Tribute 2017 Formulary
2017 Prior Authorization Criteria

ADCIRCA

Products Affected

- Adcirca

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant administration of riociguat with a specific PDE5 inhibitor (eg, sildenafil, tadalafil, vardenafil)
Required Medical Information	Treatment of pulmonary arterial hypertension (PAH) (World Health Organization group 1)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	None

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Tribute 2017 Formulary
2017 Prior Authorization Criteria

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic anaplastic lymphoma kinase positive non-small cell lung cancer. Documentation of intolerance or disease progression following therapy with crizotinib
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic, ALK positive non-small cell lung cancer and have progressed or are intolerant to crizotinib.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	12 months
Other Criteria	None

Tribute 2017 Formulary
2017 Prior Authorization Criteria

ARMODAFINIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome confirmed by sleep lab evaluation, e.g., multiple sleep latency test, polysomnography), B) excessive sleepiness associated with narcolepsy confirmed by sleep lab evaluation and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine), OR C) excessive sleepiness associated with shift work disorder with a primary complaint of excessive sleepiness or insomnia which temporally associated with a work period (usually night work) that occurs during the habitual sleep phase or polysomnography and the MSLT demonstrate loss of a normal sleep-wake pattern.
Age Restrictions	17 years of age or older
Prescriber Restrictions	None
Coverage Duration	OSA/hypopnea syndrome: 6 months (initial), 12 months (renewal). Other diagnoses: 12 months.
Other Criteria	None

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. First clinical episode with MRI features consistent with multiple sclerosis.
Exclusion Criteria	Severe hepatic impairment. Current treatment with leflunomide. Patients who are pregnant or women of childbearing potential not using reliable contraception.
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (e.g., relapsing-remitting MS or progressive-relapsing MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease)

BAVENCIO

Products Affected

- Bavencio

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic Merkel cell carcinoma or locally advanced or metastatic urothelial carcinoma, in patients with disease progression on or following platinum-containing chemotherapy, or within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	None

BEXAROTENE

Products Affected

- Bexarotene

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of cutaneous T-cell lymphoma (CTCL) and patient is not a candidate for or had an inadequate response, is intolerant to, or has a contraindication to at least one prior systemic therapy (e.g., corticosteroids) for cutaneous manifestations of CTCL
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	Female patients of child-bearing potential have a documented negative pregnancy test one week prior to the initiation of therapy. For renewal, Patient has not had disease progression while on therapy and female patients of child-bearing potential are not pregnant and are continuing to use adequate birth-control measures during therapy.

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Signed statement of diagnosis from the physician, hepatic panel and CBC, trial and failure ofofimiatinib or dasatinibi and documentation of a 90 day response
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

BRIVIACT

Products Affected

- Briviact

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of partial-onset seizures, member must have history of inadequate response, contraindication, or intolerance to levetiracetam prior to approval.
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 Months
Other Criteria	None

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients who have or are at risk for severe hemorrhage and/or patients with a recent history of bleeding or hemoptysis.
Required Medical Information	Diagnosis of advanced renal cell carcinoma (RCC) AND patient have received prior antiangiogenic therapy.
Age Restrictions	Adults 18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

Tribute 2017 Formulary
2017 Prior Authorization Criteria

COPAXONE

Products Affected

- Copaxone Subcutaneous Solution Prefilled Syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing-remitting multiple sclerosis OR diagnosis of first clinical episode with MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient does not have progressive disease and responding to therapy.

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable OR metastatic malignant melanoma with BRAF V600E OR V600K mutation. Documentation of combination therapy with vemurafenib
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

CYSTARAN

Products Affected

- Cystaran

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Demonstrated cysteamine hypersensitivity or penicillamine hypersensitivity
Required Medical Information	Patient has a diagnosis of cystinosis AND patient has corneal cystine crystal accumulation
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

Tribute 2017 Formulary
2017 Prior Authorization Criteria

DARZALEX

Products Affected

- Darzalex Intravenous SOLUTION 100 MG/5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma, documented pretreatment with 3 prior therapies one of which must have included a proteasome inhibitor and an immunomodulatory agent OR the patient is double-refractory to proteasome inhibitor and immunomodulatory agent.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

EMPLICITI

Products Affected

- Empliciti

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma, documentation of combination therapy with lenalidomide and dexamethasone. Prescriber must document prior treatment with 1 to 3 previous therapies.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ENTRESTO

Products Affected

- Entresto

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of angioedema related to previous ACE inhibitor or ARB therapy, concomitant use or use within 36 hours of ACE inhibitors, concomitant use of aliskiren in patients with diabetes
Required Medical Information	Statement of diagnosis indicating Heart Failure (NYHA Class II through IV) and relevant lab work.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ERWINAZE

Products Affected

- Erwinaze INJECTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Appropriate diagnosis (idiopathic pulmonary fibrosis [IPF]), monitoring (hepatic function/LFTs)
Age Restrictions	None
Prescriber Restrictions	Pulmonologist
Coverage Duration	12 months
Other Criteria	none

ESRD THERAPY

Products Affected

- Aranesp (Albumin Free) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
- Aranesp (Albumin Free) Injection Solution Prefilled Syringe
- Procrit INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Pretreatment hemoglobin levels of less than 10g/dL. Dose reduction or interruption if hemoglobin exceeds 10 g/dL (CKD not on dialysis-adult, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD) in addition to supporting statement of diagnosis from physician.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	None

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Statement of diagnosis from physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

FENTANYL

Products Affected

- Fentora BUCCAL TABLET 200 MCG, 400 MCG, 600 MCG, 800 MCG
- Lazanda

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

GILENYA

Products Affected

- Gilenya

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. First clinical episode with MRI features consistent with multiple sclerosis.
Exclusion Criteria	Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500 ms. Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (quinidine, procainamide, amiodarone, sotalol).
Required Medical Information	Diagnosis of a relapsing form of multiple sclerosis or diagnosis of first clinical episode with MRI features consistent with MS AND Patient will be observed for signs and symptoms of bradycardia in a controlled setting for at least 6 hours after the first dose
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	For renewal, the patient has experienced no or slowed disease progression.

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician in patients with: 1) metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or 2) metastatic squamous NSCLC, progressing after platinum-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

GONADOTROPIN

Products Affected

- Chorionic Gonadotropin Intramuscular

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Fertility indications in females are excluded.
Required Medical Information	Diagnosis of Hypogonadotrophic hypogonadism or Prepubertal cryptorchidism
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 Months
Other Criteria	None

GROWTH HORMONE

Products Affected

- Norditropin FlexPro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

HEPATITIS C

Products Affected

- Daklinza
- Epclusa
- Harvoni
- Sovaldi
- Zepatier

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Must submit documentation of HCV genotype, subtype and quantitative HCV RNA (viral load) testing any time prior to therapy. Must document the following within 12 weeks of starting therapy, (1) CBC, INR, hepatic function panel, GFR, and TSH if interferon is being used. Must document cirrhosis status, prior treatment history (if any), and planned duration of treatment. FOR GENOTYPE 1: Must include subtype, trial/failure, contraindication, or intolerance to Zepatier prior to approval of Daklinza, Harvoni, Epclusa, or Sovaldi except in the case of post-transplant status. FOR GENOTYPES 2 and 3: Must include subtype, trial/failure, contraindication, or intolerance to Epclusa prior to approval of combination of Sovaldi and Ribavirin OR Sovaldi and Daklinza. FOR GENOTYPE 4: trial/failure, contraindication, or intolerance to Zepatier prior to approval of Harvoni, Epclusa, or Sovaldi + PEG + Ribavirin. FOR GENOTYPES 5 and 6: trial/failure, contraindication, or intolerance to Harvoni prior to approval of Epclusa or Sovaldi + PEG + Ribavirin.
Age Restrictions	Patient must be age 12 years or older for Harvoni and Sovaldi, 18 or over for all other medications.
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Duration of approval per AASLD Guidelines
Other Criteria	None

HRM-ANALGESICS

Products Affected

- Ketorolac Tromethamine Intramuscular SOLUTION 60 MG/2ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, and anticipated treatment course/duration and if formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s)- See OTHER Criteria for Alternatives list.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Analgesics: APAP/codeine, Embeda, hydrocodone/APAP, hydromorphone, methadone, morphine sulfate, Opana ER, oxymorphone ER, oxycodone, oxycodone/APAP, oxycodone/ASA, oxycodone/ibuprofen, oxymorphone IR, tramadol, tramadol/APAP

HRM-ANTIARRHYTHMICS

Products Affected

- Disopyramide Phosphate ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, and anticipated treatment course/duration and if formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s)- See OTHER Criteria for Alternatives list.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anti-arrhythmics: DIGOXIN: digoxin 0.125mg dose, propranolol, or sotalol for atrial fibrillation, DISOPYRAMIDE: dofetilide, amiodarone, propafenone, mexiletine, multaq

HRM-ANTICONVULSANTS

Products Affected

- PHENobarbital ORAL ELIXIR
- PHENobarbital ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, and anticipated treatment course/duration and if formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s)- See OTHER Criteria for Alternatives list.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anticonvulsants: Aptiom, Banzel, carbamazepine, clonazepam, diazepam, divalproex, ethosuximide, felbamate, fosphenytoin, Fycompa, gabapentin, gabitril, lamotrigine, levetiracetam, Lyrica, Onfi, oxcarbazine, Oxtellar, Peganone, phenytoin, Potiga, Primidone, Sabril, Tegretol-XR, Tiagabine, topirimate, Trokendi-XR, valproate, Vimpat, zonisamide, Dilantin, Equetro.

Tribute 2017 Formulary
2017 Prior Authorization Criteria
HRM-ANTIDEMENTIA

Products Affected

- Ergoloid Mesylates ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, and anticipated treatment course/duration and if formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s)- See OTHER Criteria for Alternatives list.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Antidementia: donepezil, Exelon patch, galantamine, Namenda XR, Namzaric, rivastigmine.

Tribute 2017 Formulary
2017 Prior Authorization Criteria
HRM-ANTIINFLAMMATORY

Products Affected

- Indomethacin ER
- Indomethacin Oral
- Ketorolac Tromethamine Injection SOLUTION 15 MG/ML, 30 MG/ML
- Ketorolac Tromethamine Oral

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, and anticipated treatment course/duration and if formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s)- See OTHER Criteria for Alternatives list.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anti-inflammatories: celecoxib, diclofenac, diflunisal, etodolac, fenoprofen, flurbiprofen, ibuprofen, ketoprofen, meclofenamate, meloxicam, nabumetone, naproxen, oxaprozin, piroxicam, sulindac, tolmetin.

Tribute 2017 Formulary
2017 Prior Authorization Criteria
HRM-ANTIPLATELET

Products Affected

- Dipyridamole Oral

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, and anticipated treatment course/duration and if formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s)- See OTHER Criteria for Alternatives list.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anti-platelets: Anagrelide, asa/dipyridamole, Brilinta, clostazol, clopidogrel

HRM-CARDIOVASCULAR

Products Affected

- GuanFACINE HCl ER
- Methyldopa ORAL
- Methyldopa-Hydrochlorothiazide
- Methyldopate HCl
- NIFEdipine Oral

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, and anticipated treatment course/duration and if formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s)- See OTHER Criteria for Alternatives list.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Cardiovascular agents: acebutolol,amilor/hctz,amlod/benazp,amlod/valsar,amlodipine,atenol/chlorth,atenolol,benazep/hctz,benazepril,benicar,benicar hct,betaxolol,bisopr/hctz,bisoprolol,candesartan,candesartan/hctz,captopril/hctz,captopril,cartia xt,carvedilol,chlorothiazide,diltiazem,dilt-xr,doxazosin,enalapril,enalapril/hctz,eprosartan,felodipine,fosinopril,fosinopril/hctz, hctz,indapamide,irbesart/hctz,irbesartan,isradipine,labetalol,lisinopril,lisinopril/hctz,losartan/losartan/hctz,methylclothia,metolazone,metoprol/hctz, metoprolol,midodrine,moexipril/hctz,moexipril,nadolol,nadolol/bend,nicardipine,nifedical xl,nimodipine,nifedipine er,nisoldipine,perindopril,pindolol,prazosin,propran/hctz,propranolol,quin

PA Criteria	Criteria Details
	april/quinapril/hctz,ramipril,spirono/hctz,taztia xt,telmis/amlod,telmis/hctz,telmisartan,terazosin,timolol,trandolapril,trand olapril/verapamil,triam/hctz,valsart/hctz,valsartan,verapamil

HRM-ESTROGENS

Products Affected

- Estradiol Oral
- Fyavolv
- Menest ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- Premarin Oral
- Premphase
- Prempro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, and anticipated treatment course/duration and if formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s)- See OTHER Criteria for Alternatives list.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Estrogens: Premarin Vaginal cream, premarin inj, raloxifene

HRM-SEDATIVE HYPNOTICS

Products Affected

- Butisol Sodium Oral TABLET 30 MG
- Zaleplon

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, and anticipated treatment course/duration and if formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s)- See OTHER Criteria for Alternatives list.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Sleep disorder agents: estazolam, flurazepam, rozerem ,temazepam, triazolam

Tribute 2017 Formulary
2017 Prior Authorization Criteria
HRM-SKELETAL MUSCLE RELAXANTS

Products Affected

- Cyclobenzaprine HCl Oral TABLET 10 MG, 5 MG
- Orphenadrine Citrate ER
- Orphenadrine Citrate Injection

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, and anticipated treatment course/duration.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

HRM-SULFONYLUREAS

Products Affected

- ChlorproPAMIDE
- GlyBURIDE Micronized
- GlyBURIDE Oral
- GlyBURIDE-MetFORMIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation to the medical necessity for using this high risk medication, and anticipated treatment course/duration and if formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s)- See OTHER Criteria for Alternatives list.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anti-Diabetics: acarbose, Avandia, cycloset, glimepiride, glimepiride/metformin, glipizide, Invokamet, Janumet, Januvia, Jentadueto, metformin, nateglinide, pioglitazone, pioglitazone/metformin, Prandimet, repaglinide, Riomet, Symlinpen, tolazamide, tolbutamide, Tradjenta, Victoza.

Tribute 2017 Formulary
2017 Prior Authorization Criteria
HYDROXYPROGESTERONE

Products Affected

- Hydroxyprogesterone Caproate Intramuscular

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Breast, cervical, hepatocellular, uterine, or vaginal cancers, hepatic or thromboembolic disease, jaundice, or vaginal bleeding
Required Medical Information	Supporting statement of diagnosis from physician
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	Up to 21 weeks
Other Criteria	None

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hormone receptor (HR)-positive, HER2-negative advanced breast cancer in postmenopausal women, in combination with letrozole as initial endocrine-based therapy or hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer, in combination with fulvestrant after disease progression following endocrine-based therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) in adult patients who are T315I-positive or for whom no other tyrosine kinase inhibitor therapy is indicated OR Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) in adult patients who are T315I-positive or for whom no other tyrosine kinase inhibitor therapy is indicated.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsed or refractory acute myeloid leukemia with an isocitrate dehydrogenase 2 mutation as detected by an FDA approved test
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

IMFINZI

Products Affected

- Imfinzi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic urothelial carcinoma. Patient must have progressed on or following platinum-containing chemotherapy, or within 12 months of neoadjuvant or adjuvant platinum containing chemotherapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	12 months
Other Criteria	None

JUXTAPID

Products Affected

- Juxtapid ORAL CAPSULE 10 MG, 20 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia and patient is receiving other lipid-lowering therapies, i.e. statins. Reauthorization: demonstration of a positive clinical response to Juxtapid therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

KANUMA

Products Affected

- Kanuma

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Lysosomal acid lipase deficiency
Age Restrictions	None
Prescriber Restrictions	Prescribed by hepatologist
Coverage Duration	12 months
Other Criteria	None

KEYTRUDA

Products Affected

- Keytruda

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable or metastatic melanoma OR first-line treatment of metastatic non-small cell lung cancer (NSCLC) in patients with high PD-L1 expressing tumors and with no EGFR or ALK genomic tumor aberrations OR treatment of metastatic NSCLC in patients with PD-L1 expression who have disease progression on or after platinum-containing chemotherapy (patients with EGFR or ALK genomic tumor aberrations should have disease progression on approved therapy for these aberrations prior to receiving Keytruda) OR recurrent or metastatic squamous cell carcinoma of the head and neck in patients with disease progression on or after platinum-containing chemotherapy OR treatment of adult or pediatric patients with classical Hodgkin lymphoma (in patients who are refractory or who have relapsed after 3 or more prior lines of therapy) OR first-line treatment (in combination with pemetrexed plus carboplatin) of metastatic nonsquamous NSCLC OR locally advanced or metastatic urothelial carcinoma (in patients who are not eligible for cisplatin-containing chemotherapy, or who have had disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy) OR unresectable or metastatic solid tumors that have been identified as having a biomarker referred to as microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

KISQALI

Products Affected

- Kisqali 200 Dose
- Kisqali 400 Dose
- Kisqali 600 Dose
- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer and intended to be used in combination with an aromatase inhibitor in postmenopausal women.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	12 months
Other Criteria	None

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Supporting statement of diagnosis and relevant medical information from physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

KYNAMRO

Products Affected

- Kynamro Subcutaneous Solution Prefilled Syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests.
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia as evidenced by one of the following: A) genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or autosomal recessive hypercholesterolemia (ARH) adaptor protein gene locus OR B) untreated/pre-treatment LDL greater than 500 mg/dL with at least one of the following: cutaneous or tendonous xanthoma before age 10 years, history of early vascular disease (men younger than 55 years, women younger than 60 years) on both sides of the family if parenteral LDL levels are unknown, elevated LDL cholesterol levels before lipid-lowering therapy consistent with heterozygous FH in both parents AND Patient has tried and had an inadequate response to the maximum tolerated dose of a high potency statin (e.g., atorvastatin, rosuvastatin), unless all statins are contraindicated.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months.
Other Criteria	For renewal, patient has responded to therapy with a decrease in LDL levels from baseline AND patient does not have contraindications to therapy.

LARTRUVO

Products Affected

- Lartruvo Intravenous SOLUTION 500 MG/50ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of soft tissue sarcoma (STS), histologic subtype for which an anthracycline-containing regimen is appropriate, previous treatment failure with radiotherapy or surgery and must document being used in combination with doxorubicin for the first 8 cycles.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

LIDOCAINE PAD

Products Affected

- Lidocaine EXTERNAL PATCH 5 %

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic colorectal cancer, previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based regimens, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For initial treatment: Absolute neutrophil count 1,500/mm(3) or greater or febrile neutropenia resolved, platelet count 75,000/mm(3) or greater, and grade 3 or 4 nonhematological reactions resolved to grade 0 or 1

LYNPARZA

Products Affected

- Lynparza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Appropriate diagnosis and testing for BRCA mutation (deleterious or suspected deleterious germline BRCA mutated (as detected by an FDA approved test) advanced ovarian cancer that has been treated with 3 or more prior lines of chemotherapy)
Age Restrictions	none
Prescriber Restrictions	none
Coverage Duration	12 months
Other Criteria	none

MAKENA

Products Affected

- Makena

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Breast, cervical, hepatocellular, uterine, or vaginal cancers, hepatic or thromboembolic disease, jaundice, or vaginal bleeding
Required Medical Information	Supporting statement of diagnosis from physician
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	21 weeks
Other Criteria	None

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Must submit documentation of HCV genotype, subtype and quantitative HCV RNA (viral load) testing any time prior to therapy. Must document the following within 12 weeks of starting therapy, (1) CBC, INR, hepatic function panel, GFR, and TSH if interferon is being used. Must document cirrhosis status, prior treatment history (if any), and planned duration of treatment. FOR GENOTYPE 1: Must include subtype, trial/failure, contraindication, or intolerance to Zepatier prior to approval of Daklinza, Harvoni, Epclusa, Mavyret or Sovaldi except in the case of post-transplant status. FOR GENOTYPES 2 and 3: Must include subtype, trial/failure, contraindication, or intolerance to Epclusa or Mavyret prior to approval of combination of Sovaldi and Ribavirin OR Sovaldi and Daklinza. FOR GENOTYPE 4: trial/failure, contraindication, or intolerance to Zepatier prior to approval of Harvoni, Epclusa, Mavyret or Sovaldi + PEG + Ribavirin. FOR GENOTYPES 5 and 6: trial/failure, contraindication, or intolerance to Mavyret or Harvoni prior to approval of Epclusa or Sovaldi + PEG + Ribavirin.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Duration of approval per AASLD Guidelines
Other Criteria	None

MODAFINIL

Products Affected

- Modafinil

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

MS INTERFERONS

Products Affected

- Avonex
- Avonex Pen Intramuscular Auto-injector Kit
- Avonex Prefilled Intramuscular Prefilled Syringe Kit
- Betaseron Subcutaneous KIT
- Plegridy
- Plegridy Starter Pack Subcutaneous Solution Pen-injector

PA Criteria	Criteria Details
Covered Uses	All-FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	none
Required Medical Information	Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis.
Age Restrictions	none
Prescriber Restrictions	none
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease)

MYTESI

Products Affected

- Mytesi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	CLINICAL NOTES TO SUPPORT A DIAGNOSIS OF CHRONIC DIARRHEA, DEFINED AS DIARRHEA PERSISTING FOR MORE THAN FOUR WEEKS, CAUSED BY THEIR MEDICATION REGIMEN OR HIV ENTEROPATHY PROVEN BY BIOPSY, AND NOT A VIRUS, PARASITE OR BACTERIUM AS EVIDENCED BY STOOL SAMPLE TAKEN IN THE PREVIOUS 3 MONTHS. PATIENT MUST HAVE TRIED AND FAILED OR HAD INTOLERANCE TO LOPERAMIDE OR DIPHENOXYLATE-ATROPINE TRIALS OF A MINIMUM OF 30 DAYS.
Age Restrictions	Adults 18 years of age or older
Prescriber Restrictions	Infectious Disease Specialist or GI Consult for new starts
Coverage Duration	12 months
Other Criteria	None

Tribute 2017 Formulary
2017 Prior Authorization Criteria

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of early stage HER2- overexpressed breast cancer. Must be used after trastuzumab therapy.
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma, documentation of combination therapy with lenalidomide and dexamethasone. History of 1 prior therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Prior authorization will be approved for the following indication(s): orthostatic dizziness, light-headedness, or the feeling that you are about to black out in adults with neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure (i.e., Parkinson disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of severe asthma (eosinophilic phenotype)
Age Restrictions	12 years of age or older
Prescriber Restrictions	Must be prescribed by a pulmonologist or immunologist
Coverage Duration	12 months
Other Criteria	None

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Parkinson disease psychosis including hallucinations and/or delusions
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 Months
Other Criteria	None

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced basal cell carcinoma of the skin and specific documentation of negative pregnancy status
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

OPDIVO

Products Affected

- Opdivo Intravenous SOLUTION 40 MG/4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of BRAF V600 wild-type or BRAF V600 mutation-positive unresectable or metastatic melanoma and used as single agent OR unresectable or metastatic melanoma in combination with ipilimumab [Yervoy] OR Diagnosis of metastatic non-small cell lung cancer (NSCLC) with progression on or after platinum-based chemotherapy and patients with EGFR or ALK genomic tumor aberrations should have disease progression (on FDA-approved EGFR- or ALK-directed therapy) prior to receiving nivolumab OR advanced renal cell carcinoma who have received prior anti-angiogenic therapy OR recurrent or metastatic squamous cell carcinoma of the head and neck in patients with disease progression on or after platinum-based chemotherapy OR classical Hodgkin lymphoma in patients who have relapsed or progressed following autologous hematopoietic stem cell transplant (HSCT) and post-transplant brentuximab vedotin OR locally advanced or metastatic urothelial carcinoma in patients with disease progression during or following a platinum-containing therapy or disease progression within 12 months of neoadjuvant or adjuvant treatment with a platinum-containing therapy.
Age Restrictions	none
Prescriber Restrictions	none
Coverage Duration	12 months
Other Criteria	none

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Initial Therapy: Diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test AND if less than 18 years of age, baseline ophthalmological exam completed. Continuation of therapy: Documentation patient is tolerating and responding to medication (i.e. improved FEV1, weight gain, decreased exacerbations, etc.)
Age Restrictions	Must be greater than or equal to 12 years of age
Prescriber Restrictions	Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation
Coverage Duration	12 months
Other Criteria	None

PCSK9 INHIBITOR

Products Affected

- Praluent Subcutaneous Solution Pen-injector
- Repatha
- Repatha Pushtronex System
- Repatha SureClick

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	FOR PRALUENT: MUST MEET CRITERIA #1 OR #3. FOR REPATHA: MUST MEET CRITERIA #1, #2 OR #3. 1. Diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by genotyping OR Simon Broome criteria: Total cholesterol greater than 290mg/dL or LDL cholesterol greater than 190mg/dL, PLUS ONE OF THE FOLLOWING: Tendon xanthomas in patient, or 1st degree relative (parent, sibling, child), or 2nd degree relative (grandparent, uncle, aunt) OR DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation 2. Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genotyping OR diagnosis based on the following: a. History of untreated LDL-C greater than 500 mg/dL AND xanthoma before 10 years of age OR b. Documentation of HeFH in both parents 3. Diagnosis of clinical atherosclerotic cardiovascular disease (CVD) as defined as one of the following: a. acute coronary syndrome, b. history of myocardial infarction, c. stable/unstable angina, d. coronary or other arterial revascularization, e. stroke, f. transient ischemic stroke (TIA), g. peripheral arterial disease presumed to be atherosclerotic region. AND MEETS CRITERIA #4, #5, and #6, 4. Provide baseline and current LDL-C 5. LDL-C greater than or equal to 100 mg/dL 6. Used in combination with maximally tolerated high-intensity statin OR MEETS CRITERIA #7 AND #8. 7. Statin intolerant 8. LDL-C greater than or equal to 100 mg/dL CONTINUING THERAPY: 1. Documented response to Praluent or Repatha, defined as ONE of the following: a. The patient is tolerating medication b. Will continue to be used in combination with maximally tolerated statin (unless statin intolerant).
Age Restrictions	Repatha: 13 years of age or older for diagnosis HoFM, Diagnosis CVD or HeFH AND Praluent or Repatha : 18 years of age or older
Prescriber	Must be prescribed by, or in consultation with, a cardiologist,

Tribute 2017 Formulary
2017 Prior Authorization Criteria

PA Criteria	Criteria Details
Restrictions	endocrinologist, or lipid specialist
Coverage Duration	Initial approval: 8 weeks, Renewal approval: 12 months
Other Criteria	None

RADICAVA

Products Affected

- Radicava

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Sulfite hypersensitivity
Required Medical Information	Diagnosis of amyotrophic lateral sclerosis and must meet all of the following: living independently, functionality retained most activities of daily living (defined as scores of 2 points or better on each individual item of the ALS Functional Rating Scale, normal respiratory function defined as percent-predicted forced vital capacity values of percent FVC greater or equal to 80 percent, disease duration of 2 years or less.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in collaboration with a neurologist
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	For renewal, patient must meet initial criteria and not have more than a 6 point decline in the ALS Functional Rating Scale from baseline.

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diabetic Neuropathic Ulcers: Diabetic patient with ulcer wound. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Diabetic Neuropathic Ulcers: Maximum 5 months.
Other Criteria	None

REXULTI

Products Affected

- Rexulti

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Statement of Diagnosis from the prescriber and documented trial and failure, contraindication, or intolerance to aripiprazole
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

RUBRACA

Products Affected

- Rubraca Oral TABLET 200 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Advanced Ovarian Cancer and all of the following criteria: 1. BRCA mutation positive as detected by an approved FDA laboratory test, 2. Previous trial/failure with two or more chemotherapy regimens, 3. Used as monotherapy, 4. Agreement of provider to perform a complete blood count (CBC) at baseline and monthly thereafter, 5. Women of reproductive potential must use an effective method of contraception during therapy and for 6 months after the last dose. Renewal will be based on lack of disease progression or unacceptable toxicity.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Hematologist or Oncologist
Coverage Duration	12 months
Other Criteria	None

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Angioedema
Required Medical Information	Diagnosis of treatment naive FLT3 mutation-positive acute myelogenous leukemia (AML) and must be used in combination with standard cytarabine and daunorubicin induction and consolidation therapy or diagnosis of systemic mastocytosis.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	12 months
Other Criteria	None

SAMSCA

Products Affected

- Samsca

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

SILDENAFIL

Products Affected

- Sildenafil Citrate Intravenous
- Sildenafil Citrate Oral

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded form Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic, non-small cell lung cancer with confirmed presence of T790M EGFR tumor mutation by cobas EGFR Mutation Test v2
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TECFIDERA

Products Affected

- Tecfidera

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting MS or progressive-relapsing MS, or secondary-progressive MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	none

TOBI POD

Products Affected

- Tobi Podhaler

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with aminoglycoside hypersensitivity
Required Medical Information	Diagnosis of cystic fibrosis AND patient has evidence of P. aeruginosa in the lungs
Age Restrictions	6 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations)

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients at increased risk of osteogenic sarcoma.
Required Medical Information	Diagnosis of osteoporosis in post-menopausal women at high risk for fracture. Member must have failed therapy with a bisphosphonate (defined by a fracture while on therapy or worsening bone density) unless such a trial is shown to be inappropriate or contraindicated (i.e., presence of severe osteoporosis [T-scores -3.0 or worse in lumbar spine, femoral neck, or total hip region], history of major osteoporotic fracture, presence of renal insufficiency, etc) AND member has at least one of the following: T-score equal to or worse than -2.5 in the lumbar spine, femoral neck, or total hip region OR a FRAX calculator based 10-year risk of at least 20% for a major osteoporotic fracture (spine, shoulder, hip, or wrist), or a 10-year risk of at least 3% for a hip fracture OR presence or history of osteoporotic fracture.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 12 months. Reauth: Treatment duration has not exceeded 24 months during patient lifetime.
Other Criteria	None

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization AND patient has tried and had an insufficient response to at least one other PAH agent (e.g., sildenafil) therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

VARIZIG

Products Affected

- VariZIG Intramuscular SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of hypersensitivity (including anaphylaxis or severe systemic reaction) to immune globulin or any component of the preparation. Severe thrombocytopenia or coagulation disorder where IM injections are contraindicated.
Required Medical Information	Documentation of immunocompromised patient, defined as: newborns of mothers with varicella shortly before or after delivery, premature infants, neonates and infants younger than 1 year, adults without evidence of immunity, pregnant women.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	CLL for patients with 17p deletion and have had at least 1 prior therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	none

VYXEOS

Products Affected

- Vyxeos

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of anthracycline hypersensitivity
Required Medical Information	Diagnosis of therapy related acute myeloid leukemia or acute myeloid leukemia with myelodysplasia related changes. If the patient has the diagnosis of therapy related acute myeloid leukemia, it must be newly diagnosed.
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	BvD determination per CMS guidelines

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician that establishes the cancer as anaplastic lymphoma kinase (ALK)-positive or ROS1-positive
Age Restrictions	None
Prescriber Restrictions	Must be prescribed by an oncologist
Coverage Duration	12 months
Other Criteria	None

YONDELIS

Products Affected

- Yondelis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis and lab values: ANC, platelet count, serum creatine phosphokinase, serum creatinine, liver function tests, and left ventricular ejection fraction.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Must be prescribed by an oncologist
Coverage Duration	12 months
Other Criteria	None

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer and patient had a complete or partial response to platinum-based chemotherapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist or gynecologist
Coverage Duration	12 months
Other Criteria	None

PART B VERSUS PART D

Products Affected

- Abelcet Intravenous SUSPENSION 5 MG/ML
- Abraxane Intravenous SUSPENSION RECONSTITUTED 100 MG
- Acetylcysteine INHALATION SOLUTION 10 %
- Acyclovir Sodium Intravenous SOLUTION 50 MG/ML
- Adriamycin Intravenous SOLUTION 2 MG/ML
- Adrucil Intravenous SOLUTION 500 MG/10ML
- Albuterol Sulfate INHALATION NEBULIZATION SOLUTION (2.5 MG/3ML) 0.083%, (5 MG/ML) 0.5%, 0.63 MG/3ML, 1.25 MG/3ML
- Aldurazyme Intravenous SOLUTION 2.9 MG/5ML
- AmBisome Intravenous SUSPENSION RECONSTITUTED 50 MG
- Aminosyn II Intravenous SOLUTION 10 %, 8.5 %
- Aminosyn II/Electrolytes Intravenous SOLUTION 8.5 %
- Aminosyn/Electrolytes Intravenous SOLUTION 7 %
- Aminosyn/Electrolytes Intravenous SOLUTION 8.5 %
- Aminosyn-HBC Intravenous SOLUTION 7 %
- Aminosyn-PF Intravenous SOLUTION 10 %, 7 %
- Aminosyn-RF Intravenous SOLUTION 5.2 %
- Amphotericin B INJECTION SOLUTION RECONSTITUTED 50 MG
- Aprepitant ORAL CAPSULE 125 MG, 40 MG, 80 & 125 MG, 80 MG
- Arcalyst Subcutaneous SOLUTION RECONSTITUTED 220 MG
- Arranon Intravenous SOLUTION 5 MG/ML
- Astagraf XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
- Atgam Intravenous INJECTABLE 50 MG/ML
- Azasan ORAL TABLET 100 MG, 75 MG
- AzaTHIOprine Oral TABLET 50 MG
- AzaTHIOprine Sodium INJECTION SOLUTION RECONSTITUTED 100 MG
- Azithromycin Intravenous SOLUTION RECONSTITUTED 500 MG
- Benlysta Intravenous SOLUTION RECONSTITUTED 120 MG, 400 MG
- BiCNU Intravenous SOLUTION RECONSTITUTED 100 MG
- Bivigam Intravenous SOLUTION 10 GM/100ML
- Bleomycin Sulfate INJECTION SOLUTION RECONSTITUTED 30 UNIT
- Budesonide INHALATION SUSPENSION 0.25 MG/2ML, 0.5 MG/2ML, 1 MG/2ML
- Busulfan Intravenous SOLUTION 6 MG/ML
- Calcitonin (Salmon) NASAL SOLUTION 200 UNIT/ACT
- CARBOplatin Intravenous SOLUTION 150 MG/15ML
- Carimune NF Intravenous SOLUTION RECONSTITUTED 6 GM
- Cerezyme Intravenous SOLUTION RECONSTITUTED 400 UNIT
- CISplatin Intravenous SOLUTION 100 MG/100ML
- Cladribine Intravenous SOLUTION 10 MG/10ML
- Clindamycin Phosphate Injection SOLUTION 300 MG/2ML, 900 MG/6ML
- Clinimix E/Dextrose (2.75/10) Intravenous SOLUTION 2.75 %
- Clinimix E/Dextrose (2.75/5) Intravenous SOLUTION 2.75 %
- Clinimix E/Dextrose (4.25/10) Intravenous SOLUTION 4.25 %
- Clinimix E/Dextrose (4.25/25) Intravenous SOLUTION 4.25 %
- Clinimix E/Dextrose (4.25/5) Intravenous SOLUTION 4.25 %

- Clinimix E/Dextrose (5/15) Intravenous SOLUTION 5 %
- Clinimix E/Dextrose (5/20) Intravenous SOLUTION 5 %
- Clinimix E/Dextrose (5/25) Intravenous SOLUTION 5 %
- Clinimix/Dextrose (2.75/5) Intravenous SOLUTION 2.75 %
- Clinimix/Dextrose (4.25/10) Intravenous SOLUTION 4.25 %
- Clinimix/Dextrose (4.25/20) Intravenous SOLUTION 4.25 %
- Clinimix/Dextrose (4.25/25) Intravenous SOLUTION 4.25 %
- Clinimix/Dextrose (4.25/5) Intravenous SOLUTION 4.25 %
- Clinimix/Dextrose (5/15) Intravenous SOLUTION 5 %
- Clinimix/Dextrose (5/20) Intravenous SOLUTION 5 %
- Clinimix/Dextrose (5/25) Intravenous SOLUTION 5 %
- Clofarabine Intravenous SOLUTION 1 MG/ML
- Cosmegen Intravenous SOLUTION RECONSTITUTED 0.5 MG
- Cromolyn Sodium INHALATION NEBULIZATION SOLUTION 20 MG/2ML
- Cyclophosphamide ORAL CAPSULE 25 MG, 50 MG
- CycloSPORINE Intravenous SOLUTION 50 MG/ML
- CycloSPORINE Modified Oral CAPSULE 100 MG, 25 MG, 50 MG
- CycloSPORINE Modified ORAL SOLUTION 100 MG/ML
- CycloSPORINE ORAL CAPSULE 100 MG, 25 MG
- Cyramza Intravenous SOLUTION 100 MG/10ML, 500 MG/50ML
- Cytarabine (PF) INJECTION SOLUTION 100 MG/ML
- Cytarabine INJECTION SOLUTION 20 MG/ML
- Dacarbazine Intravenous SOLUTION RECONSTITUTED 200 MG
- DAUNOrubicin HCl Intravenous INJECTABLE 5 MG/ML
- Depo-Provera Intramuscular SUSPENSION 400 MG/ML
- Dexrazoxane Intravenous SOLUTION RECONSTITUTED 250 MG
- Dextrose Intravenous SOLUTION 10 %, 5 %
- DOXOrubicin HCl Intravenous SOLUTION 2 MG/ML
- DOXOrubicin HCl Liposomal Intravenous INJECTABLE 2 MG/ML
- Dronabinol ORAL CAPSULE 10 MG, 2.5 MG, 5 MG
- Elaprase Intravenous SOLUTION 6 MG/3ML
- Eligard Subcutaneous KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG
- Elitek Intravenous SOLUTION RECONSTITUTED 1.5 MG, 7.5 MG
- Emend Intravenous SOLUTION RECONSTITUTED 150 MG
- Emend ORAL SUSPENSION RECONSTITUTED 125 MG
- Engerix-B INJECTION SUSPENSION 10 MCG/0.5ML, 10 MCG/0.5ML (0.5ML SYRINGE), 20 MCG/ML
- Envarsus XR Oral Tablet Extended Release 24 Hour 0.75 MG, 1 MG, 4 MG
- Epirubicin HCl Intravenous SOLUTION 200 MG/100ML
- Erbitux Intravenous SOLUTION 100 MG/50ML
- Etopophos Intravenous SOLUTION RECONSTITUTED 100 MG
- Etoposide Intravenous SOLUTION 500 MG/25ML
- Fabrazyme Intravenous SOLUTION RECONSTITUTED 35 MG
- Faslodex Intramuscular SOLUTION 250 MG/5ML
- Firmagon Subcutaneous SOLUTION RECONSTITUTED 120 MG, 80 MG

- Flebogamma DIF Intravenous SOLUTION 5 GM/50ML
- Fluconazole in Sodium Chloride Intravenous SOLUTION 200-0.9 MG/100ML-%, 400-0.9 MG/200ML-%
- Fluorouracil Intravenous SOLUTION 2.5 GM/50ML
- Folotyn Intravenous SOLUTION 40 MG/2ML
- FreAmine HBC Intravenous SOLUTION 6.9 %
- GamaSTAN S/D Intramuscular INJECTABLE , (10ML), (2ML)
- Gammagard INJECTION SOLUTION 2.5 GM/25ML
- Gammagard S/D Less IgA Intravenous SOLUTION RECONSTITUTED 10 GM, 5 GM
- Gammaked INJECTION SOLUTION 1 GM/10ML
- Gammaplex Intravenous SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- Gamunex-C INJECTION SOLUTION 1 GM/10ML
- Ganciclovir Sodium Intravenous SOLUTION RECONSTITUTED 500 MG
- Gengraf ORAL CAPSULE 100 MG, 25 MG, 50 MG
- Gengraf ORAL SOLUTION 100 MG/ML
- Granisetron HCl Intravenous SOLUTION 0.1 MG/ML, 1 MG/ML
- Granisetron HCl Oral TABLET 1 MG
- Hepatamine Intravenous SOLUTION 8 %
- Herceptin Intravenous SOLUTION RECONSTITUTED 440 MG
- HYDROmorphone HCl PF INJECTION SOLUTION 10 MG/ML, 50 MG/5ML
- IDArubicin HCl Intravenous SOLUTION 10 MG/10ML
- Ifosfamide Intravenous SOLUTION RECONSTITUTED 1 GM
- Imovax Rabies Intramuscular INJECTABLE 2.5 UNIT/ML
- Ipratropium Bromide Inhalation SOLUTION 0.02 %
- Ipratropium-Albuterol Inhalation SOLUTION 0.5-2.5 (3) MG/3ML
- Irinotecan HCl Intravenous SOLUTION 100 MG/5ML
- Jevtana Intravenous SOLUTION 60 MG/1.5ML
- Kepivance Intravenous SOLUTION RECONSTITUTED 6.25 MG
- Kyprolis Intravenous SOLUTION RECONSTITUTED 30 MG, 60 MG
- Leucovorin Calcium Injection SOLUTION RECONSTITUTED 100 MG
- Leucovorin Calcium INJECTION SOLUTION RECONSTITUTED 350 MG
- Levoleucovorin Calcium Intravenous SOLUTION 175 MG/17.5ML
- LEVOleucovorin Calcium Intravenous SOLUTION RECONSTITUTED 50 MG
- Melphalan HCl Intravenous SOLUTION RECONSTITUTED 50 MG
- Mesna Intravenous SOLUTION 100 MG/ML
- Methotrexate Oral TABLET 2.5 MG
- Methotrexate Sodium (PF) Injection SOLUTION 1 GM/40ML
- Methotrexate Sodium INJECTION SOLUTION 50 MG/2ML
- Methotrexate Sodium INJECTION SOLUTION RECONSTITUTED 1 GM
- Metoprolol Tartrate Intravenous SOLUTION 1 MG/ML, 5 MG/5ML
- Metoprolol Tartrate Intravenous Solution Cartridge 5 MG/5ML
- MetroNIDAZOLE in NaCl Intravenous SOLUTION 500-0.79 MG/100ML-%
- Mircera Injection Solution Prefilled Syringe 100 MCG/0.3ML, 50 MCG/0.3ML, 75 MCG/0.3ML
- Mitomycin Intravenous SOLUTION RECONSTITUTED 20 MG, 40 MG
- Mitomycin Intravenous SOLUTION RECONSTITUTED 5 MG
- Mustargen INJECTION SOLUTION RECONSTITUTED 10 MG
- Mycophenolate Mofetil HCl Intravenous SOLUTION RECONSTITUTED 500 MG

- Mycophenolate Mofetil Oral CAPSULE 250 MG
- Mycophenolate Mofetil ORAL SUSPENSION RECONSTITUTED 200 MG/ML
- Mycophenolate Mofetil Oral TABLET 500 MG
- Mycophenolate Sodium Oral Tablet Delayed Release 180 MG, 360 MG
- Mycophenolic Acid ORAL TABLET DELAYED RELEASE 180 MG, 360 MG
- Naglazyme Intravenous SOLUTION 1 MG/ML
- Nebupent INHALATION SOLUTION RECONSTITUTED 300 MG
- NephrAmine Intravenous SOLUTION 5.4 %
- Nulojix Intravenous SOLUTION RECONSTITUTED 250 MG
- Nutrilipid Intravenous EMULSION 20 %
- Ondansetron HCl INJECTION SOLUTION 4 MG/2ML, 4 MG/2ML (2ML SYRINGE)
- Ondansetron HCl Oral SOLUTION 4 MG/5ML
- Ondansetron HCl ORAL TABLET 24 MG, 4 MG, 8 MG
- Ondansetron Oral TABLET DISPERSIBLE 4 MG, 8 MG
- Oxaliplatin Intravenous SOLUTION 100 MG/20ML
- PACLitaxel Intravenous CONCENTRATE 300 MG/50ML
- Paricalcitol Intravenous SOLUTION 5 MCG/ML
- Paricalcitol Oral CAPSULE 1 MCG, 2 MCG, 4 MCG
- Plenamine Intravenous SOLUTION 15 %
- Premasol Intravenous SOLUTION 6 %
- Privigen Intravenous SOLUTION 20 GM/200ML
- Procalamine Intravenous SOLUTION 3 %
- Prograf Intravenous SOLUTION 5 MG/ML
- Prolastin-C Intravenous SOLUTION RECONSTITUTED 1000 MG
- Proleukin Intravenous SOLUTION RECONSTITUTED 22000000 UNIT
- Prosol Intravenous SOLUTION 20 %
- Pulmozyme INHALATION SOLUTION 1 MG/ML
- RabAvert Intramuscular SUSPENSION RECONSTITUTED
- Rapamune ORAL SOLUTION 1 MG/ML
- Recombivax HB INJECTION SUSPENSION 10 MCG/ML, 10 MCG/ML (1ML SYRINGE), 40 MCG/ML, 5 MCG/0.5ML
- SandIMMUNE ORAL CAPSULE 100 MG, 25 MG
- SandIMMUNE ORAL SOLUTION 100 MG/ML
- Sirolimus ORAL TABLET 0.5 MG, 1 MG, 2 MG
- Tacrolimus Oral CAPSULE 0.5 MG, 1 MG, 5 MG
- Tazicef INJECTION SOLUTION RECONSTITUTED 2 GM
- Tecentriq Intravenous SOLUTION 1200 MG/20ML
- Tetanus-Diphtheria Toxoids Td Intramuscular SUSPENSION 2-2 LF/0.5ML
- Thiotepa Injection SOLUTION RECONSTITUTED 15 MG
- Thymoglobulin Intravenous SOLUTION RECONSTITUTED 25 MG
- Tobramycin INHALATION NEBULIZATION SOLUTION 300 MG/5ML
- Toposar Intravenous SOLUTION 1 GM/50ML
- Topotecan HCl Intravenous SOLUTION RECONSTITUTED 4 MG
- Torisel Intravenous SOLUTION 25 MG/ML
- Travasol Intravenous SOLUTION 10 %
- Treanda Intravenous SOLUTION RECONSTITUTED 100 MG
- Trelstar Mixject Intramuscular SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG
- Trexall ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG
- Trisenox Intravenous SOLUTION 10 MG/10ML
- Tysabri Intravenous CONCENTRATE 300 MG/15ML

- Vectibix Intravenous SOLUTION 100 MG/5ML
- Ventavis INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML
- VinBLAStine Sulfate Intravenous SOLUTION 1 MG/ML
- Vincasar PFS Intravenous SOLUTION 1 MG/ML
- VinCRIStine Sulfate Intravenous SOLUTION 1 MG/ML
- Vinorelbine Tartrate Intravenous SOLUTION 50 MG/5ML
- Xatmep Oral SOLUTION 2.5 MG/ML
- Zoledronic Acid Intravenous CONCENTRATE 4 MG/5ML
- Zoledronic Acid Intravenous SOLUTION 5 MG/100ML
- Zortress ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG

Details

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

Tribute 2017 Formulary
2017 Prior Authorization Criteria

Alphabetical Listing