Prior Authorization Group Description	**ACTHAR**
Drug Name	ACTHAR
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**AMPYRA**
Drug Name	AMPYRA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate to severe renal impairment (CrCL less than or equal to 50mL/min) and/or history of seizures.
Required Medical Information	Patient must have the ability to walk 25 feet (with or without assistance) prior to starting Ampyra.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	To continue therapy, the patient must experience improvement in walking speed or other objective measure of walking ability since starting Ampyra. Ampyra at doses exceeding 10mg twice daily are not covered.

Prior Authorization Group Description	**HRM-ANTIDIABETICS**
Drug Name	GLUCOVANCE
Tier	4
Drug Name	CHLORPROPAMIDE, GLYBURIDE, GLYBURIDE MICRONIZED, GLYBURIDE/METFORMIN HCL
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient tried and failed at least one of the following: glipizide, glipizide/metformin, glimepiride or has contraindication to all alternatives.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Applies to patients 65 years of age or older. Patient will be monitored for hypoglycemia. Conservative dosing will be used to minimize hypoglycemic events.
Prior Authorization Group Description	**AUBAGIO**
Drug Name	AUBAGIO
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe hepatic impairment. Pregnancy. Concomitant use with leflunomide.
Required Medical Information	Serum transaminase and bilirubin levels must be drawn within 6 months prior to initiation of therapy with Aubagio. For female patients of childbearing potential: Pregnancy was excluded prior to initiation of therapy and patient will use reliable contraception during treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**BOTOX**
Drug Name	BOTOX
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Infection at the site of injection
Required Medical Information	For overactive bladder and urinary incontinence: trial and failure of an anticholinergic medication. For headache prophylaxis in patients with chronic migraine: must have at least 15 headache days per month with headaches lasting 4 hours per day or longer. For axillary hyperhidrosis: must have a trial and failure of topical agents.
Age Restrictions	For blepharospasm and strabismus: 12 years of age and older. For cervical dystonia: 16 years of age and older. For all other indications: 18 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**BPH vs ED**
Drug Name	CIALIS
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D like Benign Prostatic Hyperplasia
Exclusion Criteria	Not covered for the treatment of Erectile Dysfunction. Maximum dose: 5mg daily.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**HRM-DIGOXIN**
Drug Name	LANOXIN 0.25MG
Tier	4
Drug Name	DIGOXIN 0.25MG, DIGOX 0.25MG, DIGITEK 0.25MG
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient has tried a lower dose or has contraindications to a lower dose.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Applies to patients 65 years of age or older. The patient has been counseled on the signs and symptoms of toxicity. The patient's symptoms are well controlled with no evidence of side-effects or toxicity.

Prior Authorization Group Description	**DAKLINZA**
Drug Name	DAKLINZA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient must not be on a strong CYP3A inducer (such as phenytoin, carbamazepine, rifampin, St. John's wort). Patient must not have been previously treated with an NS5A inhibitor.
Required Medical Information	Patient has a diagnosis of chronic hepatitis C virus genotype 1A, 1B, 2, or 3 infection. Daklinza will be used in combination with Sovaldi (sofosbuvir).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 or 24 weeks
Other Criteria	N/A

Prior Authorization Group Description	**DYSPORT**
Drug Name	DYSPORT
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Infection at the site of injection.
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**EXJADE**
Drug Name	EXJADE, JADENU
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with a creatinine clearance (CrCL) less than 40mL/min. Patients with a platelet count less than 50 million/L.
Required Medical Information	(1) For chronic iron overload due to blood transfusions, diagnosis of chronic iron overload due to blood transfusions and current serum ferritin level greater than 1000mcg/L. (2) For iron overload in patients with NON-transfusion-dependent thalassemia (NTDT), a) Diagnosis of a NON-transfusion thalassemia syndrome and chronic iron overload, b) for initiation of Exjade: i)pretreatment LIC of at least 5mg per gram of dry weight and ii) pretreatment serum ferritin levels greater than 300mcg/L and iii) For patients currently on Exjade therapy: current LIC is greater than 3mg per gram of dry weight or Exjade will be withheld until the LIC reaches above 5mg per gram of dry weight.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**FARYDAK**
Drug Name	FARYDAK
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of recent myocardial infarction or unstable angina, QTcF greater than 450 msec or significant baseline ST-segment ot T-wave abnormalities.
Required Medical Information	Patient must have multiple myeloma and received at least 2 prior regimens, including bortezomib and an immunomodulatory agent. Must be used in combination with bortezomib and dexamethazone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	24 weeks
Other Criteria	For renewals: Patients must have clinical benefit. Patient must not have experienced unresolved severe or medically significant toxicity. Total treatment duration will not exceed 16 cycles (48 weeks).
Prior Authorization Group Description	**FIRAZYR**
Drug Name	FIRAZYR
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient been advised to seek immediate medical attention in addition to treatment with Firazyr. Patient has been counseled to use no more than 3 doses in a 24 hour period.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**FLECTOR**
Drug Name	FLECTOR
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Application to non-intact skin from any etiology.
Required Medical Information	Patient has been counseled to not wear the patch while bathing or showering.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**GILENYA**
Drug Name	GILENYA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Recent occurrence (within the last 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, class III or IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless a patient has a pacemaker. Baseline QTc interval greater than or equal to 500ms. Treatment with Class Ia or Class III anti-arrhythmic drugs.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	GROWTH HORMONE
Drug Name	GENOTROPIN, GENOTROPIN MINIQUICK (0.4MG, 0.6MG, 0.8MG, 1MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG, 2MG), HUMATROPE, NORDITROPIN FLEXPRO (15/1.5ML), NORDITROPIN NORDIFLEX PEN, NUTROPIN AQ NUSPIN, NUTROPIN AQ PEN, OMNITROPE (5.8MG), SAIZEN, SEROSTIM, TEV-TROPIN, ZORBTIVE
Tier	5
Drug Name	GENOTROPIN MINIQUICK 0.2MG, NORDITROPIN FLEXPRO 5/1.5ML, 10/1.5ML), OMNITROPE (5/1.5ML, 10/1.5ML)
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Closed epiphyses in pediatric patients. Acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma or acute respiratory failure. Active malignancy. Active proliferative or severe non-proliferative diabetic retinopathy. For Prader-Willi Syndrome only: severe obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**HARVONI**
Drug Name	HARVONI
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D including genotype 1 chronic Hepatitis C infection.
Exclusion Criteria	N/A
Required Medical Information	For patients that are treatment-naïve, without cirrhosis, and HCV RNA is less than 6 million: therapy for 8 or 12 weeks depending on prescriber discretion. For 12 week therapy: Patient is treatment-naïve, without cirrhosis. OR Patient is treatment-naïve, with cirrhosis. OR Patient is treatment-experienced, without cirrhosis. For 24 week therapy: Patient is treatment-experienced with cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 or 24 weeks. 8 weeks per prescriber discretion.
Other Criteria	N/A
Prior Authorization Group Description	**HRM-HYPNOTICS**
Drug Name	ZALEPLON, ZOLPIDEM TARTRATE, ZOLPIDEM TARTRATE ER
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient has tried safer alternatives. The prescriber attests that the lowest effective dose will be used to minimize side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Applies to patients 65 years of age or older.

Prior Authorization Group Description	**IVIG**
Drug Name	BIVIGAM, FLEBOGAMMA, FLEBOGAMMA DIF, GAMMAPLEX, HIZENTRA, OCTAGAM, PRIVIGEN
Tier	5
Drug Name	GAMASTAN S/D, GAMMAGARD LIQUID, GAMMAKED, GAMUNEX-C
Tier	4
Drug Name	GAMMAGARD S/D, CARIMUNE NONOFILTERED, OCTAGAM (2GM/20ML)
Tier	3
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and despensed or administered for the individual.
Prior Authorization Group Description	**KALYDECO**
Drug Name	KALYDECO
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D like Cystic Fibrosis.
Exclusion Criteria	Not covered unless diagnosed with gene mutation G551D
Required Medical Information	Statement from physician or lab results showing patient has cystic fibrosis with gene mutation G551D.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**KORLYM**
Drug Name	KORLYM
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D like Cushing's syndrome with hyperglycemia.
Exclusion Criteria	Not covered if patient is pregnant. Maximum dose: 1200mg daily, not to exceed 20mg/kg/day.
Required Medical Information	Statement from physician verifying that non-hormonal contraception will be used during treatment and for one month after discontinuation of therapy unless the patient has had surgical sterilization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribing physician must be an endocrinologist.
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**LETAIRIS**
Drug Name	LETAIRIS
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	NYHA Functional Class II or III symptoms. For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, AND 2) Patient will use reliable contraception during treatment and for one month after stopping treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**LIDODERM**
Drug Name	LIDODERM
Tier	4
Drug Name	LIDOCAINE
Tier	2
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient has a diagnosis of post-herpetic neuralgia or diabetic neuropathy. The patch will only be applied to intact skin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**HRM-MUSCLE RELAXANTS**
Drug Name	CYCLOBENZAPRINE
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The medication will be used as an adjunct to rest and physical therapy. The prescriber must attest that the medication will only be used for a short period (up to 2 or 3 weeks). The patient has tried and failed or has contraindications to potentially safer alternatives.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Applies to patients 65 years of age or older

Prior Authorization Group Description	**HRM-NITROFURANTOIN**
Drug Name	FURADANTIN
Tier	4
Drug Name	NITROFURANTOIN, NITROFURANTOIN MACROCRYSTAL, NITROFURANTOIN MONOHYDRATE
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Creatinine clearance less than or equal to 60mL/min
Required Medical Information	The presciber has considered the risk for pulmonary and hepatic toxicity and acknowledges that the benefits outweigh the risks. The patient has tried and failed at least one of the following: trimethoprim, trimethoprim/sulfamethoxazole, ciprofloxacin or has contraindications to all alternatives.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Applies to patients 65 years of age or older that have greater than 90 days of therapy per year.

Prior Authorization Group Description	**NUVIGIL**
Drug Name	NUVIGIL
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetimine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder.
Age Restrictions	17 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**OLYSIO**
Drug Name	OLYSIO
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Must be given in combination with pegylated interferon and ribavirin or in combination with Sovaldi (with or without ribavirin) in patients ineligible to interferon.
Age Restrictions	17 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A
Prior Authorization Group Description	**ORKAMBI**
Drug Name	ORKAMBI
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has cystic fibrosis and is homozygous for the F508del mutation in the CFTR gene. Patient had baseline ALT, AST, and bilirubin assessed.
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**POMALYST**
Drug Name	POMALYST
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For multiple myeloma: 1) Patient received prior therapy with Velcade (bortezomib) AND Revlimid (lenalidomide), 2) disease has progressed during or within 60 days of completion of last therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**PRALUENT**
Drug Name	PRALUENT
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of heterozygous familial hypercholesterolemia or clinical atherosclerotic cardiovascular disease and requires additional lowering of LDL cholesterol. Patient is on maximally tolerated statin therapy. Patient will be started on the 75mg dose. For a diagnosis of clinical atherosclerotic cardiovascular disease: patient has tried at least two statins (rosuvastatin, atorvastatin, simvastatin, pravastatin, lovastatin, or fluvastatin).
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**PROVIGIL**
Drug Name	PROVIGIL
Tier	4
Drug Name	MODAFINIL
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of excessive sleepiness associated with chronic obstructive sleep apnea (OSA) /hypopnea syndrome and documentation of residual excessive sleepiness OR Diagnosis of excessive sleepiness associated with narcolepsy and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetimine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder.
Age Restrictions	16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**REMODULIN**
Drug Name	REMODULIN
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Congestive heart failure due to severe left ventricular systolic dysfunction.
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiagram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH AND Patient has New York Heart Association (NYHA) Functional Class II-IV.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

Prior Authorization Group Description	**RESPIRATORY PDE-5 INHIBITOR**
Drug Name	ADCIRCA, REVATIO
Tier	5
Drug Name	SILDENAFIL
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Receiving nitrate therapy (includes intermittent use)
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiagram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND patient has WHO Group I PAH AND patient has New York Heart Association (NYHA) Functional Class II or III.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**SOLARAZE**
Drug Name	SOLARAZE
Tier	3
Drug Name	DICLOFENAC SODIUM
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**SOVALDI**
Drug Name	SOVALDI
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Must be given in combination with pegylated interferon, and/or ribavirin, and/or simeprevir
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 wk:G1 triple tx or w/ simeprevir, G2, G4. 24 wk:G1 dual tx, G3. 16 wk:G2 non-responder. 48 wk:HCC
Other Criteria	N/A

Prior Authorization Group Description	**TASIGNA**
Drug Name	TASIGNA
Tier	3
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Uncorrected hypokalemia or hypomagnesemia, long QT syndrome. Use of concomitant drugs known to prolong the QT interval or strong CYP3A4 inhibitors.
Required Medical Information	For newly diagnosed CML, patient must be positive for the Ph chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) newly diagnosed CML and Tasigna is used for first line treatment, OR 2) resistance to imatinib, OR 3) intolerance to imatinib.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**TECFIDERA**
Drug Name	TECFIDERA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient must have a complete blood count within the past 6 months before initiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	To continue therapy, the patient must demonstrate stabilization or improvement while on Tecfidera.
Prior Authorization Group Description	**TECHNIVIE**
Drug Name	TECHNIVIE
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient does not have cirrhosis or severe hepatic impairment.
Required Medical Information	Patient has a diagnosis of chronic hepatitis C virus genotype 4 infection. Technivie will be used in combination with ribavirin. Treatment without ribavirin can be considered in treatment naïve patients ineligible for ribavirin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A

Prior Authorization Group Description	**TRACLEER**
Drug Name	TRACLEER
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy. Concomitant use with cyclosporine or glyburide. For initial therapy: alanine aminotransferase (ALT)/aspartate aminotransferase (AST) level greater than 3 times the upper limit of normal (ULN).
Required Medical Information	NYHA Functional Class II to IV symptoms. For female patients of childbearing potential: 1) Pregnancy was excluded prior to initiation of therapy, and 2) Patient will use reliable contraception during treatment and for one month after stopping treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A
Prior Authorization Group Description	**TRANSMUCOSAL FENTANYL PRODUCTS**
Drug Name	ABSTRAL, FENTORA, LAZANDA, SUBSYS, ACTIQ (200MCG, 400MCG, 600MCG, 800MCG, 1200MCG, 1600MCG)
Tier	5
Drug Name	FENTANYL CITRATE ORAL
Tier	2
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A. Long-Acting opioid is being prescribed. B. The patient is opioid tolerant (patients are considered opioid-tolerant if they have been taking at least 60mg of oral morphine per day, 25mcg of transdermal fentanyl/hr, 30mg of oral oxycodone daily, 8mg of oral hydromorphone daily, 25mg oral oxymorphone daily or an equianalgesic dose of another opioid for a week or longer.)
Age Restrictions	16 years of age or older for Actiq; 18 years of age or older all others
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

Prior Authorization Group Description	**VIEKIRA**
Drug Name	VIEKIRA
Tier	5
Covered Uses	All FDA-approved indications not otherwise excluded from Part D including genotype 1 chronic Hepatitis C infection.
Exclusion Criteria	N/A
Required Medical Information	For 12 week monotherapy: Patient does not have cirrhosis and has genotype 1B. For 12 week therapy with ribavirin: Patient has genotype 1A without cirrhosis or has genotype 1B with cirrhosis. For 24 week therapy with ribavirin: Patient has genotype 1A with cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 or 24 weeks per medical information provided.
Other Criteria	N/A
Prior Authorization Group Description	**XEOMIN**
Drug Name	XEOMIN
Tier	4
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Infection at the site of injection.
Required Medical Information	For blepharospasm: must have prior treatment with onabotulinumtoxinA (Botox)
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A