

Elderplan FIDA Total Care (Medicare-Medicaid Plan)

Crterios para la PA

Grupo de autorización previa	ACITRETIN
Nombres de los medicamentos	ACITRETIN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, Prevention of non-melanoma skin cancers in high risk individuals.
Criterios de exclusión	Severely impaired liver function or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracycline.
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	If the patient is able to bear children, the patient and/or guardian signed a Patient Agreement/Informed Consent (e.g., Do Your P.A.R.T) which includes confirmation of 2 negative pregnancy tests.
Grupo de autorización previa	ACTIMMUNE
Nombres de los medicamentos	ACTIMMUNE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, atopic dermatitis.
Criterios de exclusión	
Información médica requerida	For chronic granulomatous disease, Actimmune is used for reducing the frequency and severity of serious infections associated with chronic granulomatous disease. For atopic dermatitis, the condition is resistant to conservative treatments (e.g., topical medications, phototherapy).
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

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Grupo de autorización previa	ADAGEN
Nombres de los medicamentos	ADAGEN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Severe combined immunodeficiency disease (SCID) is due to adenosine deaminase (ADA) deficiency. Condition failed to respond to bone marrow transplantation or patient is not currently a suitable candidate for bone marrow transplantation.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	ADCIRCA
Nombres de los medicamentos	ADCIRCA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Treatment with nitrate therapy on a regular or intermittent basis. Concomitant treatment with a guanylate cyclase stimulator (e.g., Adempas).
Información médica requerida	PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	ADEMPAS
Nombres de los medicamentos	ADEMPAS
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Treatment with a nitrate or nitric oxide donor medication (e.g., amyl nitrite) on a regular or intermittent basis. Concomitant treatment with a phosphodiesterase inhibitor (e.g., sildenafil, tadalafil, vardenafil, dipyridamole, theophylline).
Información médica requerida	For pulmonary arterial hypertension (PAH) (WHO Group 1): 1) PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI) or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Restricciones de edad	18 years of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	AFINITOR
Nombres de los medicamentos	AFINITOR, AFINITOR DISPERZ
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangi leiomyomatosis.
Criterios de exclusión	
Información médica requerida	Breast cancer: 1) The patient has advanced hormone receptor positive, HER2 negative disease, AND 2) Afinitor will be used in combination with exemestane, AND 3) The patient's disease a) has progressed within 12 months prior to starting Afinitor, OR b) was previously treated with a nonsteroidal aromatase inhibitor, OR c) was previously treated with tamoxifen. Renal cell carcinoma: 1) The disease is relapsed or medically unresectable, AND 2) For disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. Classical Hodgkin lymphoma: 1) The disease is relapsed or refractory AND 2) Afinitor will be used as a single agent. Thymomas and Thymic carcinomas: 1) The disease has progressed on a platinum-based chemotherapy regimen AND 2) Afinitor will be used as a single agent. Soft tissue sarcoma: 1) The patient has one of the following subtypes of STS: a) perivascular epithelioid cell tumors (PEComa), or b) angiomyolipoma, or c) lymphangi leiomyomatosis, AND 2) Afinitor will be used as a single agent. Subependymal giant cell astrocytoma associated with tuberous sclerosis complex (TSC): The patient is not a candidate for curative surgical resection. Renal angiomyolipoma associated with TSC: The patient does not require immediate surgery.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

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Grupo de autorización previa ALDURAZYME
Nombres de los medicamentos ALDURAZYME
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D
Criterios de exclusión
Información médica requerida The diagnosis of mucopolysaccharidosis I is confirmed by either an enzyme assay showing a deficiency of alpha-L-iduronidase enzyme activity or by DNA testing. Patients with Scheie syndrome must have moderate to severe symptoms.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

Grupo de autorización previa ALECENSA
Nombres de los medicamentos ALECENSA
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D.

Criterios de exclusión

Información médica requerida

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

Grupo de autorización previa ALGLUCOSIDASE
Nombres de los medicamentos LUMIZYME
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D.

Criterios de exclusión

Información médica requerida Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by DNA testing that identifies mutations in the GAA gene.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

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Grupo de autorización previa	ALOSETRON
Nombres de los medicamentos	ALOSETRON HYDROCHLORIDE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Patient has a history of any of the following conditions: Chronic or severe constipation or sequelae from constipation. Intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions. Ischemic colitis. Impaired intestinal circulation, thrombophlebitis or hypercoagulable state. Crohn's disease or ulcerative colitis. Diverticulitis. Severe hepatic impairment.
Información médica requerida	1) Lotronex is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) chronic IBS symptoms lasting at least 6 months AND 3) gastrointestinal tract abnormalities have been ruled out AND 4) inadequate response to conventional therapy.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	ALPHA1-PROTEINASE INHIBITOR
Nombres de los medicamentos	ARALAST NP, PROLASTIN-C, ZEMAIRA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D
Criterios de exclusión	
Información médica requerida	Patients must have clinically evident emphysema. Patients must have a pretreatment serum alpha1-proteinase inhibitor level less than 11 micromoles/L (80 mg/dl). Patients must have a pretreatment post-bronchodilation FEV1 greater than, or equal to, 25 percent and less than, or equal to, 80 percent of predicted.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	AMPYRA
Nombres de los medicamentos	AMPYRA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment and the ability to walk 25 feet (with or without assistance). For continuation of therapy: Patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting Ampyra.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	ANABOLIC STEROIDS
Nombres de los medicamentos	OXANDROLONE
Usos cubiertos	All FDA approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting) or due to chronic disease or Turner's syndrome.
Criterios de exclusión	Pregnancy. Known or suspected carcinoma of the prostate or breast in male patients. Carcinoma of the breast in females with hypercalcemia. Nephrosis, the nephrotic phase of nephritis. Hypercalcemia.
Información médica requerida	Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	6 months
Otros criterios	

Grupo de autorización previa	ANADROL
Nombres de los medicamentos	ANADROL-50
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting), Fanconi's anemia.
Criterios de exclusión	Pregnancy. Carcinoma of the prostate or breast in male patients. Carcinoma of the breast in women with hypercalcemia. Nephrosis or the nephrotic phase of nephritis. Severe hepatic dysfunction.
Información médica requerida	Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	6 Months
Otros criterios	

Grupo de autorización previa	APOKYN
Nombres de los medicamentos	APOKYN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Concomitant treatment with a serotonin 5HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, and alosetron).
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	ARCALYST
Nombres de los medicamentos	ARCALYST
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D. Prevention of gout flares in patients initiating or continuing urate-lowering therapy.
Criterios de exclusión	
Información médica requerida	For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (new starts): all of the following criteria must be met: 1) serum uric acid concentration greater than or equal to 445 micromol/L (7.5 mg/dL) prior to initiating Arcalyst, 2) two or more gout flares within the previous 12 months, 3) inadequate response, intolerance or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, and 4) concurrent use with urate-lowering therapy (i.e., allopurinol or febuxostat). For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (continuation): 1) Member must have achieved or maintain a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline and 2) have continued use of urate-lowering therapy concurrently with Arcalyst. CAPS: 12 years of age or older. Gout: 18 years of age or older.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	For prevention of gout flares: 4 months. Other: Plan Year
Otros criterios	Abbreviation: CAPS = Cryopyrin-Associated Periodic Syndromes.

Grupo de autorización previa
Nombres de los medicamentos
Usos cubiertos

AVASTIN

AVASTIN

All FDA-approved indications not otherwise excluded from Part D, breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, endometrial cancer, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma subtypes: angiosarcoma, solitary fibrous tumor, and hemangiopericytoma, malignant pleural mesothelioma, choroidal neovascularization associated with: ocular histoplasmosis, pathologic myopia, angioid streaks, inflammatory conditions, or of idiopathic etiology, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema due to retinal vein occlusion, diabetic macular edema, ocular neovascularization of the choroid, retina, or iris associated with proliferative diabetic retinopathy, neovascular glaucoma, and retinopathy of prematurity.

Criterios de exclusión
Información médica requerida

For CRC, Avastin (AV) will be used with a fluoropyrimidine- or irinotecan-based regimen (i.e., capecitabine, CapeOx, FOLFIRI, FOLFOX, FOLFOXIRI, or 5-FU with leucovorin) for: 1) perioperative (neoadjuvant/adjuvant/postoperative) therapy for advanced or metastatic disease or 2) treatment (tx) of unresectable advanced or metastatic disease. For NSCLC, the disease is unresectable, locally advanced, recurrent, or metastatic for patients with tumors of non-squamous cell histology, and no hx of recent hemoptysis and 1) AV will be used as first-line therapy or as subsequent therapy after prior therapy with erlotinib, afatinib, gefitinib or crizotinib a) AV will be used with cisplatin- or carboplatin-based regimens and b) Patient has distant mets or locoregional recurrence with evidence of disseminated disease, OR 2) AV will be used as a continuation maintenance tx (i.e., continuation of AV as first-line therapy beyond 4-6 cycles in the absence of disease progression) for tumor that is negative or unknown for both EGFR and ALK mutations and a) AV will be used alone or in combination with pemetrexed if previously used with a firstline pemetrexed/platinum chemotherapy regimen and b) Patient has achieved tumor response or stable disease following first-line chemotherapy. For malignant sex cord-stromal tumors, AV is used for clinical relapse in patient with granulosa cell tumors. For breast CA, 1) HER2-negative recurrent or metastatic disease and 2) AV is used with paclitaxel. For endometrial CA, AV is used alone for patients who progressed on prior cytotoxic chemotherapy.

Restricciones de edad
Restricciones de la persona autorizada a dar recetas
Duración de la cobertura

Colorectal cancer perioperative therapy: 3 months. Other: Plan Year.

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Otros criterios

For angiosarcoma, Avastin is used as a single-agent. For solitary fibrous tumor or hemangiopericytoma, Avastin is used with temozolomide. For malignant pleural mesothelioma, Avastin is used with pemetrexed and cisplatin. For RCC, 1) relapsed or for surgically unresectable RCC and 2) Avastin is used as a) first-line tx with interferon alfa-2 for disease with clear cell histology or b) first-line tx as a single-agent for disease with non-clear cell histology, or c) subsequent tx as a single-agent for disease with predominant clear cell histology following prior cytokine tx. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Grupo de autorización previa
Nombres de los medicamentos

B VS. D

ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ADRUCIL, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMIFOSTINE, AMINOSYN, AMINOSYN 7%/ELECTROLYTES, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 8.5%/ELECTROL, AMINOSYN M, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-PF 7%, AMINOSYN-RF, AMPHOTERICIN B, APREPITANT, AZACITIDINE, AZATHIOPRINE, BENDEKA, BICNU, BLEOMYCIN SULFATE, BUDESONIDE, BUSULFEX, CALCITONIN-SALMON, CALCITRIOL, CARBOPLATIN, CISPLATIN, CLADRIBINE, CLINIMIX 2.75%/DEXTROSE 5, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 2, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 5%/DEXTROSE 25%, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DACARBAZINE, DAUNORUBICIN HCL, DEPO-PROVERA, DEXRAZOXANE, DIPHTHERIA/TETANUS TOXOID, DOCEFREZ, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HCL LIPOSOME, DRONABINOL, DURAMORPH, ELITEK, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FLUDARABINE PHOSPHATE, FLUOROURACIL, FORTICAL, FREAMINE HBC 6.9%, FREAMINE III, FUSILEV, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, HYDROXYPROGESTERONE CAPRO, IDARUBICIN HCL, IFEX, IFOSFAMIDE, INTRALIPID, INTRON A, INTRON A W/DILUENT, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTODAX (OVERFILL), KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVOCARNITINE, LEVOLEUCOVORIN, LEVOLEUCOVORIN CALCIUM, LIDOCAINE HCL, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MIACALCIN, MITOMYCIN, MITOXANTRONE HCL, MORPHINE SULFATE, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEBUPENT, NEORAL, NEPHRAMINE, NIPENT, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE, PROGRAF, PROLEUKIN, PROSOL, RAPAMUNE, RECOMBIVAX HB, SANDIMMUNE, SIROLIMUS, TACROLIMUS, TAXOTERE, TENIVAC, TETANUS/DIPHTHERIA TOXOID, TOPOSAR, TOPOTECAN HCL, TPN ELECTROLYTES, TRAVASOL, TREANDA, TRISENOX, TROPHAMINE, VINBLASTINE SULFATE, VINCASAR PFS, VINCRISTINE SULFATE, VINOURELBINE TARTRATE, ZOLEDRONIC ACID, ZORTRESS

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Usos cubiertos	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.
Grupos de autorización previa	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	N/A
Otros criterios	
Grupos de autorización previa	BANZEL
Nombres de los medicamentos	BANZEL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	The patient has Familial Short QT Syndrome.
Información médica requerida	
Restricciones de edad	1 year of age or older.
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupos de autorización previa	BELEODAQ
Nombres de los medicamentos	BELEODAQ
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	BENLYSTA
Nombres de los medicamentos	BENLYSTA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Severe active lupus nephritis. Severe active central nervous system lupus.
Información médica requerida	Diagnosis of active, autoantibody-positive systemic lupus erythematosus (SLE). Member is currently receiving standard therapy for SLE (eg, corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) or has tried and had an inadequate response or intolerance to standard therapy for SLE.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Initial: 6 months. Renewal: Plan Year.
Otros criterios	For renewals, member is benefiting from Benlysta therapy (eg, reduction of steroid dose, decrease in pain medications).
Grupo de autorización previa	BETASERON
Nombres de los medicamentos	BETASERON
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	BEXAROTENE
Nombres de los medicamentos	BEXAROTENE, TARGRETIN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).
Criterios de exclusión	
Información médica requerida	For capsule formulation: Patient has any of the following types of cutaneous T-cell lymphomas: mycosis fungoides, Sezary syndrome, primary cutaneous anaplastic large cell lymphoma, lymphomatoid papulosis. For primary cutaneous anaplastic large cell lymphoma and lymphomatoid papulosis: 1) The disease is CD30-positive, and 2) bexarotene will be used as a single agent. For gel formulation: For cutaneous T-cell lymphoma, patient has a diagnosis of stage I to III mycosis fungoides. For primary cutaneous B-cell lymphoma, patient has either primary cutaneous marginal zone lymphoma or primary cutaneous follicle center lymphoma.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	BOSENTAN
Nombres de los medicamentos	TRACLEER
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Patient has had NYHA Functional Class II to IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	BOSULIF
Nombres de los medicamentos	BOSULIF
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Diagnosis of CML was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets any of the following: 1) Patient has chronic phase CML and meets one of the following conditions: a) experienced intolerance or toxicity to a prior tyrosine kinase inhibitor (TKI) (eg, imatinib, dasatinib, nilotinib, ponatinib), or b) experienced resistance to a prior TKI and is negative for T315I mutation, OR 2) Patient has accelerated or blast phase CML and meets one of the following: a) has not received prior therapy with a TKI, b) experienced intolerance or toxicity to a prior TKI, or c) experienced resistance to a prior TKI and is negative for T315I mutation, OR 3) Patient received a hematopoietic stem cell transplant.
Restricciones de edad	18 years of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	BRIVIACT
Nombres de los medicamentos	BRIVIACT
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	BUPRENORPHINE
Nombres de los medicamentos	BUPRENORPHINE HCL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	1) The drug is being prescribed for the treatment of opioid dependence AND 2) If the patient is pregnant and being prescribed buprenorphine for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) If buprenorphine is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) If buprenorphine is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Induction 3 months, Maintenance Plan Year, Pregnancy 10 months
Otros criterios	
Grupo de autorización previa	BUPRENORPHINE-NALOXONE
Nombres de los medicamentos	BUPRENORPHINE HCL/NALOXON, SUBOXONE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	CABOMETYX
Nombres de los medicamentos	CABOMETYX
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D
Criterios de exclusión	
Información médica requerida	The disease expresses clear cell histology and is advanced or metastatic. The patient has received and progressed on or after prior treatment with a vascular endothelial growth factor receptor targeting tyrosine kinase inhibitor.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	CAPRELSA
Nombres de los medicamentos	CAPRELSA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, differentiated thyroid cancer subtypes: papillary, follicular, Hurthle cell.
Criterios de exclusión	
Información médica requerida	For medullary thyroid cancer: 1) disease is symptomatic or progressive and 2) patient has unresectable locoregional or metastatic disease. For differentiated thyroid cancer: 1) histologic subtype is papillary, follicular, or Hurthle cell, 2) disease is symptomatic and/or progressive, 3) disease is iodine-refractory, and 4) patient has unresectable recurrent or persistent locoregional disease OR metastatic disease.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	CARBAGLU
Nombres de los medicamentos	CARBAGLU
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, methylmalonic acidemia, propionic acidemia.
Criterios de exclusión	
Información médica requerida	Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	CAYSTON
Nombres de los medicamentos	CAYSTON
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	The diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Pseudomonas aeruginosa is present in the cultures of the airway.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan year
Otros criterios	

Grupo de autorización previa	CERDELGA
Nombres de los medicamentos	CERDELGA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	CYP2D6 extensive metabolizers or intermediate metabolizers taking a strong or moderate CYP2D6 inhibitor (e.g., paroxetine, terbinafine) concomitantly with a strong or moderate CYP3A inhibitor (e.g., ketoconazole, fluconazole). CYP2D6 intermediate metabolizers or poor metabolizers taking a strong CYP3A inhibitor (e.g., ketoconazole). CYP2D6 indeterminate metabolizers (i.e., CYP2D6 genotype cannot be determined). CYP2D6 ultra-rapid metabolizers. Use concomitantly with enzyme replacement therapy.
Información médica requerida	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. Member is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Restricciones de edad	18 years of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	CEREZYME
Nombres de los medicamentos	CEREZYME
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, type 3 Gaucher disease
Criterios de exclusión	Concomitant therapy with miglustat (Zavesca) or eliglustat (Cerdelga)
Información médica requerida	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. For Type 1 Gaucher disease, the patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. For Type 3 Gaucher disease, the patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, splenomegaly, developmental delay, or ophthalmoplegia (gaze palsy).
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	CHANTIX
Nombres de los medicamentos	CHANTIX, CHANTIX CONTINUING MONTH, CHANTIX STARTING MONTH PA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	6 Months
Otros criterios	

Grupo de autorización previa	CINRYZE
Nombres de los medicamentos	CINRYZE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Diagnostic laboratory testing for HAE has been performed (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels). For patients with HAE with C1 inhibitor deficiency, C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test. For patients with HAE with normal C1 inhibitor, other causes of angioedema have been ruled out (eg, drug-induced) and EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	CLORAZEPATE
Nombres de los medicamentos	CLORAZEPATE DIPOTASSIUM
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) (e.g., escitalopram, sertraline) or a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., duloxetine, venlafaxine ER) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal AND 4) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.

Restricciones de edad
Restricciones de la persona autorizada a dar recetas
Duración de la cobertura
Otros criterios

Anxiety Disorders-4 Months, All other Diagnoses-Plan Year

Grupo de autorización previa	CLOZAPINE ODT
Nombres de los medicamentos	CLOZAPINE ODT
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	History of clozapine-induced agranulocytosis or severe granulocytopenia. Dementia-related psychosis.
Información médica requerida	The patient is unwilling or unable to take tablets or capsules orally or is at high risk for non-compliance.

Restricciones de edad
Restricciones de la persona autorizada a dar recetas
Duración de la cobertura
Otros criterios

Plan Year

Grupo de autorización previa	COMETRIQ
Nombres de los medicamentos	COMETRIQ
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D
Criterios de exclusión	
Información médica requerida	Medullary thyroid cancer which meets one of the following: 1) Unresectable locoregional disease that is symptomatic or structurally progressive, 2) Asymptomatic distant metastases if structurally progressive and unresectable, 3) Symptomatic or progressive metastatic disease
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	COTELLIC
Nombres de los medicamentos	COTELLIC
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	CYSTAGON
Nombres de los medicamentos	CYSTAGON
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D
Criterios de exclusión	
Información médica requerida	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

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Grupo de autorización previa	CYSTARAN
Nombres de los medicamentos	CYSTARAN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Diagnosis of cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing. The patient has corneal cystine crystal accumulation.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	DAKLINZA
Nombres de los medicamentos	DAKLINZA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, chronic hepatitis C genotype 2 or 4 infection.
Criterios de exclusión	Use with a strong inducer of CYP3A, including phenytoin, carbamazepine, rifampin and St. John's wort
Información médica requerida	Chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants (eg, NS3 Q80K polymorphism) where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Criteria will be applied consistent with current AASLD-IDSA guidance
Otros criterios	For HCV/HIV coinfection, patient meets criteria for requested regimen.

Grupo de autorización previa	DEFERASIROX
Nombres de los medicamentos	EXJADE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D
Criterios de exclusión	
Información médica requerida	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L. For chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes: A) For initiation of the deferasirox therapy: Pretreatment liver iron concentration (LIC) is at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw) AND pretreatment serum ferritin levels are greater than 300 mcg/L on 2 consecutive measurements 1 month apart. B) For continuation of the deferasirox therapy: Current LIC is greater than 3 mg Fe/g dw or the deferasirox therapy will be withheld until the LIC reaches above 5 mg Fe/g dw.
Restricciones de edad	2 years of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	DIAZEPAM
Nombres de los medicamentos	DIAZEPAM, DIAZEPAM INTENSOL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) (e.g., escitalopram, sertraline) or a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., duloxetine, venlafaxine ER) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of skeletal muscle spasms OR 4) For adjunctive therapy in the treatment of convulsive disorders AND 5) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura

Otros criterios

Anxiety Disorders-4 Months, All other Diagnoses-Plan Year

Grupo de autorización previa

Nombres de los medicamentos

Usos cubiertos

Criterios de exclusión

Información médica requerida

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura

Otros criterios

ELIQUIS

ELIQUIS

All FDA-approved indications not otherwise excluded from Part D.

Plan Year

Grupo de autorización previa	EMSAM
Nombres de los medicamentos	EMSAM
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Pheochromocytoma.
Información médica requerida	1) Patient will be monitored closely for suicidal thoughts and behavior and clinical worsening AND 2) Patient experienced an inadequate treatment response to any one of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (SNRIs (e.g., venlafaxine)), selective serotonin reuptake inhibitors (SSRIs (e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline)), tricyclic or tetracyclic antidepressants (e.g., amitriptyline, nortriptyline) OR 3) Patient is unable to swallow oral formulations.
Restricciones de edad	18 years of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	EPO
Nombres de los medicamentos	PROCRIT
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa).
Criterios de exclusión	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer. Use to facilitate preoperative autologous blood donation.
Información médica requerida	For all uses except surgery: 1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL (less than 9 g/dL for anemia in CHF only). 2) For reauthorizations (patient received erythropoietin in previous month), an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. Additional requirements for anemia due to myelosuppressive cancer chemotherapy: 1) For initial therapy, at least 2 more months of chemotherapy is expected. 2) For reauthorizations, current Hgb is less than 11 g/dL. Additional requirements for CKD not on dialysis reauthorization: 1) Current Hgb is less than or equal to 10 g/dL OR Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) Patient has symptomatic anemia AND 2) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL. 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for HIV: 1) Concomitant use of zidovudine at a maximum dose of 4200 mg per week. 2) For initial therapy, pretreatment serum erythropoietin level is less than or equal to 500 mU/mL. 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for anemia due to CHF, RA, hepatitis C treatment, or patients whose religious beliefs forbid blood transfusions: 1) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery. 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	16 weeks

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Otros criterios	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion.
Grupo de autorización previa	ERIVEDGE
Nombres de los medicamentos	ERIVEDGE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Patient meets one of the following criteria: 1) patient has nodal or distant metastatic basal cell carcinoma (BCC), OR 2) patient has residual or recurrent disease and further surgery and radiation are contraindicated or not appropriate, OR 3) patient cannot achieve negative margins by Mohs surgery or more extensive surgical procedures.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	ESBRIET
Nombres de los medicamentos	ESBRIET
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Initial Review Only: The patient does not have a known etiology for interstitial lung disease. The patient has completed a high-resolution computed tomography study of the chest which reveals the usual interstitial pneumonia pattern. If the study reveals the possible usual interstitial pneumonia pattern, the diagnosis is supported by surgical lung biopsy. If a surgical lung biopsy has not been conducted, the diagnosis is supported by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis. For initial and continuation: Esbriet will not be used in combination with Ofev.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Initial: 6 months, Renewal: Plan Year
Otros criterios	For continuation only: The patient has experienced a reduction in disease progression.

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Grupo de autorización previa FABRAZYME
Nombres de los medicamentos FABRAZYME
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión
Información médica requerida Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by DNA testing. Patient has clinical signs and symptoms of Fabry disease.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

Grupo de autorización previa FARYDAK
Nombres de los medicamentos FARYDAK
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión

Información médica requerida The patient has received at least two prior regimens, including bortezomib and an immunomodulatory agent (eg, lenalidomide, thalidomide, pomalidomide). Farydak will be used in combination with bortezomib and dexamethasone. The patient does not have a baseline QTc interval greater than, or equal to, 450 ms. The patient will be monitored for severe diarrhea.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

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Grupo de autorización previa	FENTANYL PATCH
Nombres de los medicamentos	FENTANYL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Significant respiratory depression. Known or suspected paralytic ileus.
Información médica requerida	1) The patient has been evaluated and will be monitored regularly for the development of addiction, abuse, or misuse of fentanyl patch AND 2) The patient can safely take the requested dose based on their current opioid use history. [Note: Fentanyl patch is indicated for use in opioid-tolerant patients. Patients considered opioid-tolerant are those who are taking, for one week or longer, at least 60mg of morphine daily, or at least 30mg of oral oxycodone daily, or at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid.] AND 3) Fentanyl patch is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	FERRIPROX
Nombres de los medicamentos	FERRIPROX
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	FILGRASTIM
Nombres de los medicamentos	GRANIX, NEUPOGEN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL), leukemic relapse following allogeneic stem cell transplantation, myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia.
Criterios de exclusión	Use of a G-CSF product within 24 hours prior to or following chemotherapy or radiotherapy. For treatment of chemotherapy-induced FN, patient received prophylactic pegylated G-CSF (e.g., Neulasta) during the current chemotherapy cycle.
Información médica requerida	For prophylaxis of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For the treatment of anemia in MDS patients must meet all of the following: 1) Patient has symptomatic anemia, 2) The requested G-CSF product will be used in combination with epoetin or darbepoetin, 3) Patient has MDS with a low or intermediate-1 risk stratification, 4) The serum erythropoietin level is less than, or equal to, 500 mU/ml. For neutropenia in MDS: 1) Member is neutropenic, 2) Patient experiences recurrent or resistant infections.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	6 months
Otros criterios	For prevention of neutropenia: Patient will not receive chemotherapy and radiotherapy concurrently

Grupo de autorización previa	FIRAZYR
Nombres de los medicamentos	FIRAZYR
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, ACE inhibitor-induced angioedema.
Criterios de exclusión	
Información médica requerida	For hereditary angioedema (HAE): Diagnostic laboratory testing for HAE has been performed (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels). For patients with HAE with C1 inhibitor deficiency, C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test. For patients with HAE with normal C1 inhibitor: Other causes of angioedema have been ruled out (eg, drug induced) and EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema.
Restricciones de edad	18 years of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	For HAE, Firazyr is being requested for the treatment of acute HAE attacks.

Grupo de autorización previa	FORTEO
Nombres de los medicamentos	FORTEO
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For all indications: patient has had an oral bisphosphonate trial of at least 1-year duration unless contraindicated or intolerant to an oral bisphosphonate. For primary or hypogonadal osteoporosis and postmenopausal osteoporosis: Patient has a) a history of an osteoporotic vertebral or hip fracture OR b) a pre-treatment T-score of less than or equal to -2.5 OR c) a pre-treatment T-score of less than or equal to -1 but greater than -2.5 AND a pre-treatment FRAX score of either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. For glucocorticoid-induced osteoporosis in postmenopausal women and men 50 years of age or older: 1) Patient is currently receiving or will be initiating glucocorticoid therapy, and 2) Patient has a) a history of fragility fracture OR b) a pre-treatment T-score of less than or equal to -2.5 OR c) a pre-treatment FRAX score of either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. For glucocorticoid-induced osteoporosis in premenopausal women and men less than 50 years of age: 1) Patient is currently receiving or will be initiating glucocorticoid therapy, and 2) The anticipated glucocorticoid length of therapy is at least 3 months, and 3) Patient has a history of a fragility fracture.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura

24 months (lifetime)

Otros criterios

Grupo de autorización previa

FYCOMPA

Nombres de los medicamentos

FYCOMPA

Usos cubiertos

All FDA-approved indications not otherwise excluded from Part D.

Criterios de exclusión

Información médica requerida

The patient and caregivers will be advised to contact the healthcare provider immediately if any serious psychiatric or behavioral reactions are observed.

Restricciones de edad

12 years of age or older.

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura

Plan Year

Otros criterios

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Grupo de autorización previa	GATTEX
Nombres de los medicamentos	GATTEX
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Patient was dependent on parenteral support for at least 12 months prior to initiation of therapy with Gattex. For continuation: requirement for parenteral support has decreased from baseline while on Gattex therapy.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	GILENYA
Nombres de los medicamentos	GILENYA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses).
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	GILOTRIF
Nombres de los medicamentos	GILOTRIF
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For non-small cell lung cancer (NSCLC), patient meets either of the following: 1) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) Patient had EGFR mutation testing and is positive for exon 19 deletions or exon 21 (L858R) substitution mutations AND Gilotrif is prescribed for use as any of the following: a) First-line therapy as a single agent for recurrent or metastatic disease (EGFR mutation discovered prior to first-line chemotherapy or during first-line chemotherapy), or b) Subsequent therapy as a single agent for recurrent or metastatic disease following disease progression on afatinib or erlotinib.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	GLATIRAMER
Nombres de los medicamentos	COPAXONE, GLATOPA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, first clinical episode of MS.
Criterios de exclusión	
Información médica requerida	Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	GROWTH HORMONE
Nombres de los medicamentos	NORDITROPIN FLEXPPO
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D (including pediatric growth hormone deficiency (GHD), Turner syndrome (TS), Noonan syndrome (NS), chronic kidney disease (CKD), small for gestational age (SGA), Prader-Willi syndrome (PWS), idiopathic short stature (ISS), short stature homeobox-containing gene deficiency (SHOXD), adult GHD), HIV-associated wasting/cachexia, short bowel syndrome (SBS).
Criterios de exclusión	Active malignancy. Closed epiphyses (except PWS, adult GHD, HIV-associated wasting/cachexia and SBS).
Información médica requerida	Pediatric GHD, TS, CKD, SHOXD, NS: 1) younger than 2.5 yrs old, when applicable: pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity, 2) 2.5 yrs old or older: pre-tx 1-year ht velocity more than 2 SD below mean OR pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) failed 2 growth hormone (GH) stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) patient is a neonate or was diagnosed with GHD as a neonate. TS: confirmed by karyotyping. Growth failure associated with CKD: not post-kidney transplant. SGA: 1) birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2. PWS: confirmed by one of the following: 1) deletion in the chromosomal 15q11.2-q13 region, OR 2) maternal uniparental disomy in chromosome 15, OR 3) imprinting defects or translocations involving chromosome 15. SHOXD: confirmed by molecular or genetic testing. ISS: 1) pediatric GHD ruled out with appropriate provocative test more than 10 ng/mL AND 2) pre-tx ht more than 2.25 SD below mean AND 3) adult ht prediction below 63 inches for boys, 59 inches for girls. Adult GHD: 1) failed 2 GH stimulation tests (peak below 5 ng/mL) prior to starting tx, OR 2) structural abnormality of the hypothalamus/pituitary and 3 or more pituitary hormone deficiencies, OR 3) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary, OR 4) low pre-tx IGF-1 and failed 1 GH stimulation test (peak below 5 ng/mL) prior to starting tx. SGA: 2 years of age or older. NS and SHOXD: 3 years of age or older.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	Endocrinologist, Geneticist, Pediatric nephrologist, Infectious disease specialist, Gastroenterologist/Nutritional support specialist.
Duración de la cobertura	HIV-associated wasting: 12 wks. All other indications: Plan Year.

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HIV-associated wasting/cachexia: 1) on antiretroviral treatment, AND 2) suboptimal response to at least 1 other therapy for wasting or cachexia (eg, megestrol, dronabinol, cyproheptadine, or testosterone therapy if hypogonadal) OR contraindication or intolerance to alternative therapies, AND 3) prior to starting GH tx, body mass index (BMI) less than 18.5 kg/m² AND experienced unintentional weight loss greater than 5 percent of body weight in the previous 6 months. SBS: Used in conjunction with optimal management of SBS. Renewal for pediatric GHD, TS, NS, CKD, SGA, PWS patients with open epiphyses, ISS, or SHOXD: patient is experiencing improvement. Also for renewal for PWS only: body composition and psychomotor function have improved or stabilized. Renewal for PWS patients with closed epiphyses: current IGF-1 level is not elevated for age and gender. Renewal for adult GHD patients: current IGF-1 level is normal for age and gender (does not apply to patients with: a) structural abnormality of the hypothalamus/pituitary and 3 or more pituitary hormone deficiencies, and b) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary). Renewal for HIV-associated wasting: demonstrated response to GH therapy (ie, BMI has improved or stabilized).

Grupo de autorización previa	HERCEPTIN
Nombres de los medicamentos	HERCEPTIN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, esophageal and esophagogastric junction cancer, leptomeningeal metastases from HER2-positive breast cancer
Criterios de exclusión	
Información médica requerida	For HER2-positive breast cancer, Herceptin is used either: 1) For neoadjuvant treatment in combination with chemotherapy, OR 2) For adjuvant treatment in combination with chemotherapy for tumors at least 0.6cm or node positive, OR 3) For recurrent or metastatic disease in combination with aromatase inhibition for hormone-receptor positive disease, OR 4) For recurrent or metastatic disease in patients without previous treatment with Herceptin for recurrent or metastatic disease who meet 4a or 4b. 4a) Patients are hormone-receptor negative or are hormone-receptor positive and endocrine refractory, have symptomatic visceral disease, or visceral crisis. 4b) Patients use Herceptin as a single agent, in combination with chemotherapy, in combination with pertuzumab and docetaxel or paclitaxel, OR 5) For recurrent or metastatic disease in patient with previous treatment with Herceptin for recurrent or metastatic disease who meet 5a or 5b. 5a) Patients are hormone-receptor negative or are hormone-receptor positive and endocrine refractory, have symptomatic visceral disease, or visceral crisis, OR 5b) Patients use Herceptin in combination with capecitabine, in combination with lapatinib without chemotherapy, in combination with pertuzumab with or without chemotherapy and the patient previous received chemotherapy and Herceptin in the absence of pertuzumab. For esophageal, gastric, or esophagogastric junction cancer: 1) The disease is locally advanced or metastatic, AND 2) Herceptin is used with cisplatin and fluorouracil or cisplatin and capecitabine.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Grupo de autorización previa	HETLIOZ
Nombres de los medicamentos	HETLIOZ
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For initial therapy and continuation of HetlioZ therapy:1) diagnosis of Non-24 Hour Sleep-Wake Disorder, AND 2) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas), AND 3) unable to perceive light in both eyes. For patients currently on HetlioZ therapy, must meet at least one of the following: 1) increased total nighttime sleep OR 2) decreased daytime nap duration
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Initiation: 3 Months, Renewal: Plan Year
Otros criterios	
Grupo de autorización previa	HIGH RISK MEDICATION
Nombres de los medicamentos	CYPROHEPTADINE HCL, DISOPYRAMIDE PHOSPHATE, GUANFACINE ER, NORPACE CR, TRANSDERM-SCOP
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Grupo de autorización previa	HRM-ANTICONVULSANTS
Nombres de los medicamentos	PHENOBARBITAL, PHENOBARBITAL SODIUM
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Grupo de autorización previa HRM-ANTIDEPRESSANTS TCA
Nombres de los medicamentos AMITRIPTYLINE HCL, DOXEPIN HCL, IMIPRAMINE HCL, TRIMIPRAMINE MALEATE
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D, Neuropathic pain for amitriptyline or imipramine.

Crterios de exclusión

Información médica requerida

Restricciones de edad

Restricciones de la persona

autorizada a dar recetas

Duración de la cobertura

Otros criterios

Plan Year

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Depression: 1) Two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs SSRIs (citalopram, escitalopram, fluoxetine, or sertraline), SNRIs (duloxetine, venlafaxine, or venlafaxine ER), bupropion, mirtazapine, or trazodone AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Neuropathic pain for amitriptyline or imipramine: Two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs duloxetine, gabapentin, pregabalin, or lidocaine patch AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

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Grupo de autorización previa	HRM-ANTIPARKINSON
Nombres de los medicamentos	BENZTROPINE MESYLATE, TRIHEXYPHENIDYL HCL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	<p>This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) EPS: 1) One non-HRM alternative formulary drug amantadine has not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug amantadine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug amantadine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug amantadine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.</p> <p>Parkinson's: Two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole have not been tried. AND 2) The patient has a contraindication to two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.</p>

Grupo de autorización previa	HRM-ANTIPSYCHOTICS
Nombres de los medicamentos	THIORIDAZINE HCL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone. AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone. AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Grupo de autorización previa	HRM-CLOMIPRAMINE
Nombres de los medicamentos	CLOMIPRAMINE HCL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Grupo de autorización previa	HRM-DIGOXIN
Nombres de los medicamentos	DIGITEK, DIGOX, DIGOXIN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Reduction in dose is inappropriate AND 2) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Grupo de autorización previa	HRM-ESTROGENS
Nombres de los medicamentos	ESTRADIOL, FYAVOLV, JINTELI, NORETHINDRONE ACETATE/ETH
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Grupo de autorización previa	HRM-GLYBURIDE
Nombres de los medicamentos	GLYBURIDE, GLYBURIDE MICRONIZED
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs glimepiride, glipizide, or metformin have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs glimepiride, glipizide, or metformin AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs glimepiride, glipizide, or metformin have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs glimepiride, glipizide, or metformin AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Grupo de autorización previa	HRM-HYDROXYZINE
Nombres de los medicamentos	HYDROXYZINE HCL, HYDROXYZINE PAMOATE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	<p>This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For pruritus 1) A non-HRM alternative formulary drug levocetirizine has not been tried. AND 2) The patient has a contraindication to a non-HRM alternative formulary drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) A non-HRM alternative formulary drug levocetirizine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. For anxiety 1) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.</p>

Grupo de autorización previa	HRM-HYDROXYZINE INJ
Nombres de los medicamentos	HYDROXYZINE HCL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	<p>This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Alcohol Withdrawal Syndrome: 1) One non-HRM alternative formulary drug clorazepate or lorazepam have not been tried AND 2) The patient has a contraindication to one non-HRM alternative formulary drug clorazepate or lorazepam AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative formulary drug clorazepate or lorazepam have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug clorazepate or lorazepam AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient Anxiety: 1) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER have not been tried AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 7) If being requested for nausea/vomiting, prescriber must acknowledge that medication benefits outweigh potential risks for this patient.</p>

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Grupo de autorización previa	HRM-HYPNOTICS
Nombres de los medicamentos	ESZOPICLONE, ZOLPIDEM TARTRATE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
Grupo de autorización previa	HRM-MEGESTROL AC
Nombres de los medicamentos	MEGESTROL ACETATE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, oral suspension - palliative treatment of advanced carcinoma of the breast or endometrium (i.e., recurrent, inoperable, or metastatic disease).
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Grupo de autorización previa	HRM-NITROFURANTOIN
Nombres de los medicamentos	NITROFURANTOIN MACROCRYST, NITROFURANTOIN MONOHYDRAT
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

Grupo de autorización previa	HRM-PROMETHAZINE
Nombres de los medicamentos	PHENADOZ, PHENERGAN, PROMETHAZINE HCL, PROMETHEGAN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	<p>This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)</p> <p>Rhinitis: 1) One non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal have not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient</p> <p>Urticaria: 1) One non-HRM alternative formulary drug levocetirizine have not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug levocetirizine have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 7) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 8) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient</p>

Grupo de autorización previa	HRM-SKELETAL MUSCLE RELAXANTS
Nombres de los medicamentos	CARISOPRODOL, CYCLOBENZAPRINE HCL, METHOCARBAMOL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Grupo de autorización previa	HUMIRA
Nombres de los medicamentos	HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CROHNS DISEASE, HUMIRA PEN-PSORIASIS STAR
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis, uveitis.
Criterios de exclusión	
Información médica requerida	Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Humira (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response to at least a 3-month trial of methotrexate (MTX) despite adequate dosing (i.e., titrated to 25 mg/week), 2) Intolerance or contraindication to MTX, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD or a targeted synthetic DMARD (e.g., Xeljanz), 4) Intolerance to a prior biologic DMARD or a targeted synthetic DMARD, 5) Severely active RA. For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): Patient meets ANY of the following criteria: 1) Inadequate response to at least a 3-month trial of MTX, 2) Intolerance or contraindication to MTX, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD, 4) Intolerance to a prior biologic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to at least a 4-week NSAID trial at maximum recommended or tolerated dose OR intolerance and/or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year

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Otros criterios

For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to immunosuppressant therapy (e.g., corticosteroids, azathioprine, mercaptopurine) or intolerance or contraindication to immunosuppressant therapy, AND 2) Patient is naive to TNF inhibitor therapy or patient lost response to previous TNF inhibitor therapy due to antibody formation. For active psoriatic arthritis (PsA) (new starts only): Patient meets ANY of the following: 1) Inadequate response to at least a 3-month trial of MTX, sulfasalazine, or leflunomide, 2) Intolerance or contraindication to MTX, sulfasalazine, or leflunomide, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD, 4) Intolerance to a prior biologic DMARD, 5) Severely active PsA as evidenced by ANY of the following: a) multiple swollen joints, b) structural damage in the presence of inflammation, c) clinically relevant extra-articular manifestations (e.g., extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), 6) Active enthesitis and/or dactylitis (i.e., sausage finger), 7) Predominant axial disease (i.e., extensive spinal involvement).

Grupo de autorización previa	HYPNOTIC BENZODIAZEPINES
Nombres de los medicamentos	TEMAZEPAM
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	This Prior Authorization requirement only applies to patients 65 years of age or older.(The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has not been tried. AND 2) The patient has a contraindication to two non-HRM alternative drugs Silenor (3mg or 6mg) and trazodone. AND 3) Prescriber must acknowledge that medication benefits outweigh potential risk in a patient 65 years of age or older. OR 4) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug Silenor (3mg or 6mg) or trazodone. AND 6) Prescriber must acknowledge that medication benefits outweigh potential risk in a patient 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	IBRANCE
Nombres de los medicamentos	IBRANCE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D. Single-agent therapy for the treatment of well-differentiated/dedifferentiated liposarcoma for retroperitoneal sarcomas.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	ICLUSIG
Nombres de los medicamentos	ICLUSIG
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For CML or Ph+ ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
Restricciones de edad	18 years of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	IMATINIB
Nombres de los medicamentos	IMATINIB MESYLATE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, Ph+ lymphoblastic lymphoma, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, and melanoma.
Criterios de exclusión	
Información médica requerida	For CML or Ph+ ALL/lymphoblastic lymphoma, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor (eg, dasatinib, nilotinib, bosutinib, ponatinib). For melanoma, c-Kit mutation is positive.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	IMBRUVICA
Nombres de los medicamentos	IMBRUVICA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, small lymphocytic lymphoma, lymphoplasmacytic lymphoma.
Criterios de exclusión	
Información médica requerida	For Waldenstrom's macroglobulinemia and lymphoplasmacytic lymphoma (WM/LPL): Imbruvica is used as a single agent.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	INCRELEX
Nombres de los medicamentos	INCRELEX
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Closed epiphyses
Información médica requerida	Must meet all of the following prior to beginning Increlex therapy (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) stimulation test showing a normal or elevated growth hormone level. For renewal, patient is experiencing improvement AND the current IGF-1 level is normal for age and gender.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	Endocrinologist
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	INLYTA
Nombres de los medicamentos	INLYTA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, papillary, Hurthle cell, or follicular thyroid carcinoma.
Criterios de exclusión	
Información médica requerida	For renal cell carcinoma: 1) Inlyta will be used as a single agent and 2) the disease is relapsed or medically unresectable. For disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. For thyroid carcinoma: 1) The disease has papillary, Hurthle cell, or follicular histology, 2) Nexavar is not an appropriate option for the patient, 3) the disease is unresectable or metastatic, 4) the disease is radioiodine refractory, and 5) the disease is progressive or symptomatic.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	IRESSA
Nombres de los medicamentos	IRESSA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	ISOTRETINOIN
Nombres de los medicamentos	CLARAVIS, MYORISAN, ZENATANE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, Cutaneous T-cell Lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), Keratosis follicularis (Darier Disease), Lamellar ichthyosis, Neuroblastoma, Pityriasis rubra pilaris, Transient acantholytic dermatosis (Grover Disease), severe refractory Rosacea, refractory Acne, Reduction of the development of skin cancer (squamous cell cancers) in high risk patients.
Criterios de exclusión	
Información médica requerida	For acne (severe recalcitrant nodular or refractory) or severe refractory rosacea and patient had inadequate treatment responses to any topical acne product and an oral antibiotic [Note: topical products include salicylic acid, benzoyl peroxide, azelaic acid, adapalene, tretinoin, tazarotene, clindamycin, erythromycin, or metronidazole for rosacea] [Note: oral antibiotics include minocycline, doxycycline, tetracycline, erythromycin, trimethoprim-sulfamethoxazole, trimethoprim, azithromycin].
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	For acne (severe recalcitrant nodular or refractory) or severe refractory rosacea treatment will be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course.

Grupo de autorización previa	ITRACONAZOLE
Nombres de los medicamentos	ITRACONAZOLE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, Coccidioidomycosis, Cryptococcosis, Sporotrichosis, Penicilliosis, Microsporidiosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea manuum/Tinea pedis.
Criterios de exclusión	Current use of certain drugs metabolized by CYP3A4. If the patient has the diagnosis of onychomycosis, evidence of ventricular dysfunction, such as congestive heart failure (CHF).
Información médica requerida	1) If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed with a fungal diagnostic test OR 2) Pityriasis versicolor or Tinea versicolor OR 3) If for the treatment of tinea corporis, tinea cruris, tinea manuum, tinea pedis, the patient has experienced either an inadequate treatment response, adverse event, intolerance, or contraindication to griseofulvin OR 4) Diagnosis of blastomycosis, histoplasmosis, aspergillosis, coccidioidomycosis, cryptococcosis, sporotrichosis, penicilliosis, microsporidiosis.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Onychomycosis, Versicolor (pityriasis or tinea), Tinea-3mo, Systemic infection-6mo
Otros criterios	Criteria apply to capsule dosage form only.

Grupo de autorización previa	IVIG
Nombres de los medicamentos	BIVIGAM, CARIMUNE NANOFILTERED, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, primary immunodeficiency, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, idiopathic thrombocytopenic purpura, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
Criterios de exclusión	IgA deficiency with antibodies to IgA and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin or product components.
Información médica requerida	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL OR 2) History of recurrent bacterial infections, patient is not able to take combination antiretroviral therapy, and antibiotic prophylaxis was not effective. For dermatomyositis and polymyositis: standard first-line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For myasthenia gravis: IVIG is requested for worsening weakness, acute exacerbation or use in preparation for surgery. PRCA is secondary to parvovirus B19 infection.
Restricciones de edad	For pediatric HIV infection: age 12 years or younger
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Grupo de autorización previa	JAKAFI
Nombres de los medicamentos	JAKAFI
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For polycythemia vera, patient has had an inadequate response to or is intolerant of hydroxyurea.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	JUXTAPID
Nombres de los medicamentos	JUXTAPID
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Otros criterios), 2) Prior to initiation of treatment with Juxtapid, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin, rosuvastatin), fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, 3) Prior to initiation of treatment with Juxtapid, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated LDL-C greater than 160 mg/dL. For renewal of therapy: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	Lipid specialist, cardiometabolic specialist, cardiologist, or endocrinologist
Duración de la cobertura	Plan Year
Otros criterios	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, b) Diagnosis of definite FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of definite FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, 2) Simon-Broome Diagnostic Criteria for definite FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or 3) Dutch Lipid Clinic Network Criteria for definite FH: Total score greater than 8 points.

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Grupo de autorización previa	KALYDECO
Nombres de los medicamentos	KALYDECO
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Use in combination with Orkambi
Información médica requerida	The patient has a diagnosis of cystic fibrosis. The patient has one of the following documented mutations to the CFTR gene that was confirmed by genetic testing: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, or R117H.
Restricciones de edad	Granules: 2 years of age and older, Tablets: 6 years of age and older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	KETOCONAZOLE
Nombres de los medicamentos	KETOCONAZOLE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, Cushing's syndrome
Criterios de exclusión	Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine.
Información médica requerida	The patient's liver status will be assessed prior to therapy and as needed during therapy.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	6 months
Otros criterios	1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, and paracoccidioidomycosis AND other antifungal therapies are ineffective, unavailable, or not tolerated OR 2) Ketoconazole (Nizoral) is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative.

Grupo de autorización previa	KEYTRUDA
Nombres de los medicamentos	KEYTRUDA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For melanoma: Patient has unresectable or metastatic disease. Keytruda will be used as a single agent. Keytruda is used for first-line therapy OR Keytruda is used for second-line therapy and patient meets both of the following criteria: 1) Patient has experienced disease progression, AND 2) Patient has not received Keytruda previously. For HNSCC, patient has recurrent or metastatic disease and the patient has experienced disease progression on or after platinum-containing chemotherapy.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	KORLYM
Nombres de los medicamentos	KORLYM
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Korlym is being used to control hyperglycemia secondary to hypercortisolism in a patient with endogenous Cushing's syndrome who has type 2 diabetes mellitus or glucose intolerance. Patient has had surgery that was not curative or the patient is not a candidate for surgery.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	Endocrinologist
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	KUVAN
Nombres de los medicamentos	KUVAN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For patients who have not yet received a therapeutic trial of Kuvan: a) patients less than or equal to 12 years of age have a baseline blood Phe level greater than 6 mg/dL OR b) patients greater than 12 years of age have a baseline blood Phe level greater than 10 mg/dL. For patients for whom this is the first treatment after a therapeutic trial of Kuvan: a) patient must have experienced a reduction in blood Phe level of greater than or equal to 30 percent from baseline OR b) patient has demonstrated an improvement in neuropsychiatric symptoms.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Initial: 2 months. Continuation of treatment: Plan Year.
Otros criterios	

Grupo de autorización previa	KYNAMRO
Nombres de los medicamentos	KYNAMRO
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Otros criterios), 2) Prior to initiation of treatment with Kynamro, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin, rosuvastatin), fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, 3) Prior to initiation of treatment with Kynamro, patient is/was experiencing an inadequate response to such combination regimen, as demonstrated by treated LDL-C greater than 160 mg/dL. For renewal of therapy, 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	Lipid specialist, cardiometabolic specialist, cardiologist, or endocrinologist
Duración de la cobertura	Plan Year
Otros criterios	Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, b) Diagnosis of definite FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, sudden premature cardiac death. Diagnosis of definite FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, 2) Simon-Broome Diagnostic Criteria for definite FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or 3) Dutch Lipid Clinic Network Criteria for definite FH: Total score greater than 8 points.

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Grupo de autorización previa	LENVIMA
Nombres de los medicamentos	LENVIMA 10 MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For differentiated thyroid cancer: 1) histologic subtype is papillary, follicular, or Hurthle cell, 2) disease is symptomatic and/or progressive, 3) disease is iodine-refractory, and 4) patient has unresectable recurrent or persistent locoregional disease OR metastatic disease.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	LETAIRIS
Nombres de los medicamentos	LETAIRIS
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	LEUKINE
Nombres de los medicamentos	LEUKINE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, prevention and treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL) or acute myeloid leukemia (AML), neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia.
Criterios de exclusión	Use of Leukine within 24 hours prior to or following chemotherapy or radiotherapy. For treatment of chemotherapy-induced FN, patient received prophylactic pegylated G-CSF (eg, Neulasta) during the current chemotherapy cycle.
Información médica requerida	For prophylaxis of myelosuppressive chemotherapy-induced FN the patient must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN the patient must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For MDS: Patient has neutropenia and experiences recurrent or resistant infections.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	6 months
Otros criterios	For prevention of neutropenia: Patient will not receive chemotherapy and radiotherapy concurrently
Grupo de autorización previa	LIDOCAINE PATCHES
Nombres de los medicamentos	LIDOCAINE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g. neuropathy associated with radiation treatment or chemotherapy]).
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

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Grupo de autorización previa	LONSURF
Nombres de los medicamentos	LONSURF
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For metastatic colorectal cancer, KRAS (with or without NRAS) mutation testing is performed on either the primary tumor or metastases to confirm RAS mutation status. The patient must have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if KRAS or NRAS wild type, an anti-EGFR therapy.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	LUPRON
Nombres de los medicamentos	LEUPROLIDE ACETATE, LUPRON DEPOT, LUPRON DEPOT-PED
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, in combination with growth hormone for children with growth failure and advancing puberty (leuprolide acetate only), breast cancer (Lupron Depot 3.75mg only), malignant sex cord-stromal tumors (Lupron 3.75mg and 11.25 mg only), epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer (Lupron Depot 3.75mg only), preoperative use for uterine leiomyomata (Lupron Depot 3.75mg and 11.25mg only).
Criterios de exclusión	Undiagnosed abnormal vaginal bleeding (Lupron 3.75mg and 11.25mg only). Pregnancy (Lupron 3.75mg and 11.25mg only). Breast feeding (Lupron 3.75mg and 11.25mg only).
Información médica requerida	For central precocious puberty (CPP), patients not currently receiving therapy must meet ALL of the following criteria: 1) Diagnosis of CPP confirmed by: a) A pubertal response to a GnRH agonist OR a pubertal level of a third generation LH assay AND, b) Assessment of bone age versus chronological age AND, c) Appropriate diagnostic imaging of the brain to exclude an intracranial tumor. 2) The onset of sexual characteristics occurred prior to eight years of age for female patients OR prior to nine years of age for male patients. For prostate cancer (PC): If the patient has regional disease as initial ADT, metastatic disease as initial ADT, progressive castration-naive disease, or recurrent disease as defined as a biochemical failure after previous therapy, then no further information is required. If the patient has lymph node-positive disease found during pelvic lymph node dissection (PLND), then Lupron Depot must be used without external beam radiation therapy (EBRT) as adjuvant therapy. If the patient has none of the abovementioned criteria and has intermediate risk stratification (IRS), then Lupron Depot must be used with EBRT as initial ADT. If the patient has none of the abovementioned criteria and has high or very high risk stratification, then Lupron Depot must be used with EBRT or EBRT and docetaxel as initial ADT. If the patient has none of the abovementioned criteria and has very high risk stratification and is not a candidate for definitive therapy, Lupron Depot may be used without EBRT as initial ADT. For endometriosis (ENDO) retreatment patient must meet all of the following: 1) Patient has had a recurrence of symptoms, 2) Patient will be receiving add-back therapy (e.g., norethindrone), AND 3) Bone mineral density is within normal limits.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	For PC with IRS: 6 months (MO). Fibroids: 3 MO: Max 6 MO. ENDO: 6 MO: max 12 MO. Others: Plan Year.

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For prostate cancer: Use as neoadjuvant therapy prior to radical prostatectomy is not approvable. For uterine fibroids patient must meet one of the following: 1) Diagnosis of anemia (e.g., hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) Lupron Depot will be used in the preoperative setting to facilitate surgery. For uterine fibroids retreatment, bone mineral density is within normal limits. For epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: Lupron (3.75mg only) will be used as a single agent AND disease is persistent or recurrent. For breast cancer (3.75mg only) patient must meet all of the following: 1) Premenopausal woman, 2) Hormone receptor positive disease.

Grupo de autorización previa

LYNPARZA

Nombres de los medicamentos

LYNPARZA

Usos cubiertos

All FDA-approved indications not otherwise excluded from Part D.

Criterios de exclusión**Información médica requerida****Restricciones de edad****Restricciones de la persona****autorizada a dar recetas****Duración de la cobertura**

Plan Year

Otros criterios**Grupo de autorización previa**

MEGESTROL

Nombres de los medicamentos

MEGESTROL ACETATE

Usos cubiertos

All FDA-approved indications not otherwise excluded from Part D.

Criterios de exclusión

Pregnancy

Información médica requerida**Restricciones de edad****Restricciones de la persona****autorizada a dar recetas****Duración de la cobertura**

Plan Year

Otros criterios

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Grupo de autorización previa	MEKINIST
Nombres de los medicamentos	MEKINIST
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Mekinist will be used as a single agent or in combination with Tafinlar for patients with a diagnosis of unresectable or metastatic melanoma AND tumor is positive for BRAF V600E or V600K mutation.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	MEMANTINE
Nombres de los medicamentos	MEMANTINE HCL, MEMANTINE HYDROCHLORIDE, NAMENDA XR, NAMENDA XR TITRATION PACK
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	The drug is being prescribed for the treatment of moderate to severe dementia of the Alzheimer's type.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	This edit only applies to patients less than 30 years of age.
Grupo de autorización previa	MOZOBIL
Nombres de los medicamentos	MOZOBIL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	6 months
Otros criterios	

Grupo de autorización previa NAGLAZYME
Nombres de los medicamentos NAGLAZYME
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D
Criterios de exclusión
Información médica requerida Diagnosis of mucopolysaccharidosis VI (MPS VI) disease was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by DNA testing

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

Grupo de autorización previa NATPARA
Nombres de los medicamentos NATPARA
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión Acute postsurgical hypoparathyroidism (within 6 months of surgery). Hypoparathyroidism due to calcium-sensing receptor mutations. Any of the following risk factors for osteosarcoma: Paget's disease of bone, unexplained elevations of alkaline phosphatase, open epiphyses (ie, children or young adults), hereditary disorder that predisposes to osteosarcoma, history of external beam or implant radiation therapy involving the skeleton.
Información médica requerida Natpara is prescribed to control hypocalcemia associated with hypoparathyroidism. Natpara will be used in conjunction with calcium supplements with or without calcitriol (activated vitamin D). For initial therapy only: 1) total serum calcium levels are inadequately controlled despite treatment with optimized doses of calcium supplements and calcitriol, 2) total serum calcium level (albumin-corrected) is above 7.5 mg/dL, 3) serum 25-hydroxyvitamin D level is within the normal range, and 4) serum magnesium level is within the normal range. For continuation of therapy only: 1) total serum calcium level (albumin-corrected) is within the low-normal range (generally between 8 mg/dL and 9 mg/dL) OR the dose of Natpara, calcitriol, or calcium supplement is being adjusted to achieve total serum calcium levels within the low-normal range, and 2) serum 25-hydroxyvitamin D level is within the normal range.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Initial: 6 months Renewal: Plan Year

Otros criterios

Grupo de autorización previa	NEXAVAR
Nombres de los medicamentos	NEXAVAR
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, osteosarcoma, soft tissue sarcoma subtypes: angiosarcoma, desmoid tumors (aggressive fibromatosis), gastrointestinal stromal tumor (GIST), medullary thyroid carcinoma, acute myeloid leukemia.
Criterios de exclusión	
Información médica requerida	For hepatocellular carcinoma: 1) Nexavar will be used as a single agent and 2) the disease is a) metastatic, OR b) unresectable and the patient is not a candidate for liver transplantation, OR c) the patient is not a candidate for surgery due to performance status or comorbidities. For renal cell carcinoma: 1) The patient has relapsed or medically unresectable disease, 2) Nexavar will be used as a single agent, and 3) for disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) The disease is unresectable or metastatic, 2) the disease is radioiodine-refractory, and 3) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For osteosarcoma: Nexavar will be used as a single agent. For gastrointestinal stromal tumor: The disease has progressed after treatment with imatinib, sunitinib, or regorafenib. For acute myeloid leukemia: 1) The disease is relapsed or refractory, 2) the patient has FLT3-ITD mutation-positive disease, 3) the patient cannot tolerate more aggressive regimens, and 4) Nexavar will be used in combination with azacitidine or decitabine.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	NINLARO
Nombres de los medicamentos	NINLARO
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	NORTHERA
Nombres de los medicamentos	NORTHERA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Prior to initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing, supported by serial blood pressure measurements. Northera will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) Dopamine beta hydroxylase deficiency, OR 3) Non-diabetic autonomic neuropathy
Restricciones de edad	18 years of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	3 months
Otros criterios	Patients currently on Northera must experience a sustained decrease in dizziness to continue on therapy.

Grupo de autorización previa	NUEDEXTA
Nombres de los medicamentos	NUEDEXTA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Patient is currently using quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong the QT interval and are metabolized by CYP2D6 (examples: thioridazine and pimozide). Patient has a prolonged QT interval or congenital long QT syndrome (LQTS), or heart failure or a history suggestive of torsades de pointes (TdP). Patient has complete atrioventricular (AV) block without an implanted pacemaker or is at high risk of complete AV block.

Información médica requerida

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

Grupo de autorización previa	NUPLAZID
Nombres de los medicamentos	NUPLAZID
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Dementia-related psychosis that is unrelated to the hallucinations and delusions associated with Parkinson's disease psychosis.

Información médica requerida The diagnosis of Parkinson's disease was made prior to the onset of psychotic symptoms.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

Grupo de autorización previa	NUVIGIL
Nombres de los medicamentos	ARMODAFINIL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography OR 3) Diagnosis is Shift Work Disorder (SWD).
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa
Nombres de los medicamentos
Usos cubiertos

OCTREOTIDE
OCTREOTIDE ACETATE, SANDOSTATIN LAR DEPOT
All FDA-approved indication not otherwise covered under Part D, meningiomas, thymomas and thymic carcinomas, adrenal gland neuroendocrine tumors (NETs), NETs of the gastrointestinal (GI) tract, thymus, and lung, pancreatic NETs, and poorly differentiated (high-grade)/large or small cell NETs.

Criterios de exclusión
Información médica requerida

Meningiomas: 1) Patient has recurrent or progressive disease (dx), 2) Dx is unresectable, 3) Dx is refractory to radiation therapy, and 4) Somatostatin receptor status (SRS) is positive. Thymomas and thymic carcinomas: 1) Patient has locally advanced, advanced, or recurrent dx, 2) Dx is unresectable OR patient has residual dx following resection, 3) Patient has progressed on at least one prior chemotherapy regimen, and 4) SRS is positive OR patient has symptoms of carcinoid syndrome. NETs of GI tract: Patient has 1) distant metastases OR 2) unresectable dx, OR 3) primary site of tumor is gastric, tumor is less than or equal to 2 cm, AND patient has hypersecretion of gastrin. NETs of thymus: Patient has distant metastases OR unresectable dx. NETs of lung: 1) Patient has distant metastases OR 2) Patient has a) NET that is low-grade (typical carcinoid) or intermediate-grade (atypical carcinoid), AND b) Stage IIIB dx that is T4 due to multiple lung nodules or Stage IV dx, AND c) SRS is positive or patient has symptoms of carcinoid syndrome. Pancreatic NETs: 1) For gastrinoma, glucagonoma, and VIPoma, patient's SRS is positive OR patient has hormone-related symptoms, OR 2) For insulinoma, non-functioning pancreatic tumor, somatostatinoma, pancreatic polypeptidoma, cholecystikininoma, ACTH-secreting pancreatic NET, and parathyroid hormone-related protein-secreting pancreatic NET, patient has a) distant metastases or unresectable dx AND b) SRS is positive OR patient has hormone-related symptoms. Adrenal gland NETs: 1) Patient has a diagnosis of non-ACTH dependent Cushing's syndrome, and 2) Cortisol production is symmetric, and 3) Tumors are less than 4 cm, and 4) SRS is positive. Poorly differentiated (high-grade)/large or small cell NETs (excluding lung): 1) Patient has metastatic or unresectable dx, 2) SRS is positive, and 3) Patient has hormone-related symptoms.

Restricciones de edad
Restricciones de la persona autorizada a dar recetas
Duración de la cobertura
Otros criterios

Plan Year
Acromegaly: Patient has 1) clinical evidence of acromegaly, 2) a high pre-treatment IGF-1 level for age and/or gender, and 3) an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why patient has not had surgery or radiotherapy. For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

Grupo de autorización previa	ODOMZO
Nombres de los medicamentos	ODOMZO
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Pregnancy
Información médica requerida	Member has a diagnosis of locally advanced basal cell carcinoma (BCC). Member experienced disease recurrence following surgery or radiation therapy OR member is not a candidate for surgery or radiation therapy. For females of reproductive potential, pregnancy has been ruled out with a negative pregnancy test result.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	OFEV
Nombres de los medicamentos	OFEV
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Initial Review Only: The patient does not have a known etiology for interstitial lung disease. The patient has completed a high-resolution computed tomography study of the chest which reveals the usual interstitial pneumonia pattern. If the study reveals the possible usual interstitial pneumonia pattern, the diagnosis is supported by surgical lung biopsy. If a surgical lung biopsy has not been previously conducted, the diagnosis is supported by a multidisciplinary discussion between a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis. For initial and continuation: Ofev will not be used in combination with Esbriet.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Initial: 6 months, Renewal: Plan Year
Otros criterios	For continuation only: The patient has experienced a reduction in disease progression.

Grupo de autorización previa	ONFI
Nombres de los medicamentos	ONFI
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	2 years of age or older.
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	OPSUMIT
Nombres de los medicamentos	OPSUMIT
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	ORAL-INTRANASAL FENTANYL
Nombres de los medicamentos	FENTANYL CITRATE ORAL TRA, FENTORA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Significant respiratory depression. Known or suspected paralytic ileus.
Información médica requerida	1) The patient has CANCER related pain AND 2) The ICD diagnosis code provided supports the CANCER RELATED diagnosis [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER RELATED diagnosis.] AND 3) The drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain AND 4) The patient can safely take the requested dose based on their current opioid use history. [Note: The TIRF (Transmucosal Immediate-Release Fentanyl) products (Abstral, Actiq, Fentora, Lazanda, Onsolis, and Subsys) are indicated for opioid- tolerant patients. Patients considered opioid tolerant are those who are taking at least: 60 mg of oral morphine/day, 25 mcg of transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of another opioid for a week or longer.]

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

Grupo de autorización previa

Nombres de los medicamentos ORFADIN

Usos cubiertos All FDA-approved indications not otherwise excluded from Part D.

Criterios de exclusión

Información médica requerida Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) and appropriate clinical picture of the patient, or 2) DNA testing (mutation analysis).

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

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Grupo de autorización previa	ORKAMBI
Nombres de los medicamentos	ORKAMBI
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Use in combination with Kalydeco
Información médica requerida	The patient is positive for the F508del mutation on both alleles of the CFTR gene.
Restricciones de edad	6 years of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	PEGASYS
Nombres de los medicamentos	PEGASYS, PEGASYS PROCLICK
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia (CML), giant cell tumor of the bone (GCTB).
Criterios de exclusión	Decompensated cirrhosis (Child Turcotte Pugh class B or C)
Información médica requerida	For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines. For chronic hepatitis B: 1) For pt with cirrhosis, must have been HBsAg positive for at least 6 months AND must have serum HBV-DNA greater than or equal to 10,000 copies/mL or greater than or equal to 2,000 IU/mL regardless of HBeAg status. 2) For pts without cirrhosis, must have been HBsAg positive for at least 6 months. If HBeAg positive, pt must have serum HBV-DNA greater than 100,000 copies/mL or greater than 20,000 IU/mL. If HBeAg negative, pt must have serum HBV-DNA greater than 10,000 copies/mL or greater than 2,000 IU/mL. Must have persistent or intermittently elevated ALT greater than 2 times the upper limit of normal OR liver biopsy showing chronic hepatitis with moderate to severe inflammation or significant fibrosis.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	HCV=12 to 48 wks depending on treatment regimen. HBV=48 wks. CML and GCTB=Plan Year.
Otros criterios	

Grupo de autorización previa	PHENYLBUTYRATE
Nombres de los medicamentos	BUPHENYL, SODIUM PHENYLBUTYRATE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing. Buphenyl will be used for chronic management of UCD.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	POMALYST
Nombres de los medicamentos	POMALYST
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis.
Criterios de exclusión	
Información médica requerida	For multiple myeloma: 1) The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent (ie, thalidomide, lenalidomide) AND a proteasome inhibitor (ie, bortezomib, carfilzomib), 2) Pomalyst will be used as a single agent or in combination with dexamethasone, and 3) the patient will be monitored for thromboembolism. For systemic light chain amyloidosis: 1) Pomalyst will be used in combination with dexamethasone and 2) the patient will be monitored for thromboembolism.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	PRALUENT
Nombres de los medicamentos	PRALUENT
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Member must have one of the following conditions (new starts and continuation): 1) Prior clinical atherosclerotic cardiovascular disease (ASCVD) or cardiovascular event (see Otros criterios), or 2) Heterozygous familial hypercholesterolemia (HeFH): Definite diagnosis of FH (See Otros criterios). For new starts: For members with prior clinical ASCVD or cardiovascular event, at least one of the following requirements is met: 1) Current LDL-C level 70 mg/dL or greater after treatment with a high-intensity statin (eg, atorvastatin, rosuvastatin), 2) Current LDL-C level 70 mg/dL or greater with intolerance to a high-intensity statin AND is taking a maximally tolerated dose of any statin, 3) Current LDL-C level 70 mg/dL or greater with contraindication to statin (see Otros criterios) OR intolerance to any dose of two statins, or 4) Recent treatment (ie, within the last 120 days) with another PCSK9 inhibitor. For members with HeFH, at least one of the following requirements is met: 1) With ASCVD: See requirements for members with prior ASCVD above, 2) Current LDL-C level 100 mg/dL or greater after treatment with a high-intensity statin (eg, atorvastatin, rosuvastatin), 3) Current LDL-C level 100 mg/dL or greater with intolerance to a high-intensity statin AND is taking a maximally tolerated dose of any statin, 4) Current LDL-C level 100 mg/dL or greater with contraindication to statin (see Otros criterios) OR intolerance to any dose of two statins, or 5) Recent treatment (ie, within the last 120 days) with another PCSK9 inhibitor. For continuation: Response to therapy as demonstrated by a reduction in LDL-C.
Restricciones de edad	18 years of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year

Otros criterios

Clinical ASCVD or cardiovascular event defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure [eg, PTCA, CABG], stroke of presumed atherosclerotic origin, transient ischemic attack, peripheral arterial disease of presumed atherosclerotic origin, findings from CT angiogram or catheterization consistent with clinical ASCVD). Diagnosis of FH must be confirmed by one of the following: 1) Genetic confirmation: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, 2) Simon-Broome Diagnostic Criteria for definite FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or 3) Dutch Lipid Clinic Network Criteria for definite FH: Total score greater than 8 points. Contraindication to statin must be due to one of the following: 1) Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (eg, ALT level at least 3 times ULN), 2) Women who are pregnant or may become pregnant, or 3) Nursing mothers.

Grupo de autorización previa	PRIVIGEN
Nombres de los medicamentos	PRIVIGEN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
Criterios de exclusión	IgA deficiency with antibodies to IgA and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin or product components. Hyperprolinemia.
Información médica requerida	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections, patient is not able to take combination antiretroviral therapy, and antibiotic prophylaxis was not effective. For dermatomyositis and polymyositis: standard first-line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For myasthenia gravis: IVIG is requested for worsening weakness, acute exacerbation or use in preparation for surgery. PRCA is secondary to parvovirus B19 infection.
Restricciones de edad	For pediatric HIV infection: age 12 years or younger
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Grupo de autorización previa	PROMACTA
Nombres de los medicamentos	PROMACTA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For chronic or persistent immune thrombocytopenia (ITP): For new starts: a) Patient has had an inadequate response or is intolerant to corticosteroids, immunoglobulins or splenectomy, AND b) Untransfused platelet count at time of diagnosis is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. For continuation of therapy, platelet (plt) count response to Promacta: a) Current plt count is 50,000-200,000/mcL OR b) Current plt count is less than 50,000/mcL and sufficient to avoid clinically important bleeding OR c) Current plt count is less than 50,000/mcL and patient has not received a maximal dose of Promacta for at least 4 weeks OR d) Current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: For new starts: a) Promacta is used for initiation and maintenance of interferon-based therapy, AND b) Untransfused platelet count at time of diagnosis is less than 75,000/mcL. For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): For new starts: a) Patient has had an inadequate response to immunosuppressive therapy, AND b) Untransfused platelet count at time of diagnosis is less than or equal to 30,000/mcL. For continuation of therapy, plt count response to Promacta: a) Current plt count is 50,000-200,000/mcL OR b) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks OR c) Current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. Adequate platelet response = APR. Inadequate platelet response = IRP
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	HCV:6mo, ITP/AA initial:6mo, ITP/AA APR reauth: Plan Yr, ITP IPR reauth:3mo, AA IPR reauth:16wks
Otros criterios	

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Grupo de autorización previa	PULMOZYME
Nombres de los medicamentos	PULMOZYME
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan year
Otros criterios	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Grupo de autorización previa	QUININE SULFATE
Nombres de los medicamentos	QUININE SULFATE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, Babesiosis, uncomplicated Plasmodium vivax malaria
Criterios de exclusión	Prolonged QT interval. Glucose-6-phosphate dehydrogenase (G6PD) deficiency. Myasthenia gravis. Optic neuritis.
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	1 month
Otros criterios	

Grupo de autorización previa	RAVICTI
Nombres de los medicamentos	RAVICTI
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing. Ravicti will be used for chronic management of UCD. Patient has experienced intolerance to prior Buphenyl therapy OR patient has not tried Buphenyl because of a comorbid condition that prohibits a trial due to its sodium content (e.g., heart failure, hypertension, renal impairment, edema).
Restricciones de edad	2 months of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	REGRANEX
Nombres de los medicamentos	REGRANEX
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Neoplasm(s) at site(s) of application.
Información médica requerida	1) For the treatment of lower extremity diabetic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply AND 2) Good ulcer care practices including initial sharp debridement, pressure relief, and infection control will be performed.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	20 weeks
Otros criterios	

Grupo de autorización previa	RELISTOR
Nombres de los medicamentos	RELISTOR
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Known or suspected mechanical gastrointestinal obstruction. At increased risk of recurrent obstruction due to the potential for gastrointestinal perforation.
Información médica requerida	1) Relistor is being prescribed for opioid-induced constipation in an adult patient with advanced illness who is receiving palliative care when response to laxative therapy has not been sufficient OR 2) Relistor is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried.(Note: Examples are Amitiza or Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: Examples are Amitiza or Movantik) OR 6) The patient has a contraindication to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: Examples are Amitiza or Movantik).
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	4 Months
Otros criterios	

Grupo de autorización previa	REMICADE
Nombres de los medicamentos	REMICADE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D. Axial spondyloarthritis. Behcet's syndrome. Granulomatosis with polyangiitis (Wegener's granulomatosis). Hidradenitis suppurativa. Juvenile idiopathic arthritis. Pyoderma gangrenosum. Sarcoidosis. Takayasu's arteritis. Uveitis.
Criterios de exclusión	
Información médica requerida	Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Remicade (or other biologic). For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) Inadequate response to at least a 3-month trial of self-injectable TNF inhibitor (eg, Cimzia, Humira) OR 3) Intolerance to a self-injectable TNF inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (eg, corticosteroids, sulfasalazine, azathioprine, mesalamine) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Remicade will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (eg, Cimzia, Humira) or intolerance to a self-injectable TNF inhibitor. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to at least a 4-week NSAID trial at maximum recommended or tolerated dose OR intolerance and/or contraindication to NSAIDs.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year

Otros criterios

For active psoriatic arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of MTX, sulfasalazine, or leflunomide OR 2) Intolerance or contraindication to MTX, sulfasalazine, or leflunomide OR 3) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (eg, Humira, Cimzia), OR 4) Intolerance to a self-injectable TNF inhibitor, OR 5) Severely active PsA as evidenced by ANY of the following: a) multiple swollen joints, b) structural damage in the presence of inflammation, c) clinically relevant extra-articular manifestations (eg, extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), OR 6) Active enthesitis and/or dactylitis (ie, sausage finger) OR 7) Predominant axial disease (ie, extensive spinal involvement). For chronic moderate to severe plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (e.g., feet, hands, face, neck and/or groin) are affected AND 2) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (e.g., Humira) or intolerance to a self-injectable TNF inhibitor. For juvenile idiopathic arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (e.g., Humira) OR 2) Intolerance to a self-injectable TNF inhibitor. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis (e.g., methotrexate, azathioprine, or mycophenolate mofetil).

Grupo de autorización previa

REMODULIN

Nombres de los medicamentos

REMODULIN

Usos cubiertos

All FDA-approved indications not otherwise excluded from Part D.

Criterios de exclusión

Información médica requerida

Patient has had NYHA Functional Class II, III, or IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura

Plan Year

Otros criterios

Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

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Grupo de autorización previa	REVLIMID
Nombres de los medicamentos	REVLIMID
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, classical Hodgkin lymphoma, non-Hodgkin's lymphoma with the following subtypes: chronic lymphocytic leukemia/small lymphocytic lymphoma, AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, lymphoma associated with Castleman's disease, diffuse large B-cell lymphoma, follicular lymphoma, nongastric/gastric MALT lymphoma, primary cutaneous B-cell lymphoma, splenic marginal zone lymphoma, multicentric Castleman's disease.
Criterios de exclusión	
Información médica requerida	For all indications: The patient will be monitored for thromboembolism. For multiple myeloma: Revlimid is prescribed for primary, maintenance, or salvage therapy. For primary therapy: 1) The prescribed regimen includes dexamethasone, OR 2) The prescribed regimen is Revlimid, melphalan, and prednisone for a patient who is not a stem cell transplant candidate. For myelodysplastic syndrome (MDS): 1) Patient must have low- to intermediate-1 risk MDS with symptomatic anemia. For multicentric Castleman's disease: 1) The disease has progressed following treatment of relapsed, refractory, or progressive disease AND 2) Revlimid will be used as monotherapy. For all subtypes of NHL except Castleman's disease: 1) The disease is relapsed, refractory, or progressive AND 2) Revlimid will be used as monotherapy or in combination with rituximab. For systemic light chain amyloidosis: Revlimid will be used with either: a) dexamethasone OR b) dexamethasone AND cyclophosphamide.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	RITUXAN
Nombres de los medicamentos	RITUXAN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, primary CNS lymphoma, leptomeningeal metastases from lymphomas, Hodgkin's lymphoma (lymphocyte-predominant), non-Hodgkin's lymphoma subtypes [marginal zone lymphomas (splenic, MALT), Mantle cell lymphoma, Burkitt lymphoma, AIDS-related B-cell lymphoma, relapsed/refractory hairy cell leukemia, small lymphocytic lymphoma (SLL), post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma, lymphoblastic lymphoma, Castleman's disease], acute lymphoblastic leukemia, refractory immune or idiopathic thrombocytopenic purpura (ITP), acquired blood factor VIII deficiency, autoimmune hemolytic anemia, chronic graft-versus-host disease (GVHD), Waldenstrom's macroglobulinemia, lymphoplasmacytic lymphoma, Sjogren syndrome, thrombotic thrombocytopenic purpura, and prevention of Epstein-Barr virus (EBV)-related PTLD.
Criterios de exclusión	
Información médica requerida	Prior to initiating therapy, patient has been screened for hepatitis B virus (HBV) infection with Hepatitis B serologic assays. For moderately to severely active rheumatoid arthritis (new starts only): 1) Rituxan is used in combination with methotrexate unless methotrexate is contraindicated or not tolerated and 2) member has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor. Hematologic malignancies must be CD20-positive. For Burkitt lymphoma and ALL, Rituxan is used as a component of a chemotherapy regimen. For diffuse large B-cell lymphoma (DLBCL), patient meets one of the following conditions: 1) has relapsed or refractory disease and will use Rituxan as a component of a chemotherapy regimen if patient is a candidate for high dose therapy with autologous stem cell rescue, 2) has relapsed or refractory disease and is not a candidate for high dose therapy with autologous stem cell rescue OR 3) does not have relapsed or refractory disease and will use Rituxan as a component of a chemotherapy regimen. For Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA), Rituxan will be used in combination with glucocorticoids.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	SABRIL
Nombres de los medicamentos	SABRIL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For infantile spasms (IS): Sabril is used as a single agent in the treatment of IS. For complex partial seizures (CPS): 1) patient had an inadequate response to at least 2 alternative therapies for CPS (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine), AND 2) Sabril is used as adjunctive therapy. Initial treatment of infantile spasms: 1 month to 2 years. CPS: 10 years of age or older.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	SIGNIFOR
Nombres de los medicamentos	SIGNIFOR
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Patient has had pituitary surgery that was not curative or the patient is not a candidate for surgery. Patient must have controlled blood glucose levels or is receiving optimized antidiabetic therapy. Fasting plasma glucose and/or hemoglobin A1c levels must be obtained at baseline. For continuation of therapy, patient must show a clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	Endocrinologist
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	SILDENAFIL
Nombres de los medicamentos	REVATIO, SILDENAFIL
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Treatment with a nitrate therapy on a regular or intermittent basis. Concomitant treatment with a guanylate cyclase stimulator (e.g., Adempas).
Información médica requerida	PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	SIRTURO
Nombres de los medicamentos	SIRTURO
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Sirturo being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis (e.g. central nervous system), or infection caused by the non-tuberculous mycobacteria (NTM).
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	6 Months
Otros criterios	

Grupo de autorización previa	SOMATULINE DEPOT
Nombres de los medicamentos	SOMATULINE DEPOT
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, adrenal gland neuroendocrine tumors (NETs), NETs of the gastrointestinal (GI) tract, thymus, and lung, pancreatic NETs, and poorly differentiated (high-grade)/large or small cell NETs.
Criterios de exclusión	
Información médica requerida	Acromegaly: Patient has 1) clinical evidence of acromegaly, AND 2) a high pre-treatment IGF-1 level for age and/or gender, AND 3) had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. NETs of the GI tract: Patient has 1) distant metastases, OR 2) unresectable disease, OR 3) primary site of the tumor is gastric, tumor is less than or equal to 2 centimeters, AND the patient has hypersecretion of gastrin. NETs of the thymus: Patient has distant metastases OR unresectable disease. NETs of the lung: Patient has distant metastases OR unresectable disease. Pancreatic NETs: 1) For gastrinoma, glucagonoma, and VIPoma, patient's somatostatin receptor status is positive OR patient has hormone-related symptoms, OR 2) For insulinoma, non-functioning pancreatic tumor, somatostatinoma, pancreatic polypeptidoma, cholecystikininoma, ACTH-secreting pancreatic NET, and parathyroid hormone-related protein-secreting pancreatic NET, patient has a) distant metastases or unresectable disease AND b) somatostatin receptor status is positive OR patient has hormone-related symptoms. Adrenal Gland NETs: 1) Patient has a diagnosis of non-ACTH dependent Cushing's syndrome, AND 2) The cortisol production is symmetric, AND 3) Tumors are less than 4 centimeters, AND 4) Somatostatin receptor status is positive. Poorly differentiated (high-grade)/large or small cell NETs (excluding lung): 1) Patient has metastatic or unresectable disease, AND 2) Somatostatin receptor status is positive, AND 3) Patient has hormone-related symptoms.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

Grupo de autorización previa	SOMAVERT
Nombres de los medicamentos	SOMAVERT
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Patient must meet all of the following: 1) Patient has clinical evidence of acromegaly, AND 2) Patient has a high pre-treatment IGF-1 level for age and/or gender, AND 3) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy, AND 4) Patient had an inadequate or partial response to a) octreotide (Sandostatin or Sandostatin LAR), or b) lanreotide (Somatuline Depot), or c) pasireotide (Signifor LAR) OR patient is intolerant or has a contraindication to a) octreotide, or b) lanreotide, or c) pasireotide.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	For continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

Grupo de autorización previa	SOVALDI
Nombres de los medicamentos	SOVALDI
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, chronic hepatitis C genotype 5 or 6 infection.
Criterios de exclusión	
Información médica requerida	Chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants (eg, NS3 Q80K polymorphism) where applicable, liver transplantation status if applicable. For patients with genotype 1, 2, 3, or 4 infection and hepatocellular carcinoma awaiting liver transplantation: must meet MILAN criteria. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Criteria will be applied consistent with current AASLD-IDSA guidance
Otros criterios	For HCV/HIV coinfection, patient meets criteria for requested regimen and will not receive treatment with tipranavir. For patients prescribed a treatment regimen that includes Olysio, no prior treatment failure with an HCV protease inhibitor (eg, telaprevir, simeprevir, boceprevir, paritaprevir) despite adequate dosing and duration of therapy. MILAN criteria defined as: 1) tumor size 5 cm or less in diameter in pts with single hepatocellular carcinoma OR 3 tumor nodules or less, each 3 cm or less in diameter in pts with multiple tumors, and 2) no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor.

Grupo de autorización previa SPRYCEL
Nombres de los medicamentos SPRYCEL
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D, gastrointestinal stromal tumor (GIST).

Criterios de exclusión

Información médica requerida For CML or Ph+ ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor (e.g., nilotinib). If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have PDGFRA D842V mutation and disease progression on imatinib, sunitinib, or regorafenib.

Restricciones de edad 15 years of age or older

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

Grupo de autorización previa STIVARGA
Nombres de los medicamentos STIVARGA
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D.

Criterios de exclusión

Información médica requerida For unresectable advanced or metastatic colorectal cancer, KRAS/NRAS mutation testing is performed on either the primary tumor or metastases to confirm RAS mutation status. The patient must have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, and, if KRAS or NRAS wild type, an anti-EGFR therapy. Stivarga must be used as a single agent. For locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST), the patient must have been previously treated with imatinib or sunitinib.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

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Grupo de autorización previa	SUTENT
Nombres de los medicamentos	SUTENT
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), angiosarcoma, solitary fibrous tumor, hemangiopericytoma, chordoma (bone cancer), lung neuroendocrine tumor, thymic carcinoma.
Criterios de exclusión	
Información médica requerida	For renal cell carcinoma: 1) The disease is relapsed or medically unresectable and 2) Sutent will be used as a single agent. For gastrointestinal stromal tumor: The patient experienced disease progression on imatinib or was intolerant to imatinib. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) Nexavar is not an appropriate option for the patient, 2) the disease is unresectable or metastatic, 3) the disease is radioiodine-refractory, and 4) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For thymic carcinoma: 1) Sutent will be used as a single agent and 2) the disease has progressed on a platinum-based chemotherapy regimen.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	SYLATRON
Nombres de los medicamentos	SYLATRON
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, giant cell tumor of the bone.
Criterios de exclusión	
Información médica requerida	For giant cell tumor of the bone, patient has unresectable disease OR surgical resection is likely to result in severe morbidity.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	For melanoma, Sylatron must be requested within 84 days (12 weeks) of the surgical resection.

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Grupo de autorización previa	SYMLIN
Nombres de los medicamentos	SYMLINPEN 120, SYMLINPEN 60
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Recurrent severe hypoglycemia that required assistance during the past 6 months. Gastroparesis. Patient requires drug therapy to stimulate gastrointestinal motility. Hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia). HbA1c level greater than 9 percent.
Información médica requerida	1) The patient is currently receiving optimal mealtime insulin therapy AND 2) The patient has experienced an inadequate treatment response to insulin AND 3) The patient has a diagnosis of type 1 or type 2 diabetes mellitus
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	1) If the patient has been receiving Symlin for at least 3 months, patient demonstrated a reduction in HbA1c since starting Symlin therapy
Grupo de autorización previa	SYNRIBO
Nombres de los medicamentos	SYNRIBO
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For CML, the patient has experienced resistance, toxicity or intolerance to prior therapy with at least two tyrosine kinase inhibitors (TKIs) (eg, imatinib, dasatinib, nilotinib, bosutinib, ponatinib).
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	TAFINLAR
Nombres de los medicamentos	TAFINLAR
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, CNS metastases, and non-small cell lung cancer.
Criterios de exclusión	
Información médica requerida	For unresectable or metastatic melanoma: 1) Tafinlar will be used in combination with Mekinist for patients with a diagnosis of BRAF V600E or V600K mutation positive disease OR 2) Tafinlar will be used as a single agent for BRAF V600E or V600K mutation positive disease AND clinical deterioration is anticipated in less than or equal to 12 weeks. For CNS metastases: Tafinlar has activity against the primary tumor (melanoma) AND Tafinlar will be used as a single agent. For NSCLC: The tumor is positive for the BRAF V600E mutation
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	TAGRISSE
Nombres de los medicamentos	TAGRISSE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	TARCEVA
Nombres de los medicamentos	TARCEVA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, chordoma, renal cell carcinoma (RCC).
Criterios de exclusión	
Información médica requerida	For locally advanced, recurrent or metastatic non-small cell lung cancer (NSCLC) with positive EGFR mutation (exon 19 deletions or exon 21 L858R substitution mutations), Tarceva is prescribed for use as ANY of the following: 1) First-line therapy as a single agent (EGFR mutation discovered prior to first-line chemotherapy or during first-line chemotherapy), 2) Subsequent therapy as a single agent following disease progression on erlotinib, 3) Subsequent therapy in combination with chemotherapy following disease progression on afatinib or erlotinib, or 4) Subsequent therapy as a single agent following progression on a cytotoxic regimen for metastatic disease in members who have not previously received erlotinib. For metastatic NSCLC with negative or unknown EGFR mutation, Tarceva is prescribed for use as subsequent therapy as a single agent following progression on a cytotoxic regimen in a patient who has not previously received erlotinib. For pancreatic cancer, Tarceva is prescribed in combination with gemcitabine for locally advanced unresectable or metastatic pancreatic cancer. For chordoma, Tarceva is prescribed as a single agent for recurrent disease. For RCC, Tarceva is prescribed as a single agent for relapsed or unresectable stage IV disease with non-clear cell histology.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	TASIGNA
Nombres de los medicamentos	TASIGNA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST).
Criterios de exclusión	
Información médica requerida	For CML or Ph+ ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor (eg, dasatinib). If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For Ph+ ALL, 1) patient has relapsed or refractory Ph+ ALL, OR 2) patient has received hematopoietic stem cell transplant after achieving complete response to induction chemotherapy. If patient relapsed after or is refractory to initial tyrosine kinase inhibitor-containing therapy for ALL, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.
Restricciones de edad	18 years of age or older
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	TAZORAC
Nombres de los medicamentos	TAZORAC
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	1) For patients being treated for plaque psoriasis Tazorac must be applied to less than 20 percent of the patient's body surface area AND 2) For patients being treated for plaque psoriasis a trial of at least one topical corticosteroid (e.g., clobetasol, fluocinonide, mometasone, triamcinolone) (patient may still be using a corticosteroid product in addition to Tazorac) OR 3) patient experienced an adverse event, intolerance, or contraindication to topical corticosteroids.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	For patients who are able to bear children, the pregnancy status of the patient has been evaluated and the patient made aware of the potential risks of fetal harm and importance of birth control while using Tazorac.

Grupo de autorización previa	TECENTRIQ
Nombres de los medicamentos	TECENTRIQ
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	TESTOSTERONE CYPIONATE INJ
Nombres de los medicamentos	TESTOSTERONE CYPIONATE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, Gender Identity Disorder in Female-to-Male transgender
Criterios de exclusión	
Información médica requerida	1) Drug is being prescribed for a male patient with congenital or acquired primary hypogonadism (i.e., testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchidectomy) who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values OR 2) Drug is being prescribed for a male patient with congenital or acquired hypogonadotropic hypogonadism (i.e., gonadotropin or luteinizing hormone-releasing hormone [LHRH] deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation) who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values OR 3) Drug is being prescribed for female-to-male gender reassignment in a patient who is 14 years of age or older and able to make an informed, mature decision to engage in therapy
Restricciones de edad	14 years of age or older (female-to-male gender reassignment)
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	TESTOSTERONE ENANTHATE INJ
Nombres de los medicamentos	TESTOSTERONE ENANTHATE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	1) Drug is being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal and who has had an incomplete response to other therapy for metastatic breast cancer OR 2) Drug is being prescribed for a pre-menopausal patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor OR 3) Drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 4) Drug is being prescribed for delayed puberty in a male patient.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	TETRABENAZINE
Nombres de los medicamentos	TETRABENAZINE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, chronic tics associated with Tourette's syndrome, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Criterios de exclusión	Active suicide ideation. Untreated or inadequately treated depression.
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	THALOMID
Nombres de los medicamentos	THALOMID
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, HIV-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, myelofibrosis with myeloid metaplasia, multicentric Castleman's disease.
Criterios de exclusión	
Información médica requerida	For all indications: The patient will be monitored for thromboembolism. For cachexia: Cachexia must be due to cancer or HIV-infection. For Kaposi's sarcoma: The patient has HIV infection.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	TOBRAMYCIN
Nombres de los medicamentos	TOBRAMYCIN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, non-cystic fibrosis bronchiectasis.
Criterios de exclusión	
Información médica requerida	The patient has a diagnosis of cystic fibrosis that is confirmed by appropriate diagnostic or genetic testing OR the patient has a diagnosis of non-cystic fibrosis bronchiectasis. Pseudomonas aeruginosa is present in the patient's airway cultures OR the patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual

Grupo de autorización previa	TOPICAL LIDOCAINE
Nombres de los medicamentos	LIDOCAINE, LIDOCAINE HCL, LIDOCAINE HCL JELLY, LIDOCAINE/PRILOCAINE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	3 Months
Otros criterios	1) The prescribed quantity falls within the manufacturer's published dosing guidelines. 2) If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use. 3) Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Grupo de autorización previa	TOPICAL TESTOSTERONES
Nombres de los medicamentos	ANDRODERM, AXIRON
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa TOPICAL TRETINOIN
Nombres de los medicamentos AVITA, TRETINOIN
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión
Información médica requerida
Restricciones de edad
Restricciones de la persona autorizada a dar recetas
Duración de la cobertura Plan Year
Otros criterios

Grupo de autorización previa TRELSTAR
Nombres de los medicamentos TRELSTAR MIXJECT
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D, adjuvant therapy for prostate cancer, initial ADT for prostate cancer, progressive, metastatic, and recurrent prostate cancer.
Criterios de exclusión
Información médica requerida If the patient has regional disease as initial ADT, metastatic disease as initial ADT, progressive castration-naïve disease, or recurrent disease as defined as a biochemical failure after previous therapy, then no further information is required. If the patient has lymph node-positive disease found during pelvic lymph node dissection (PLND), then Trelstar must be used without external beam radiation therapy (EBRT) as adjuvant therapy. If the patient has none of the abovementioned criteria and has intermediate risk stratification, then Trelstar must be used with EBRT as initial ADT. If the patient has none of the abovementioned criteria and has high or very high risk stratification, then Trelstar must be used with EBRT or EBRT and docetaxel as initial ADT. If the patient has none of the abovementioned criteria and has very high risk stratification and is not a candidate for definitive therapy, Trelstar may be used without EBRT as initial ADT.
Restricciones de edad
Restricciones de la persona autorizada a dar recetas
Duración de la cobertura For immediate risk stratification: 6 months. Others: Plan Year.
Otros criterios Use as neoadjuvant therapy prior to radical prostatectomy is not approvable.

Grupo de autorización previa	TYKERB
Nombres de los medicamentos	TYKERB
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, metastatic CNS lesions.
Criterios de exclusión	
Información médica requerida	For advanced, recurrent, or metastatic HER2-positive breast cancer, Tykerb will be used in combination with: 1) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) for a postmenopausal woman with hormone receptor-positive disease, or 2) capecitabine or trastuzumab (without cytotoxic therapy) for a patient who has received prior trastuzumab-containing regimen. For metastatic CNS lesions, 1) member has recurrent HER2-positive breast cancer, 2) Tykerb is active against the primary tumor (breast), and 3) Tykerb will be used in combination with capecitabine in a patient with recurrent HER2-positive breast cancer.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	TYSABRI
Nombres de los medicamentos	TYSABRI
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Use as monotherapy. For Crohn's disease (CD), patient must have an inadequate response, intolerance or contraindication to one conventional CD therapy (eg, corticosteroid, azathioprine, mesalamine) and one TNF-inhibitor (eg, Humira, Cimzia).
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	UPTRAVI
Nombres de los medicamentos	UPTRAVI
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than or equal to 5 Wood units OR pretreatment pulmonary vascular resistance is greater than 3 Wood units for members who are experiencing clinical deterioration/worsening on current PAH therapy at maximum tolerated doses.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	VALCHLOR
Nombres de los medicamentos	VALCHLOR
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, adult T-cell leukemia/lymphoma, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
Criterios de exclusión	
Información médica requerida	Lymphomatoid papulosis: Valchlor will be used as a single agent
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan year
Otros criterios	

Grupo de autorización previa	VELCADE
Nombres de los medicamentos	VELCADE
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castlemans disease.
Criterios de exclusión	
Información médica requerida	For multiple myeloma: Velcade is prescribed for primary, maintenance, or salvage therapy. For primary therapy: 1) the prescribed regimen includes dexamethasone, OR 2) the prescribed regimen is Velcade, melphalan, and prednisone for a patient who is not a stem cell transplant candidate. For multicentric Castlemans disease: 1) The disease has progressed following treatment of relapsed, refractory, or progressive disease, and 2) Velcade will be prescribed as monotherapy or in combination with rituximab.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Grupo de autorización previa	VENCLEXTA
Nombres de los medicamentos	VENCLEXTA, VENCLEXTA STARTING PACK
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	VENTAVIS
Nombres de los medicamentos	VENTAVIS
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Patient has had NYHA Functional Class III or IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Grupo de autorización previa	VERSACLOZ
Nombres de los medicamentos	VERSACLOZ
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	History of clozapine-induced agranulocytosis or severe granulocytopenia. Dementia-related psychosis.
Información médica requerida	The patient is unwilling or unable to take tablets or capsules orally or is at high risk for non-compliance.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	VOLTAREN GEL
Nombres de los medicamentos	DICLOFENAC SODIUM
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Use during the peri-operative period in the setting of coronary artery bypass graft (CABG) surgery. Experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs.
Información médica requerida	The patient is unable to tolerate or not a suitable candidate for oral NSAID therapy (e.g., bleeding ulcer, etc.).
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	VOTRIENT
Nombres de los medicamentos	VOTRIENT
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, dermatofibrosarcoma protuberans, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma.
Criterios de exclusión	
Información médica requerida	For renal cell carcinoma: 1) The disease is relapsed or medically unresectable and 2) Votrient will be used as a single agent. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma and 2) the patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk sarcoma. For GIST, the disease has progressed on treatment with imatinib, sunitinib, or regorafenib. For angiosarcoma or pleomorphic rhabdomyosarcoma, Votrient will be used as a single agent. For retroperitoneal/intra-abdominal sarcoma or extremity/superficial trunk sarcoma, Votrient will be used as a single agent for progressive, unresectable, or metastatic disease. For uterine sarcoma: 1) Votrient will be used as a single agent and 2) for stage I disease, the disease is medically inoperable. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) Nexavar is not an appropriate option for the patient, 2) the disease is unresectable or metastatic, 3) the disease is radioiodine-refractory, and 4) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For dermatofibrosarcoma protuberans: 1) The disease is metastatic and 2) Votrient will be used as a single agent.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	XALKORI
Nombres de los medicamentos	XALKORI
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer (NSCLC) with MET amplification, inflammatory myofibroblastic tumors (IMT).
Criterios de exclusión	
Información médica requerida	For NSCLC, patient meets all of the following: 1) Tumor is ALK-positive, ROS1-positive, or demonstrates MET amplification, and 2) Patient has recurrent or metastatic disease, and 3) Xalkori is being used as a single agent. For IMT, the tumor is ALK-positive and Xalkori is being used as a single agent.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	XELJANZ
Nombres de los medicamentos	XELJANZ, XELJANZ XR
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Combination therapy with a potent immunosuppressant such as azathioprine or cyclosporine
Información médica requerida	Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Xeljanz/Xeljanz XR or previous biologic DMARD. For moderately to severely active rheumatoid arthritis (new starts only), patient meets at least one of the following criteria: 1) Inadequate response to at least a 3-month trial of methotrexate (MTX) despite adequate dosing (i.e., titrated to 25 mg/week), 2) Intolerance or contraindication to MTX, 3) Inadequate response to at least a 3-month trial of any prior biologic DMARD (eg, adalimumab), 4) Intolerance to any prior biologic DMARD.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	XGEVA
Nombres de los medicamentos	XGEVA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For bone metastases from prostate cancer (solid tumor), patient has castration-recurrent disease. For giant cell tumor of the bone, patient has unresectable disease or surgical resection is likely to result in severe morbidity. For hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy (eg, zoledronic acid, pamidronate) defined as albumin-corrected serum calcium level of greater than 12.5 mg/dL despite IV bisphosphonate therapy.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Hypercalcemia of malignancy: initial = 2 months, renewal = Plan Year. All other dx = Plan Year.
Otros criterios	For hypercalcemia of malignancy renewal requests: patient has demonstrated a response to Xgeva therapy defined as albumin-corrected serum calcium level of 12.5 mg/dL or less. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Grupo de autorización previa	XIFAXAN
Nombres de los medicamentos	XIFAXAN
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Reduction in risk of overt HE recurrence-6 Months, IBS-D-Plan Year
Otros criterios	

Grupo de autorización previa	XOLAIR
Nombres de los medicamentos	XOLAIR
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For allergic asthma: 1) Xolair is used in combination with other medications for long-term control of asthma, and 2) Patient has a rapid-acting beta2-agonist available for rescue therapy. For initial therapy only: 1) Patient has a diagnosis of moderate to severe persistent asthma, 2) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 3) Patient has baseline IgE level greater than or equal to 30 IU/mL, 4) Asthma is inadequately controlled despite use of inhaled corticosteroid at the optimal dose (unless patient has an intolerance or contraindication to inhaled corticosteroid therapy), and 5) Patient is optimizing the use of a long-acting inhaled beta2-agonist, leukotriene modifier, or sustained-release theophylline (unless patient has an intolerance or contraindication to such therapies). For continuation therapy only: Patient's asthma control has improved on Xolair treatment since initiation of therapy. For chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks, and 3) Patient has remained symptomatic despite second generation H1 antihistamine therapy with maximized dosing used continuously for at least two weeks (unless patient has an intolerance or contraindication to antihistamine therapy). For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.
Restricciones de edad	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.
Restricciones de la persona autorizada a dar recetas	For CIU: allergist, dermatologist, or immunologist
Duración de la cobertura	Allergic asthma: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year.
Otros criterios	Xolair will be administered in a controlled healthcare setting with access to emergency medications (e.g., anaphylaxis kit).

Grupo de autorización previa	XTANDI
Nombres de los medicamentos	XTANDI
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	For metastatic, castration-resistant disease, the patient has been previously treated with Zytiga unless the patient has a contraindication to Zytiga therapy. For non-castration-resistant disease, Xtandi will be used in combination with androgen deprivation therapy to: 1) enhance the effectiveness of radiation therapy, OR 2) supplement androgen deprivation therapy if the patient experienced inadequate testosterone suppression, OR 3) prevent androgen flare in androgen deprivation therapy naive patients who are at risk of developing symptoms.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

Grupo de autorización previa	XYREM
Nombres de los medicamentos	XYREM
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Taking alcohol or sedative hypnotic agents while taking Xyrem.
Información médica requerida	1) The drug is being prescribed for the treatment excessive daytime sleepiness in a patient with narcolepsy without cataplexy and 2) The patient experienced an inadequate treatment response or intolerance to a CNS stimulant drug and a CNS promoting wakefulness drug OR 3) the patient has a contraindication to a CNS stimulant drug or a CNS wakefulness promoting drug (NOTE: Examples of a CNS stimulant drug are amphetamine, dextroamphetamine, or methylphenidate. Examples of a CNS wakefulness promoting drug are modafinil or armodafinil. Coverage of modafinil or armodafinil or amphetamines or methylphenidates may require prior authorization). OR 4) The drug is being prescribed for the treatment of cataplexy in a patient with narcolepsy.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

If the request is for the continuation of Xyrem, the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

Grupo de autorización previa	YERVOY
Nombres de los medicamentos	YERVOY
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, CNS metastases from primary tumor (melanoma).
Criterios de exclusión	
Información médica requerida	For unresectable or metastatic melanoma, Yervoy will be used as a single agent or in combination with nivolumab (Opdivo). For the adjuvant treatment of melanoma, member must meet all of the following: 1) Yervoy will be used as adjuvant therapy following complete resection, including total lymphadenectomy, AND 2) the disease has pathologic involvement of regional lymph nodes of more than 1 millimeter. For CNS metastases from primary tumor (melanoma), member must meet all of the following: 1) Yervoy was active against the primary tumor (melanoma), 2) the disease is recurrent, and 3) Yervoy will be used as a single agent.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	ZAVESCA
Nombres de los medicamentos	ZAVESCA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Diagnosis of Type 1 Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. Enzyme replacement therapy is not a therapeutic option (e.g., due to constraints such as allergy, hypersensitivity, or poor venous access).
Restricciones de edad	18 years of age and older.
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

Grupo de autorización previa	ZELBORAF
Nombres de los medicamentos	ZELBORAF
Usos cubiertos	All FDA-approved uses not otherwise excluded from Part D, melanoma with BRAF V600K mutation, CNS metastases from primary tumor (melanoma), NSCLC with BRAF V600E mutation, and hairy cell leukemia.
Criterios de exclusión	
Información médica requerida	For unresectable or metastatic melanoma: The tumor is positive for either BRAF V600E or V600K mutation AND clinical deterioration is anticipated in less than or equal to 12 weeks. For CNS metastases: Zelboraf has activity against the primary tumor (melanoma) AND Zelboraf will be used as a single agent. For NSCLC: The tumor is positive for the BRAF V600E mutation. For refractory hairy cell leukemia: Zelboraf will be used as a single agent.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	ZEPATIER
Nombres de los medicamentos	ZEPATIER
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C). Liver transplant recipient or awaiting liver transplantation
Información médica requerida	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants (eg, NS5A polymorphisms) where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current prescribing information and AASLD-IDSA treatment guidelines.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Criteria will be applied consistent with current AASLD-IDSA guidance.
Otros criterios	For HCV and HIV coinfection, patient meets the criteria for approval for the requested regimen.

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Grupo de autorización previa ZOLINZA
Nombres de los medicamentos ZOLINZA
Usos cubiertos All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, multiple myeloma.

Criterios de exclusión

Información médica requerida For multiple myeloma: Zolinza will be used as salvage therapy in combination with bortezomib (Velcade).

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

Grupo de autorización previa ZYDELIG

Nombres de los medicamentos ZYDELIG

Usos cubiertos All FDA-approved indications not otherwise excluded from Part D, relapsed or refractory chronic lymphocytic leukemia (CLL) as a single agent, relapsed or refractory small lymphocytic lymphoma as a single agent or in combination with rituximab, refractory or progressive follicular lymphoma, primary cutaneous B-cell lymphoma [primary cutaneous marginal zone lymphoma and follicle center lymphoma], and marginal zone lymphomas [gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].

Criterios de exclusión

Información médica requerida History of serious allergic reactions including anaphylaxis or toxic epidermal necrolysis. For relapsed or refractory CLL, Zydelig is used as a single agent or in combination with rituximab. For relapsed or refractory SLL, Zydelig is used as a single agent or in combination with rituximab and the patient has received at least two prior systemic therapies. For relapsed, refractory, or progressive follicular B-cell non-Hodgkin lymphoma, Zydelig is used as a single agent and the patient has received at least two prior systemic therapies. For gastric mucosa associated lymphoid tissue (MALT) lymphoma, the disease is recurrent or progressive. For non-gastric MALT and Splenic marginal zone lymphomas, the disease is refractory or progressive.

Restricciones de edad

Restricciones de la persona autorizada a dar recetas

Duración de la cobertura Plan Year

Otros criterios

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Grupo de autorización previa	ZYKADIA
Nombres de los medicamentos	ZYKADIA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D, anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor.
Criterios de exclusión	
Información médica requerida	For NSCLC, patient meets all of the following: 1) Tumor is ALK-positive, and 2) Disease is recurrent or metastatic, and 3) Patient has progressed on or is intolerant to crizotinib. For ALK-positive inflammatory myofibroblastic tumor: Zykadia is prescribed as a single agent.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	ZYPREXA RELPREVV
Nombres de los medicamentos	ZYPREXA RELPREVV
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	Dementia-related psychosis.
Información médica requerida	Tolerability with oral olanzapine has been established.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	
Grupo de autorización previa	ZYTIGA
Nombres de los medicamentos	ZYTIGA
Usos cubiertos	All FDA-approved indications not otherwise excluded from Part D.
Criterios de exclusión	
Información médica requerida	Patient has metastatic prostate cancer. Patient's disease is castration-resistant. Zytiga will be used in combination with prednisone.
Restricciones de edad	
Restricciones de la persona autorizada a dar recetas	
Duración de la cobertura	Plan Year
Otros criterios	

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