextrose 5%
- Ionosol-mb/dextrose 5%
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Irinotecan INJ 100MG/5ML
- Isolyte-p/dextrose 5%
- Isolyte-s
- Isotonic Gentamicin INJ 0.8MG/ML; 0.9%, 1.2MG/ML; 0.9%
- Istodax
- Ixempra Kit INJ 45MG
- Jevtana
- Kcl 0.075%/d5w/nacl 0.45%
- Kcl 0.15%/d5w/lr
- Kcl 0.15%/d5w/nacl 0.2%
- Kcl 0.15%/d5w/nacl 0.225%
- Kcl 0.15%/d5w/nacl 0.9%
- Kcl 0.3%/d5w/nacl 0.45%
- Kcl 0.3%/d5w/nacl 0.9%
- Kepivance
- Keppra INJ
- Labetalol Hcl INJ
- Lactated Ringers Viaflex
- Levalbuterol NEBU
- Levalbuterol Hcl INHALATION NEBU
- Levaquin INJ 5%; 750MG/150ML
- Levetiracetam INJ 500MG/5ML
- Levocarnitine INJ
- Levocarnitine ORAL SOLN
- Levocarnitine TABS
- Levofloxacin INJ
- Levofloxacin In D5w INJ 5%; 500MG/100ML
- Liothyronine Sodium INJ
- Lipodox
- Lipodox 50
- Liposyn III INJ 2.5%; 10%, 2.5%; 30%
- Magnesium Sulfate In D5w INJ 5%; 10MG/ML
- Melphalan Hydrochloride
- Meropenem INJ 500MG
- Mesna
- Methotrexate TABS
- Metoprolol Tartrate INJ
- Metronidazole In Nacl 0.79%
- Mitomycin INJ 20MG
- Mitoxantrone Hcl
- Morphine Sulfate INJ 0.5MG/ML, 1MG/ML
- Mustargen
- Mycophenolate Mofetil
- Mycophenolic Acid Dr
- Myfortic
- Nafcillin Sodium INJ 10GM, 1GM
- Nallpen/dextrose INJ 0; 1GM/50ML
- Nebupent
- Neoral
- Nephramine
- Neutrexin
- Nexium I.v.
- Nitroglycerin INJ
- Normosol-r
- Normosol-r In D5w
- Nulojix
- Ondansetron Hcl INJ 4MG/2ML
- Ondansetron Hcl ORAL SOLN

- Ondansetron Hcl ORAL TABS
- Ondansetron Odt
- Oxaliplatin INJ 100MG/20ML
- Paclitaxel INJ 300MG/50ML
- Pantoprazole Sodium INJ
- Paricalcitol
- Penicillin G Potassium In Iso-osmotic Dextrose INJ 0; 40000UNIT/ML, 0; 60000UNIT/ML
- Pentostatin
- Perforomist
- Piperacillin Sodium/tazobactam Sodium INJ 3GM; 0.375GM, 4GM; 0.5GM
- Plasma-lyte A
- Plasma-lyte-148
- Plasma-lyte-56/d5w
- Potassium Chloride INJ 10MEQ/100ML, 20MEQ/100ML, 2MEQ/ML, 30MEQ/100ML, 40MEQ/100ML
- Potassium Chloride 0.15% /nacl 0.45% Viaflex
- Potassium Chloride 0.15% D5w/nacl 0.33%
- Potassium Chloride 0.15% D5w/nacl 0.45% Viaflex
- Potassium Chloride 0.15% Nacl 0.9%
- Potassium Chloride 0.22% D5w/nacl 0.45%
- Potassium Chloride 0.3%/ Nacl 0.9%
- Potassium Chloride 0.3%/d5w
- Premasol
- Prograf
- Prolastin-c
- Proleukin
- Propranolol Hcl INJ
- Pulmicort SUSP 1MG/2ML
- Rabavert
- Rapamune
- Recombivax Hb INJ 10MCG/ML, 40MCG/ML
- Rifampin INJ
- Ringers Injection
- Rituxan
- Sandimmune SOLN
- Simulect INJ 20MG
- Sirolimus TABS
- Sodium Chloride INJ 0.9%, 2.5MEQ/ML, 3%, 5%
- Sodium Chloride 0.45% Viaflex
- Sodium Edecrin
- Sulfamethoxazole/trimethoprim INJ
- Tacrolimus ORAL CAPS
- Taxotere INJ 80MG/2ML, 80MG/4ML
- Tazicef INJ 1GM, 2GM, 6GM
- Teflaro
- Tetanus Toxoid Adsorbed
- Thiotepa INJ
- Thymoglobulin
- Tobramycin Sulfate INJ 10MG/ML, 80MG/2ML
- Tobramycin Sulfate/sodium Chloride INJ 0.9%; 0.8MG/ML
- Toposar INJ 1GM/50ML
- Topotecan Hcl INJ 4MG
- Torisel
- Torsemide INJ 20MG/2ML
- Tranexamic Acid INJ
- Travasol
- Treanda INJ 100MG
- Trexall
- Trisenox
- Trophamine INJ 97MEQ/L; 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML
- Twinrix
- Tygacil
- Valproate Sodium INJ

- Vancomycin Hcl INJ 1000MG, 10GM, 500MG
- Vectibix INJ 100MG/5ML
- Velcade
- Verapamil Hcl INJ
- Vibativ INJ 250MG
- Vidaza
- Vimpat INJ
- Vinblastine Sulfate INJ 10MG
- Vincasar Pfs
- Vincristine Sulfate INJ
- Vinorelbine Tartrate INJ 50MG/5ML
- Virazole
- Voriconazole INJ
- Zanosar
- Zemplar
- Zinecard INJ 250MG
- Zortress
- Zosyn INJ 5%; 2GM/50ML; 0.25GM/50ML, 5%; 3GM/50ML; 0.375GM/50ML
- Zyvox INJ

Details

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

INDEX

A

Abraxane 195
Abstral 47
Acetylcysteine 195
Actemra 1
Actemra (bcbs Ri) 1
Acthar Hp 61
Actiq (s) 2
Acyclovir Sodium 195
Adagen 3
Adagen (s) 3
Adapalene 34
Adcirca 4
Adcirca (s) 4
Adefovir Dipivoxil 62
Adempas 5
Adempas (s) 5
Adriamycin 195
Afinitor 6
Afinitor (s) 6
Afinitor Disperz 7
Afinitor Disperz (s) 7
Albuterol Sulfate 195
Aldurazyme 8
Aldurazyme (s) 8
Alimta 195
Alora 72
Aloxi 195
Alprazolam 17
Alprazolam Er 17
Alprazolam Intensol 17
Alprazolam Odt 17
Alprazolam Xr 17
Amifostine 195
Aminophylline 195
Aminosyn 195
Aminosyn II 196
Aminosyn II 4.25/dextrose25% 196
Aminosyn II 8.5%/electrolytes 196
Aminosyn-hbc 196
Aminosyn-hf 196
Aminosyn-pf 196
Aminosyn-pf 7% 196
Amiodarone Hcl 196
Amitriptyline Hcl 65
Amphotericin B 196
Ampicillin Sodium 196
Ampicillin-sulbactam 196
Ampyra 9
Ampyra (s) 9
Amrix 75
Anadrol-50 10
Anadrol-50 (s) 10
Androderm 167
Anzemet 196
Aralast Np 196
Aranesp (s) 11
Aranesp Albumin Free 11
Arcalyst 13
Arcalyst (s) 13
Arranon 196
Arzerra 196
Astagraf XL 196
Atgam 196
Aubagio 14
Aubagio (s) 14
Avastin 196
Avelox 196
Avita 168
Avonex 15
Avonex (s) 15
Azacitidine 196
Azactam In Iso-osmotic Dextrose 196
Azasan 196
Azathioprine 196

Azathioprine Sodium..... 196
Azithromycin..... 196

B

Baraclude..... 16
Baraclude (s)..... 16
Benzodiazepines (s)..... 17
Benztropine Mesylate..... 69
Betaseron..... 18
Betaseron (s)..... 18
Bethkis..... 19
Bethkis (s)..... 19
Bicnu..... 196
Bleomycin Sulfate..... 196
Boniva..... 20
Boniva IV (bcbs Ri)..... 20
Bosulif..... 21
Bosulif (s)..... 21
Botox..... 22
Botox (s)..... 22
Brovana..... 196
Budesonide..... 196
Buprenorphine Hcl..... 154
Buprenorphine Hcl/naloxone Hcl..... 153
Busulfex..... 196
Butrans..... 23
Butrans (s)..... 23

C

Calcitriol..... 196
Caprelsa..... 24
Caprelsa (s)..... 24
Carbinoxamine Maleate..... 67
Carboplatin..... 196
Carimune Nanofiltered..... 88
Carisoprodol..... 75
Carisoprodol/aspirin..... 75
Carisoprodol/aspirin/codeine..... 75
Cayston..... 25
Cayston (s)..... 25
Cefazolin Sodium..... 196
Cefotaxime Sodium..... 196
Cefoxitin Sodium..... 196
Ceftazidime..... 196
Ceftriaxone Sodium..... 196
Cefuroxime Sodium..... 196
Cefuroxime/dextrose..... 196
Celebrex..... 26
Celebrex (s)..... 26
Cellcept..... 196
Cellcept Intravenous..... 196
Cenestin..... 72
Cerezyme..... 27
Cerezyme (s)..... 27
Chlordiazepoxide Hcl..... 17
Chlordiazepoxide/amitriptyline..... 65
Chlorothiazide Sodium..... 196
Chlorpropamide..... 76
Chlorzoxazone..... 75
Cialis..... 28
Cialis 2.5 Mg, 5 Mg (s)..... 28
Cidofovir..... 196
Cimzia..... 29
Cimzia (s)..... 29
Ciprofloxacin..... 196
Ciprofloxacin I.v.-in D5w..... 196
Cisplatin..... 197
Cladribine..... 197
Clemastine Fumarate..... 67
Climara Pro..... 72
Clindamycin Phosphate Add-vantage..... 197
Clindamycin Phosphate In D5w..... 197
Clinimix 2.75%/dextrose 5%..... 197
Clinimix 4.25%/dextrose 10%..... 197
Clinimix 4.25%/dextrose 20%..... 197
Clinimix 4.25%/dextrose 25%..... 197
Clinimix 4.25%/dextrose 5%..... 197
Clinimix 5%/dextrose 15%..... 197
Clinimix 5%/dextrose 20%..... 197
Clinimix 5%/dextrose 25%..... 197
Clinisol Sf 15%..... 197
Clolar..... 197
Clomipramine Hcl..... 65
Clonazepam..... 17
Clonazepam Odt..... 17
Clorazepate Dipotassium..... 17
Colistimethate Sodium..... 197
Combipatch..... 72
Cometriq..... 30

Cometriq (s) 30
Copaxone 31
Copaxone (s) 31
Cosmegen 197
Coumadin 197
Cromolyn Sodium 197
Cubicin 197
Cyclobenzaprine Hcl 75
Cyclophosphamide 197
Cyclosporine 197
Cyclosporine Modified 197
Cyproheptadine Hcl 67
Cystaran 32
Cystaran (s) 32
Cytarabine 197
Cytarabine Aqueous 197

D

Dacarbazine 197
Dacogen 197
Dactinomycin 197
Daliresp 33
Daliresp (s) 33
Daunorubicin Hcl 197
Decitabine 197
Delestrogen 72
Dexrazoxane 197
Dextrose 10% Flex Container 197
Dextrose 10%/nacl 0.2% 197
Dextrose 10%/nacl 0.45% 197
Dextrose 2.5%/sodium Chloride 0.45% 197
Dextrose 5% 197
Dextrose 5% /electrolyte #48 Viaflex 197
Dextrose 5%/nacl 0.2% 197
Dextrose 5%/nacl 0.225% 197
Dextrose 5%/nacl 0.33% 197
Dextrose 5%/nacl 0.45% 197
Dextrose 5%/nacl 0.9% 197
Dextrose 5%/potassium Chloride 0.15% 197
Diazepam 17
Diazepam Intensol 17
Differin 34
Differin (s) 34
Diltiazem Hcl 197
Diphenhydramine Hcl 66
Dipyridamole 77
Divigel 72
Docefrez 197
Docetaxel 197
Doxepin Hcl 65
Doxercalciferol 197
Doxil 197
Doxorubicin Hcl 197
Doxycycline Hyclate 197
Dronabinol 104
Duramorph 197

E

Egrifta 35
Egrifta (s) 35
Elelyso 36
Elelyso (s) 36
Eligard 37
Eligard (s) 37
Elitek 197
Ellence 197
Emend 197
Emsam 38
Emsam (s) 38
Enbrel 39
Enbrel (s) 39
Enbrel Sureclick 39
Engerix-b 197
Enjuvia 72
Epiduo 40
Epiduo (s) 40
Epirubicin Hcl 197
Epoetin Alfa (s) 41
Epogen 41
Epoprostenol Sodium 51
Eraxis 197
Erbitux 197
Erivedge 43
Erivedge (s) 43
Erwinaze 44
Erwinaze (s) 44
Erythrocin Lactobionate 197
Esomeprazole Sodium 197
Estazolam 17
Estradiol 72

Estradiol Valerate 72
Estradiol/norethindrone Acetate 72
Estropipate 72
Etopophos 197
Etoposide 197
Exalgo 45
Exalgo (s) 45

F

Fabrazyme 46
Fabrazyme (s) 46
Famotidine 197
Famotidine Premixed 197
Fentanyl (s) 47
Fentanyl Citrate Oral Transmucosal 2
Fentora 47
Ferriprox 48
Ferriprox (s) 48
Firmagon 49
Firmagon (s) 49
Flector 50
Flector (s) 50
Flolan (s) 51
Fluconazole In Dextrose 197
Fludarabine Phosphate 197
Fluorouracil 197
Flurazepam Hcl 17
Fortaz 197
Forteo 52
Forteo (s) 52
Foscarnet Sodium 197
Freamine Hbc 6.9% 197

G

Gammagard Liquid 88
Gamunex-c 88
Ganciclovir 197
Gattex 53
Gattex (s) 53
Gazyva 54
Gazyva (s) 54
Gemcitabine Hcl 197
Gengraf 197
Genotropin 59
Genotropin Miniquick 59
Gentamicin Sulfate 197
Gentamicin Sulfate/0.9% Sodium Chloride 197
Gilenya 55
Gilenya (s) 55
Gilotrif 56
Gilotrif (s) 56
Gleevec 57
Gleevec (s) 57
Glyburide 76
Glyburide Micronized 76
Glyburide/metformin Hcl 76
Gralise 58
Gralise (s) 58
Granisetron Hcl 197
Growth Hormone (s) 59
Guanfacine Hcl 68

H

H.p. Acthar Gel (bcbs Ri) 61
Halaven 198
Hecoria 198
Hectorol 198
Heparin Sodium 198
Heparin Sodium/d5w 198
Hepatamine 198
Hepatasol 198
Hepsera 62
Hepsera (s) 62
Herceptin 198
Hizentra 88
Horizant 63
Horizant (s) 63
Hrm - Analgesics 64
Hrm - Antidepressants 65
Hrm - Antiemetic Drugs 66
Hrm - Antihistamines 67
Hrm - Antihypertensive Agents 68
Hrm - Antiparkinson Agents 69
Hrm - Anxiolytics 70
Hrm - Calcium Channel Blockers, Dihydropyridine 71
Hrm - Oral And Transdermal Estrogens And Progestins 72
Hrm - Platelet Inhibitors 73
Hrm - Sedative Hypnotic Agents 74

Hrm - Skeletal Muscle Relaxants 75
Hrm - Sulfonylureas 76
Hrm - Vasodilators 77
Humatrope 59
Humatrope Combo Pack 59
Humira 78
Humira (s) 78
Humira Pen-crohns Diseasestarter 78
Hydroxyzine Hcl 66
Hydroxyzine Pamoate 66

I

Ibandronate Sodium 20
Iclusig 80
Iclusig (s) 80
Idarubicin Hcl 198
Ifex 198
Ifosfamide 198
Ifosfamide/mesna 198
Ilaris 81
Ilaris (s) 81
Imbruvica 82
Imbruvica (s) 82
Imipenem/cilastatin 198
Imipramine Hcl 65
Imipramine Pamoate 65
Imovax Rabies (h.d.c.v.) 198
Incivek 83
Incivek (s) 83
Increlex 84
Increlex (s) 84
Infergen 85
Infergen (s) 85
Inhaled Tobramycin (s) 86
Inlyta 87
Inlyta (s) 87
Intralipid 198
Ionosol-b/dextrose 5% 198
Ionosol-mb/dextrose 5% 198
Ipratropium Bromide 198
Ipratropium Bromide/albuterol Sulfate 198
Irinotecan 198
Isolyte-p/dextrose 5% 198
Isolyte-s 198
Isotonic Gentamicin 198
Istodax 198
Ivig (s) 88
Ixempra Kit 198

J

Jakafi 89
Jakafi (s) 89
Jevtana 198
Jinteli 72
Juxtapid 90
Juxtapid (s) 90

K

Kadcyla 91
Kadcyla (bcbs Ri) 91
Kalydeco 92
Kalydeco (s) 92
Kcl 0.075%/d5w/nacl 0.45% 198
Kcl 0.15%/d5w/lr 198
Kcl 0.15%/d5w/nacl 0.2% 198
Kcl 0.15%/d5w/nacl 0.225% 198
Kcl 0.15%/d5w/nacl 0.9% 198
Kcl 0.3%/d5w/nacl 0.45% 198
Kcl 0.3%/d5w/nacl 0.9% 198
Kepivance 198
Keppra 198
Kineret 93
Kineret (s) 93
Korlym 94
Korlym (s) 94
Kuvan 95
Kuvan (s) 95
Kynamro 96
Kynamro (s) 96

L

Labetalol Hcl 198
Lactated Ringers Viaflex 198
Lazanda 47
Letairis 97
Letairis (s) 97
Leukine 98
Leukine (s) 98
Leuprolide Acetate 102
Levalbuterol 198

Levalbuterol Hcl 198
Levaquin 198
Levetiracetam 198
Levocarnitine 198
Levofloxacin 198
Levofloxacin In D5w 198
Linzess 99
Linzess (s) 99
Liothyronine Sodium 198
Lipodox 198
Lipodox 50 198
Liposyn III 198
Lorazepam 17
Lorazepam Intensol 17
Lumizyme 107
Lumizyme (s) 100
Lupaneta (s) 101
Lupaneta Pack 101
Lupron Depot 102
Lupron Depot (s) 102
Lupron Depot- Ped (s) 103
Lupron Depot-ped 103

M

Magnesium Sulfate In D5w 198
Marinol (s) 104
Mekinist 105
Mekinist (s) 105
Melphalan Hydrochloride 198
Menest 72
Menostar 72
Meperidine Hcl 64
Meperitab 64
Meprobamate 70
Meropenem 198
Mesna 198
Methocarbamol 75
Methotrexate 198
Metoclopramide Hcl 66
Metoprolol Tartrate 198
Metronidazole In Nacl 0.79% 198
Mitomycin 198
Mitoxantrone Hcl 198
Modafinil 126
Morphine Sulfate 198
Mozobil 106
Mozobil (s) 106
Mustargen 198
Mycophenolate Mofetil 198
Mycophenolic Acid Dr 198
Myfortic 198
Myozyme 100
Myozyme (s) 107

N

Nafcillin Sodium 198
Naglazyme 108
Naglazyme (s) 108
Nallpen/dextrose 198
Nebupent 198
Neoral 198
Nephramine 198
Neulasta 109
Neulasta (s) 109
Neupogen 110
Neupogen (s) 110
Neutrexin 198
Nexavar 112
Nexavar (s) 112
Nexium I.v. 198
Nifedipine 71
Nitroglycerin 198
Norditropin Flexpro 59
Norditropin Nordiflex Pen 59
Normosol-r 198
Normosol-r In D5w 198
Nplate 113
Nplate (s) 113
Nulojix 198
Nutropin 59
Nutropin Aq 59
Nutropin Aq Pen 59
Nuvigil 114
Nuvigil (s) 114

O

Octreotide Acetate 139
Olysio 115
Olysio (s) 115
Omnitrope 59

Ondansetron Hcl 198, 199
Ondansetron Odt 199
Onfi 17
Opsumit 116
Opsumit (s) 116
Orencia 117
Orencia (s) 117
Orphenadrine Citrate 75
Orphenadrine Citrate Er 75
Oxaliplatin 199
Oxandrin (s) 118
Oxandrolone 118
Oxazepam 17

P

Paclitaxel 199
Pantoprazole Sodium 199
Paricalcitol 199
Part B Versus Part D 195
Pegasys 119
Pegasys (s) 119
Pegasys Proclick 119
Peg-intron 120
Pegintron (s) 120
Peg-intron Redipen 120
Peg-intron Redipen Pak 4 120
Penicillin G Potassium In Iso-osmotic Dextrose 199
Pentazocine/acetaminophen 64
Pentazocine/naloxone Hcl 64
Pentostatin 199
Perforomist 199
Perjeta 121
Perjeta (bcbs Ri) 121
Perphenazine/amitriptyline 65
Phenadoz 66
Piperacillin Sodium/tazobactam Sodium 199
Plasma-lyte A 199
Plasma-lyte-148 199
Plasma-lyte-56/d5w 199
Pomalyst 122
Pomalyst (s) 122
Potassium Chloride 199
Potassium Chloride 0.15% /nacl 0.45% Viaflex 199
Potassium Chloride 0.15% D5w/nacl 0.33% 199
Potassium Chloride 0.15% D5w/nacl 0.45% Viaflex 199
Potassium Chloride 0.15% Nacl 0.9% 199
Potassium Chloride 0.22% D5w/nacl 0.45% 199
Potassium Chloride 0.3%/ Nacl 0.9% 199
Potassium Chloride 0.3%/d5w 199
Prefest 72
Premarin 72
Premasol 199
Prempro 72
Privigen 88
Procrit 41
Procysbi 123
Procysbi (s) 123
Prograf 199
Prolastin-c 199
Proleukin 199
Prolia 124
Prolia (bcbs Ri) 124
Promacta 125
Promacta (s) 125
Promethazine Hcl 66
Promethazine Vc 67
Promethegan 66
Propranolol Hcl 199
Provigil (s) 126
Pulmicort 199
Pulmozyme 127
Pulmozyme (s) 127

Q

Qualaquin 128
Qualaquin (s) 128
Quinine Sulfate 128

R

Rabavert 199
Rapamune 199
Ravicti 129
Ravicti (s) 129
Rebif 130
Rebif (s) 130
Rebif Titration Pack 130
Reclast (bcbs Ri) 131
Recombivax Hb 199

Relistor 133
Relistor (s) 133
Remicade 134
Remicade (bcbs Ri) 134
Remodulin 136
Remodulin (s) 136
Reserpine 68
Retin-a Micro 168
Revatio 137
Revatio (s) 137
Revlimid 138
Revlimid (s) 138
Rifampin 199
Ringers Injection 199
Rituxan 199

S

Saizen 59
Saizen Click.easy 59
Sandimmune 199
Sandostatin (s) 139
Sandostatin Lar (s) 140
Sandostatin Lar Depot 140
Savella 141
Savella (s) 141
Savella Titration Pack 141
Serostim 142
Serostim (s) 142
Signifor 143
Signifor (s) 143
Sildenafil Citrate 137
Simponi 144
Simponi (s) 144
Simponi Aria 145
Simponi Aria (s) 145
Simulect 199
Simvastatin 146
Simvastatin (s) 146
Sirolimus 199
Sodium Chloride 199
Sodium Chloride 0.45% Viaflex 199
Sodium Edecrin 199
Somatuline Depot 147
Somatuline Depot (s) 147
Somavert 148
Somavert (s) 148
Sovaldi 149
Sovaldi (s) 149
Sprycel 150
Sprycel (s) 150
Stelara 151
Stelara (s) 151
Stivarga 152
Stivarga (s) 152
Suboxone 153
Suboxone (s) 153
Subsys 47
Subutex (s) 154
Sulfamethoxazole/trimethoprim 199
Sutent 155
Sutent (s) 155
Sylatron 156
Sylatron (s) 156
Synagis 157
Synagis (s) 157
Synribo 159
Synribo (s) 159

T

Taclonex 160
Taclonex (s) 160
Tacrolimus 199
Tafinlar 161
Tafinlar (s) 161
Talwin 64
Tarceva 162
Tarceva (s) 162
Targretin 163
Targretin (s) 163
Tasigna 164
Tasigna (s) 164
Taxotere 199
Tazicef 199
Tazorac 165
Tazorac (s) 165
Tecfidera 166
Tecfidera (s) 166
Tecfidera Starter Pack 166
Teflaro 199
Temazepam 17

Testosterone (s) 167
Tetanus Toxoid Adsorbed 199
Tev-tropin 59
Thiotepa 199
Thymoglobulin 199
Ticlopidine Hcl 73
Tobi 86
Tobi Podhaler 86
Tobramycin 86
Tobramycin Sulfate 199
Tobramycin Sulfate/sodium Chloride 199
Topical Retinoids (s) 168
Toposar 199
Topotecan Hcl 199
Torisel 199
Torsemide 199
Tracleer 169
Tracleer (s) 169
Tranexamic Acid 199
Travasol 199
Treanda 199
Trelstar (s) 170
Trelstar Depot Mixject 170
Trelstar La Mixject 170
Trelstar Mixject 170
Tretinoin 168
Tretinoin Microsphere 168
Tretinoin Microsphere Pump 168
Tretin-x 168
Trexall 199
Triazolam 17
Trihexyphenidyl Hcl 69
Trimethobenzamide Hcl 66
Trimipramine Maleate 65
Trisenox 199
Trophamine 199
Twinrix 199
Tygacil 199
Tykerb 171
Tykerb (s) 171
Tysabri 172
Tysabri (s) 172
Tyvaso 173
Tyvaso (s) 173
Tyvaso Refill 173
Tyvaso Starter 173
Tyzeka 174
Tyzeka (s) 174

V

Valchlor 175
Valchlor (s) 175
Valproate Sodium 199
Vancomycin Hcl 200
Vectibix 200
Velcade 200
Veletri 176
Veletri (s) 176
Ventavis 177
Ventavis (s) 177
Verapamil Hcl 200
Vibativ 200
Victrelis 178
Victrelis(s) 178
Vidaza 200
Vimpat 200
Vinblastine Sulfate 200
Vincasar Pfs 200
Vincristine Sulfate 200
Vinorelbine Tartrate 200
Virazole 200
Vivelle-dot 72
Voriconazole 200
Votrient 179
Votrient (s) 179
Vpriv 180
Vpriv (s) 180
Vytorin 146

X

Xalkori 181
Xalkori (s) 181
Xenazine 182
Xenazine (s) 182
Xeomin 183
Xeomin (s) 183
Xgeva 184
Xgeva (bcbs Ri) 184
Xolair 185

Xolair (s) 185
Xtandi 186
Xtandi (s) 186
Xyrem 187
Xyrem (s) 187

Z

Zaleplon 74
Zaltrap 188
Zaltrap (s) 188
Zanosar 200
Zavesca 189
Zavesca (s) 189
Zelboraf 190
Zelboraf (s) 190
Zemplar 200
Ziana 168
Zinecard 200
Zoledronic Acid 131, 192
Zolinza 191
Zolinza (s) 191
Zolpidem Tartrate 74
Zolpidem Tartrate Er 74
Zometa 192
Zometa (s) 192
Zorbtive 193
Zorbtive (s) 193
Zortress 200
Zosyn 200
Zytiga 194
Zytiga (s) 194
Zyvox 200