AIMOVIG

MEDICATION(S)
AIMOVIG

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of beta blocker therapy and topiramate

ANTI-DIABETIC AGENTS

MEDICATION(S)
OZEMPIC (0.25 OR 0.5 MG/DOSE), OZEMPIC (1 MG/DOSE) 2 MG/1.5ML SOLN PEN, TRULICITY, VICTOZA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of metformin therapy

ASTHMA BIOLOGICS

MEDICATION(S)
NUCALA 100 MG/ML SOLN A-INJ, NUCALA 100 MG/ML SOLN PRSYR, XOLAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of combined inhaled steroid and long-acting beta agonists

BENLYSTA

MEDICATION(S)
BENLYSTA 200 MG/ML SOLN A-INJ, BENLYSTA 200 MG/ML SOLN PRSYR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure or contraindication to hydroxychloroquine or chloroquine therapy

BRILINTA

MEDICATION(S)
BRILINTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure or contraindication to clopidogrel therapy

CGRP ANTAGONISTS ACUTE MIGRAINE

MEDICATION(S)
NURTEC

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure or contraindication to triptan therapy

CIMZIA

MEDICATION(S)
CIMZIA, CIMZIA PREFILLED, CIMZIA STARTER KIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Documented trial and failure of more cost effective guideline treatment options for FDA approved indications

COSENTYX

MEDICATION(S)
COSENTYX 150 MG/ML SOLN PRSYR, COSENTYX (300 MG DOSE), COSENTYX SENSOREADY (300 MG), COSENTYX SENSOREADY PEN

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Documented trial and failure of more cost effective guideline treatment options for FDA approved indications

DIFICID

MEDICATION(S)
DIFICID 200 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of vancomycin therapy

DUPIXENT

MEDICATION(S)
DUPIXENT 200 MG/1.14ML SOLN PRSYR, DUPIXENT 300 MG/2ML SOLN PRSYR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Documented trial and failure of more cost effective guideline treatment options for FDA approved indications

ENBREL

MEDICATION(S)
ENBREL, ENBREL SURECLICK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Documented trial and failure of more cost effective guideline treatment options for FDA approved indications

ENTRESTO

MEDICATION(S)
ENTRESTO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of ACE-inhibitor therapy

GLYXAMBI

MEDICATION(S)
GLYXAMBI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Stabilized on DPP-4 inhibitor therapy or SGLT-2 inhibitor therapy

GRANISETRON HCL

MEDICATION(S)
GRANISETRON HCL 1 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of ondansetron therapy

HUMIRA

MEDICATION(S)
HUMIRA, HUMIRA PEDIATRIC CROHNS START 80 MG/0.8ML & 40MG/0.4ML PREF SY KT, HUMIRA PEDIATRIC CROHNS START 80 MG/0.8ML PREF SY KT, HUMIRA PEN, HUMIRA PEN-CD/UC/HS STARTER, HUMIRA PEN-PS/UV/ADOL HS START, HUMIRA PEN-PSOR/UVEIT STARTER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Documented trial and failure of more cost effective guideline treatment options for FDA approved indications

ILEVRO

MEDICATION(S)
ILEVRO

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of prednisolone ophthalmic therapy

INJECTABLE ANTIPSYCHOTIC

MEDICATION(S)

ABILIFY MAINTENA, INVEGA SUSTENNA 117 MG/0.75ML SUSP PRSYR, INVEGA SUSTENNA 156 MG/ML SUSP PRSYR, INVEGA SUSTENNA 234 MG/1.5ML SUSP PRSYR, INVEGA SUSTENNA 78 MG/0.5ML SUSP PRSYR, INVEGA TRINZA, RISPERDAL CONSTA 50 MG SRER

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

Documented non-adherence to oral alternatives

LEDIPASVIR/SOFOSBUVIR (HARVONI)

MEDICATION(S)
LEDIPASVIR-SOFOSBUVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 weeks in patients without cirrhosis, 24 weeks in patients with cirrhosis

OTHER CRITERIA
Documentation of medical necessity and inability to use BOTH of the following preferred agents: sofosbuvir-velpatasvir or glecaprevir-pibrentasvir

MOVANTIK

MEDICATION(S)
MOVANTIK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of polyethylene glycol therapy

MS AGENTS

MEDICATION(S)

AUBAGIO, AVONEX PEN, AVONEX PREFILLED, DIMETHYL FUMARATE 120 MG CAP DR, DIMETHYL FUMARATE 240 MG CAP DR, DIMETHYL FUMARATE STARTER PACK, GILENYA 0.5 MG CAP, REBIF, REBIF REBIDOSE, REBIF REBIDOSE TITRATION PACK, REBIF TITRATION PACK

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

Trial and failure of glatiramer therapy

ORAL ANTICONVULSANTS

MEDICATION(S)
BRIVIACT 10 MG TAB, BRIVIACT 10 MG/ML SOLUTION, BRIVIACT 100 MG TAB, BRIVIACT 25 MG TAB, BRIVIACT 50 MG TAB, BRIVIACT 75 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of at least 2 generic anticonvulsant medications

ORAL ANTIPSYCHOTICS

MEDICATION(S)
ASENAPINE MALEATE, CAPLYTA, LATUDA, REXULTI, VRAYLAR 1.5 MG CAP, VRAYLAR 3 MG CAP, VRAYLAR 4.5 MG CAP, VRAYLAR 6 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of at least 2 generic antipsychotic medications

PA FDA INDICATION

MEDICATION(S)

ACTEMRA 162 MG/0.9ML SOLN PRSYR, ACTEMRA ACTPEN, ACTIMMUNE, ADAPALENE 0.1 % CREAM, ADAPALENE 0.1 % GEL, ADAPALENE 0.3 % GEL, ADEMPAS, AFINITOR, AFINITOR DISPERZ, ALYQ, AMBRISENTAN, APOKYN, APTIOM, ARALAST NP, ARANESP (ALBUMIN FREE) 10 MCG/0.4ML SOLN PRSYR, ARANESP (ALBUMIN FREE) 100 MCG/0.5ML SOLN PRSYR, ARANESP (ALBUMIN FREE) 150 MCG/0.3ML SOLN PRSYR, ARANESP (ALBUMIN FREE) 200 MCG/0.4ML SOLN PRSYR, ARANESP (ALBUMIN FREE) 25 MCG/0.42ML SOLN PRSYR, ARANESP (ALBUMIN FREE) 300 MCG/0.6ML SOLN PRSYR, ARANESP (ALBUMIN FREE) 40 MCG/0.4ML SOLN PRSYR, ARANESP (ALBUMIN FREE) 500 MCG/ML SOLN PRSYR, ARANESP (ALBUMIN FREE) 60 MCG/0.3ML SOLN PRSYR, ARMODAFINIL, AUSTEDO, AVITA, BELSOMRA, BETASERON, BOSENTAN, CARBAGLU, CARISOPRODOL 250 MG TAB, CARISOPRODOL 350 MG TAB, CAYSTON, CORLANOR 5 MG TAB, CORLANOR 7.5 MG TAB, DALFAMPRIDINE ER, DALIRESP, DARAPRIM 25 MG TAB, DEFERASIROX 125 MG TAB SOL, DEFERASIROX 250 MG TAB SOL, DEFERASIROX 500 MG TAB SOL, DEFERASIROX GRANULES, DEFERIPRONE, DEPEN TITRATABS, DEPO-TESTOSTERONE 200 MG/ML SOLUTION, DIACOMIT, DICLOFENAC EPOLAMINE, DICLOFENAC SODIUM 3 % GEL, DRONABINOL, DROXIDOPA, ELIQUIS, ELIQUIS DVT/PE STARTER PACK, EPIDIOLEX, ESBRIET, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 2.5 MG TAB, EVEROLIMUS 5 MG TAB, EVEROLIMUS 7.5 MG TAB, FANAPT, FANAPT TITRATION PACK, FENTANYL CITRATE 1200 MCG LOZ HANDLE, FENTANYL CITRATE 1600 MCG LOZ HANDLE, FENTANYL CITRATE 200 MCG LOZ HANDLE, FENTANYL CITRATE 400 MCG LOZ HANDLE, FENTANYL CITRATE 600 MCG LOZ HANDLE, FENTANYL CITRATE 800 MCG LOZ HANDLE, FERRIPROX 100 MG/ML SOLUTION, FINTEPLA, FIRAZYR, FULPHILA, GATTEX, GLASSIA, GLATIRAMER ACETATE, GLATOPA, HEMADY, HETLIOZ, HUMIRA PEN-PEDIATRIC UC START, ILUMYA, IMOVAX RABIES, INCRELEX, JADENU, JADENU SPRINKLE, JAKAFI, KALYDECO, KINERET, KORLYM, LIDOCAINE 5 % PATCH, MAVYRET 100-40 MG TAB, METYROSINE, MODAFINIL, NATPARA, NEULASTA, NEULASTA ONPRO, NEXLETOL, NIVESTYM, NORDITROPIN FLEXPRO, NOXAFIL 100 MG TAB DR, NOXAFIL 40 MG/ML SUSPENSION, NUEDEXTA, NUPLAZID 10 MG TAB, NUPLAZID 34 MG CAP, OCTREOTIDE ACETATE, OFEV, OPSUMIT, ORENITRAM, ORKAMBI, OTEZLA, PLEGRIDY, PLEGRIDY STARTER PACK, PROLIA, PROMACTA, PULMOZYME, PYRIMETHAMINE 25 MG TAB, QUININE SULFATE 324 MG CAP, RABAVERT, RAVICTI, REGRANEX, RESTASIS, RESTASIS MULTIDOSE, RETACRIT, RUCONEST, SABRIL 500 MG TAB, SAMSCA, SAPROPTERIN DIHYDROCHLORIDE, SIGNIFOR, SILDENAFIL CITRATE 10 MG/ML RECON SUSP, SILDENAFIL CITRATE 20 MG TAB, SIRTURO, SIVEXTRO 200 MG TAB, SKYRIZI, SKYRIZI (150 MG DOSE), SOFOSBUVIR-VELPATASVIR, SOMATULINE DEPOT 60 MG/0.2ML SOLUTION, SOMATULINE

DEPOT 90 MG/0.3ML SOLUTION, SOMAVERT 15 MG RECON SOLN, SOMAVERT 20 MG RECON SOLN, SOMAVERT 25 MG RECON SOLN, SOMAVERT 30 MG RECON SOLN, SYMDEKO 100-150 & 150 MG TAB THPK, SYMPAZAN 10 MG FILM, SYMPAZAN 20 MG FILM, TAZAROTENE 0.1 % CREAM, TAZAROTENE 0.1 % FOAM, TAZORAC 0.05 % CREAM, TAZORAC 0.05 % GEL, TAZORAC 0.1 % GEL, TESTOSTERONE 1.62 % GEL, TESTOSTERONE 12.5 MG/ACT (1%) GEL, TESTOSTERONE 20.25 MG/1.25GM (1.62%) GEL, TESTOSTERONE 20.25 MG/ACT (1.62%) GEL, TESTOSTERONE 25 MG/2.5GM (1%) GEL, TESTOSTERONE 40.5 MG/2.5GM (1.62%) GEL, TESTOSTERONE 50 MG/5GM (1%) GEL, TESTOSTERONE CYPIONATE 200 MG/ML SOLUTION, TESTOSTERONE ENANTHATE 200 MG/ML SOLUTION, TETRABENAZINE, THALOMID, TOBI PODHALER, TOREMIFENE CITRATE, TRETINOIN 0.01 % GEL, TRETINOIN 0.025 % CREAM, TRETINOIN 0.025 % GEL, TRETINOIN 0.05 % CREAM, TRETINOIN 0.1 % CREAM, UPTRAVI 1000 MCG TAB, UPTRAVI 1200 MCG TAB, UPTRAVI 1400 MCG TAB, UPTRAVI 1600 MCG TAB, UPTRAVI 200 & 800 MCG TAB THPK, UPTRAVI 200 MCG TAB, UPTRAVI 400 MCG TAB, UPTRAVI 600 MCG TAB, UPTRAVI 800 MCG TAB, VENTAVIS, VIGABATRIN, VIGADRONE, VORICONAZOLE 200 MG TAB, VORICONAZOLE 40 MG/ML RECON SUSP, VORICONAZOLE 50 MG TAB, XARELTO, XARELTO STARTER PACK, XGEVA, XIFAXAN, XYREM

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

N/A

PA FDA INDICATION AND NCCN GUIDELINES

MEDICATION(S)

ABIRATERONE ACETATE, ALECENSA, ALUNBRIG, AYVAKIT, BALVERSA, BEXAROTENE, BOSULIF, BRAFTOVI 75 MG CAP, BRUKINSA, CABOMETYX, CALQUENCE, CAPRELSA, COMETRIQ (100 MG DAILY DOSE), COMETRIQ (140 MG DAILY DOSE), COMETRIQ (60 MG DAILY DOSE), COPIKTRA, COTELLIC, DAURISMO, ERIVEDGE, ERLEADA, ERLOTINIB HCL, FARYDAK, FIRMAGON, FIRMAGON (240 MG DOSE), FOTIVDA, GAVRETO, GILOTRIF, IBRANCE, ICLUSIG, IDHIFA, IMATINIB MESYLATE, IMBRUVICA, INLYTA, INQOVI, INREBIC, IRESSA, KISQALI (200 MG DOSE), KISQALI (400 MG DOSE), KISQALI (600 MG DOSE), KISQALI FEMARA (400 MG DOSE), KISQALI FEMARA (600 MG DOSE), KISQALI FEMARA(200 MG DOSE), KOSELUGO, LAPATINIB DITOSYLATE, LENVIMA (10 MG DAILY DOSE), LENVIMA (12 MG DAILY DOSE), LENVIMA (14 MG DAILY DOSE), LENVIMA (18 MG DAILY DOSE), LENVIMA (20 MG DAILY DOSE), LENVIMA (24 MG DAILY DOSE), LENVIMA (4 MG DAILY DOSE), LENVIMA (8 MG DAILY DOSE), LONSURF, LORBRENA, LUMAKRAS, LYNPARZA 100 MG TAB, LYNPARZA 150 MG TAB, MEKINIST, MEKTOVI, NERLYNX, NEXAVAR, NINLARO, NUBEQA, ODOMZO, ONUREG, ORGOVYX, PEMAZYRE, PIQRAY (200 MG DAILY DOSE), PIQRAY (250 MG DAILY DOSE), PIQRAY (300 MG DAILY DOSE), POMALYST, QINLOCK, RETEVMO, REVLIMID, ROZLYTREK, RUBRACA, RYDAPT, SPRYCEL, STIVARGA, SUNITINIB MALATE, SYNRIBO, TABRECTA, TAFINLAR, TAGRISSO, TALZENNA, TARGRETIN 1 % GEL, TASIGNA, TAZVERIK, TEPMETKO, TIBSOVO, TRUSELTIQ (100MG DAILY DOSE), TRUSELTIQ (125MG DAILY DOSE), TRUSELTIQ (50MG DAILY DOSE), TRUSELTIQ (75MG DAILY DOSE), TUKYSA, TURALIO, UKONIQ, VALCHLOR, VENCLEXTA, VENCLEXTA STARTING PACK, VERZENIO, VITRAKVI, VIZIMPRO, VOTRIENT, WELIREG, XALKORI, XOSPATA, XPOVIO (100 MG ONCE WEEKLY), XPOVIO (40 MG ONCE WEEKLY), XPOVIO (40 MG TWICE WEEKLY), XPOVIO (60 MG ONCE WEEKLY), XPOVIO (60 MG TWICE WEEKLY), XPOVIO (80 MG ONCE WEEKLY), XPOVIO (80 MG TWICE WEEKLY), XTANDI, YONSA, ZEJULA, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA 150 MG TAB

PA INDICATION INDICATOR

1 - All FDA-Approved Indications

OFF LABEL USES

N/A

EXCLUSION CRITERIA

N/A

REQUIRED MEDICAL INFORMATION

N/A

AGE RESTRICTION

N/A

PRESCRIBER RESTRICTION

N/A

COVERAGE DURATION

12 months

OTHER CRITERIA

NCCN guideline criteria must be met

PART D VS PART B

MEDICATION(S)

ABELCET, ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM 50 MG/ML SOLUTION, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN, AMBISOME, AMINOSYN II 15 % SOLUTION, AMINOSYN-PF 7 % SOLUTION, AMPHOTERICIN B 50 MG RECON SOLN, APREPITANT, AZATHIOPRINE 50 MG TAB, BERINERT, BIVIGAM 5 GM/50ML SOLUTION, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CINACALCET HCL, CINRYZE, CLINIMIX E/DEXTROSE (2.75/5), CLINIMIX E/DEXTROSE (4.25/10), CLINIMIX E/DEXTROSE (4.25/5), CLINIMIX E/DEXTROSE (5/15), CLINIMIX E/DEXTROSE (5/20), CLINIMIX/DEXTROSE (4.25/10), CLINIMIX/DEXTROSE (4.25/5), CLINIMIX/DEXTROSE (5/15), CLINIMIX/DEXTROSE (5/20), CLINISOL SF, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 25 MG TAB, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOSPORINE 100 MG CAP, CYCLOSPORINE 25 MG CAP, CYCLOSPORINE MODIFIED, ENGERIX-B 10 MCG/0.5ML INJECTABLE, ENGERIX-B 10 MCG/0.5ML SUSPENSION, ENGERIX-B 20 MCG/ML INJECTABLE, ENGERIX-B 20 MCG/ML SUSPENSION, FLEBOGAMMA DIF 5 GM/50ML SOLUTION, FREAMINE HBC, GAMMAGARD 2.5 GM/25ML SOLUTION, GAMMAGARD S/D LESS IGA, GAMMAKED 1 GM/10ML SOLUTION, GAMMAPLEX 10 GM/100ML SOLUTION, GAMMAPLEX 10 GM/200ML SOLUTION, GAMMAPLEX 20 GM/200ML SOLUTION, GAMMAPLEX 5 GM/50ML SOLUTION, GAMUNEX-C 1 GM/10ML SOLUTION, GENGRAF 100 MG CAP, GENGRAF 100 MG/ML SOLUTION, GENGRAF 25 MG CAP, HEPARIN SODIUM (PORCINE) 1000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 10000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 20000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 5000 UNIT/ML SOLUTION, HEPATAMINE, INTRALIPID, INTRON A, IPRATROPIUM BROMIDE 0.02 % SOLUTION, IPRATROPIUM-ALBUTEROL, LEVALBUTEROL HCL 0.31 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 0.63 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/0.5ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/3ML NEBU SOLN, LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH), LUPRON DEPOT (4-MONTH), LUPRON DEPOT (6-MONTH), MEPERIDINE HCL 100 MG/ML SOLUTION, MEPERIDINE HCL 25 MG/ML SOLUTION, MEPERIDINE HCL 50 MG/ML SOLUTION, METHOTREXATE 2.5 MG TAB, METHOTREXATE SODIUM 2.5 MG TAB, METHOTREXATE SODIUM (PF) 50 MG/2ML SOLUTION, MYCOPHENOLATE MOFETIL 200 MG/ML RECON SUSP, MYCOPHENOLATE MOFETIL 250 MG CAP, MYCOPHENOLATE MOFETIL 500 MG TAB, MYCOPHENOLATE SODIUM, NEBUPENT, NEPHRAMINE, NUTRILIPID, OCTAGAM 1 GM/20ML SOLUTION, OCTAGAM 2 GM/20ML

SOLUTION, ONDANSETRON, ONDANSETRON HCL 24 MG TAB, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 8 MG TAB, PREMASOL 10 % SOLUTION, PRIVIGEN 20 GM/200ML SOLUTION, PROCALAMINE, PROSOL, RECOMBIVAX HB, SANDIMMUNE 100 MG/ML SOLUTION, SIROLIMUS 0.5 MG TAB, SIROLIMUS 1 MG TAB, SIROLIMUS 1 MG/ML SOLUTION, SIROLIMUS 2 MG TAB, SOMATULINE DEPOT 120 MG/0.5ML SOLUTION, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP, TOBRAMYCIN 300 MG/4ML NEBU SOLN, TOBRAMYCIN 300 MG/5ML NEBU SOLN, TRAVASOL, TROPHAMINE 10 % SOLUTION, VANCOMYCIN HCL 1 GM RECON SOLN, VANCOMYCIN HCL 1000 MG RECON SOLN, VANCOMYCIN HCL 250 MG RECON SOLN, VANCOMYCIN HCL 500 MG RECON SOLN, VANCOMYCIN HCL 750 MG RECON SOLN, XATMEP

DETAILS

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

PCSK9 INHIBITORS

MEDICATION(S)
PRALUENT, REPATHA, REPATHA PUSHTRONEX SYSTEM, REPATHA SURECLICK

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of statin and ezetimibe therapy

PTH AGENTS

MEDICATION(S)
FORTEO, TERIPARATIDE (RECOMBINANT), TYMLOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Trial and failure of oral bisphosphonates

SIMPONI

MEDICATION(S)
SIMPONI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Documented trial and failure of more cost effective guideline treatment options for FDA approved indications

STELARA

MEDICATION(S)
STELARA 45 MG/0.5ML SOLN PRSYR, STELARA 90 MG/ML SOLN PRSYR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Documented trial and failure of more cost effective guideline treatment options for FDA approved indications

TALTZ

MEDICATION(S)
TALTZ

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Documented trial and failure of more cost effective guideline treatment options for FDA approved indications

TRELEGY ELLIPTA

MEDICATION(S)
TRELEGY ELLIPTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Must be stabilized on inhalers containing corticosteroids, long acting beta agonists and anticholinergic agents

VOSEVI

MEDICATION(S)
VOSEVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Documented trial and failure of previous HCV therapy

XELJANZ

MEDICATION(S)
XELJANZ, XELJANZ XR 11 MG TAB ER 24H

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
Documented trial and failure of more cost effective guideline treatment options for FDA approved indications