

# Tribute 2020 Formulary Prior Authorization Criteria

## ACITRETIN

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### Products Affected

- *acitretin*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Severely impaired liver or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracyclines. Pregnancy. Females of child-bearing potential who intend to become pregnant during therapy or at any time for at least 3 years after discontinuing therapy. Females of child-bearing potential who will not use reliable contraception while undergoing treatment and for at least 3 years following discontinuation. Females of child-bearing potential who drink alcohol during treatment or for two months after cessation of therapy
<b>Required Medical Information</b>	Diagnosis for severe, recalcitrant psoriasis (including plaque, guttate, erythrodermic palmar- plantar and pustular) AND patient must have tried and failed, contraindication or intolerance to one formulary first line agent (e.g., Topical Corticosteroids (betamethasone, fluocinonide, desoximetasone), Topical Calcipotriene/Calcitriol, Topical Calcipotriene, OR Topical Tazarotene)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## ACTIMMUNE

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### Products Affected

- ACTIMMUNE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic granulomatous disease for use in reducing the frequency and severity of serious infections associated with chronic granulomatous disease, or B.) Severe, malignant osteopetrosis (SMO)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## ADEMPAS

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### Products Affected

- ADEMPAS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form, B.) Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline), C.) Pregnancy, or D.) Patients with pulmonary hypertension associated with idiopathic interstitial pneumonia
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Pulmonary arterial hypertension (WHO group I) and diagnosis was confirmed by right heart catheterization, or B.) Chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) and patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable (Female patients must be enrolled in the ADEMPAS REMS program)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## AFINITOR

### Products Affected

- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG
- *everolimus*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	<p>Everolimus (Afinitor): Diagnosis of one of the following A.) Advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with Sutent or Nexavar, B.) Diagnosis of pancreatic neuroendocrine tumors (pNET) that are unresectable, locally advanced, or metastatic, C.) Diagnosis of renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery, D.) Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin, E.) Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection, or F.) Diagnosis of adult patients with progressive, well-differentiated, non-functional, neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin with unresectable, locally advanced, or metastatic disease. Afinitor Disperz: Diagnosis of one of the following A.) Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection, or B.) Diagnosis of partial-onset seizures associated with tuberous sclerosis complex (TSC)</p>
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or neurologist
<b>Coverage Duration</b>	12 months

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<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## ALECENSA

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### Products Affected

- ALECENSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic anaplastic lymphoma kinase positive non-small cell lung cancer
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## ALOSETRON

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### Products Affected

- *alosetron hcl*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Constipation, B.) History of Chronic or severe constipation or sequelae from constipation, C.) History of ischemic colitis, intestinal obstruction, stricture, toxic megacolon, GI perforation, adhesions, diverticulitis, Crohns disease, ulcerative colitis, D.) History of severe hepatic impairment, E.) History of impaired intestinal circulation, thrombophlebitis, or hypercoagulable state, F.) Coadministration with fluvoxamine
<b>Required Medical Information</b>	Diagnosis of irritable bowel syndrome, severe diarrhea-predominant
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## **ALPHA1-PROTEINASE INHIBITOR**

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**Products Affected**

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Not covered for patients with IgA deficiency
<b>Required Medical Information</b>	Diagnosis of alpha-1 proteinase inhibitor (alpha-1 antitrypsin) deficiency in adult patients with emphysema
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## ALUNBRIG

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### Products Affected

- ALUNBRIG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic, ALK positive non-small cell lung cancer and have progressed or are intolerant to Xalkori (crizotinib)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### AMBRISENTAN

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#### Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Pregnancy, or B.) Idiopathic pulmonary fibrosis (IPF), including those with pulmonary hypertension
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) and patient has WHO Group I PAH
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### AMPYRA

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#### Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) History of seizure. B.) Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute)
<b>Required Medical Information</b>	Diagnosis of multiple sclerosis and patient must demonstrate sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting dalfampridine
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## APOKYN

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### Products Affected

- APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with 5-HT(3) receptor antagonists (eg. ondansetron, granisetron, dolasetron, palonosetron, alosetron etc)
<b>Required Medical Information</b>	Diagnosis of Parkinson's disease (PD) and patient is experiencing acute intermittent hypomobility (defined as off episodes characterized by muscle stiffness, slow movements, or difficulty starting movements)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## ARCALYST

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### Products Affected

- ARCALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cryopyrin-associated periodic syndromes (CAPS), including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells Syndrome (MWS)
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## ARIKAYCE

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### Products Affected

- ARIKAYCE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of pulmonary Mycobacterium avium complex (MAC) infection and used as part of a combination antibacterial regimen in treatment refractory patients
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist or pulmonologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Prior Authorization Criteria

### AURYXIA

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#### Products Affected

- AURYXIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Iron overload syndrome (e.g. hemochromatosis)
<b>Required Medical Information</b>	Diagnosis of hyperphosphatemia in patients with chronic kidney disease (CKD) on dialysis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or nephrologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## AUSTEDO

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### Products Affected

- AUSTEDO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Suicidal ideation and/or untreated or inadequately treated depression. B.) Hepatic impairment. C. Taking MAOIs, reserpine, or tetrabenazine
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chorea associated with Huntington's disease (Huntington's chorea), or B.) Tardive dyskinesia
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a psychiatrist or neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## AYVAKIT

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### Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable or metastatic gastrointestinal stromal tumor, with a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

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## Prior Authorization Criteria

### BALVERSA

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#### Products Affected

- BALVERSA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic urothelial carcinoma with susceptible FGFR3 or FGFR2 genetic alterations and patient has progressed during or following at least one line of prior platinum-containing chemotherapy, including 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 an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None
Indications	N/A
Off-Label Uses	N/A

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## BANZEL

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### Products Affected

- BANZEL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Familial Short QT Syndrome
<b>Required Medical Information</b>	Diagnosis of seizures associated with Lennox-Gastaut syndrome
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## BENLYSTA

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### Products Affected

- BENLYSTA SUBCUTANEOUS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of active, autoantibody-positive, system lupus erythematosus (SLE)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a rheumatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### BEXAROTENE

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**Products Affected**

- *bexarotene*
- TARGRETIN EXTERNAL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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### BOSENTAN

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#### Products Affected

- *bosentan*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Receiving concomitant cyclosporine A or glyburide therapy, B.) Aminotransferase elevations are accompanied by signs or symptoms of liver dysfunction or injury or increases in bilirubin at least 2 times the upper limit of normal, or C.) Pregnancy
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND all of the following: A.) Patient has WHO Group I PAH, B.) Patient has New York Heart Association (NYHA) Functional Class II-IV, and C.) Female patients of reproductive potential must use two forms of reliable contraception
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### BOSULIF

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#### Products Affected

- BOSULIF

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Philadelphia chromosome-positive (Ph+) CML with resistance, relapse, or inadequate response to prior therapy with one of the following tyrosine kinase inhibitors (TKI): Gleevec [imatinib], Tasisna [nilotinib], Sprycel [dasatinib] , or B.) newly diagnosed chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia (Ph + CML)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## BRAFTOVI

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### Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of unresectable or metastatic melanoma with documented BRAF V600E or V600K mutation as detected by an FDA-approved test AND used in combination with binimetinib
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## BRUKINSA

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### Products Affected

- BRUKINSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of A.) Mantle Cell Lymphoma (MCL) and patient has tried one prior therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## CABLIVI

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### Products Affected

- CABLIVI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP) and used in combination with plasma exchange and immunosuppression therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or oncologist
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## CABOMETYX

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### Products Affected

- CABOMETYX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patients who have or are at risk for severe hemorrhage and/or patients with a recent history of bleeding or hemoptysis
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Advanced renal cell carcinoma, or B.) Advanced hepatocellular carcinoma (HCC) and patient has been previously treated with sorafenib
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## CALQUENCE

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### Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) MANTLE CELL LYMPHOMA (MCL) and patient has tried one other therapy, B.) Chronic lymphocytic leukemia, or C.) Small lymphocytic lymphoma
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### CAPRELSA

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#### Products Affected

- CAPRELSA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Congenital long QT syndrome
<b>Required Medical Information</b>	Diagnosis of medullary thyroid cancer (MTC), and disease is one of the following A.) unresectable, locally advanced, or B.) metastatic AND one of the following: patient has symptomatic disease or patient has progressive disease.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### CARBAGLU

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#### Products Affected

- CARBAGLU

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of of one of the following A.) N-acetyl glutamate synthase (NAGS) deficiency AND patient has acute hyperammonemia, or B.) N-acetyl glutamate synthase (NAGS) deficiency AND patient has chronic hyperammonemia
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## CAYSTON

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### Products Affected

- CAYSTON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	none
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing AND confirmation of P. aeruginosa in cultures of the airways
<b>Age Restrictions</b>	7 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## CIMZIA

### Products Affected

- CIMZIA PREFILLED
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Active infection, including tuberculosis, B.) Concurrent therapy with other biologics
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Active ankylosing spondylitis (AS) AND patient has trial of/or intolerance/contraindication to Humira and Enbrel , B.) Moderately to severely active Crohn disease AND patient has trial of/or intolerance/contraindication to Humira , C.) Moderate to severe plaque psoriasis AND patient has trial of/or intolerance/contraindication to Humira and Enbrel, D.) Active psoriatic arthritis AND patient has trial of/or intolerance/contraindication to Humira and Enbrel, or E.) Moderately to severely active rheumatoid arthritis (RA) AND patient has trial of/or intolerance/contraindication to Humira and Enbrel, or F.) Non-radiographic axial spondyloarthritis AND patient has had an inadequate response to AT LEAST TWO generic Formulary non-steroidal anti-inflammatory drugs (NSAIDs).
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### CINRYZE

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**Products Affected**

- CINRYZE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Hereditary angioedema (HAE)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist, immunologist, or allergist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### CLOBAZAM

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**Products Affected**

- *clobazam*
- SYMPAZAN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of seizures associated with Lennox-Gastaut syndrome
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### CNS STIMULANTS

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**Products Affected**

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Obstructive sleep apnea (OSA) confirmed by sleep lab evaluation, B.) Narcolepsy confirmed by sleep lab evaluation, or C.) Shift work disorder (SWD)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

## Tribute 2020 Formulary Prior Authorization Criteria

### COMETRIQ

#### Products Affected

- COMETRIQ (100 MG DAILY DOSE)
- COMETRIQ (140 MG DAILY DOSE)
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following a.) Gastrointestinal perforation, B.) Fistula, or C.) Severe hemorrhage
<b>Required Medical Information</b>	Diagnosis of Progressive, metastatic medullary thyroid cancer (MTC)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## COPIKTRA

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### Products Affected

- COPIKTRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of relapsed or refractory (with history of 2 prior therapies) of one of the following A) chronic lymphocytic leukemia, B) small lymphocytic lymphoma, or C) follicular lymphoma
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### CORLANOR

#### Products Affected

- CORLANOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Decompensated acute heart failure, B.) hypotension (i.e. blood pressure less than 90/50 mmHg), C.) sick sinus syndrome or sinoatrial block or 3rd degree AV block (unless a functioning demand pacemaker is present), D.) bradycardia (i.e., resting heart rate less than 60 bpm prior to treatment), or E.) Severe hepatic impairment (Child-Pugh C)
<b>Required Medical Information</b>	Diagnosis of one of the following A.) stable, symptomatic chronic heart failure with left ventricular ejection fraction 35% or less, who are in sinus rhythm with resting heart rate 70 beats per minute or more and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use, or B.) stable, symptomatic heart failure due to dilated cardiomyopathy in patients who are in sinus rhythm with an elevated heart rate
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### COSENTYX

#### Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Failure, contraindication, or intolerance to Enbrel (etanercept) AND Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Cosentyx therapy. All indications (Initial, reauth): Patient is not receiving Cosentyx in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Cosentyx in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]. For a diagnosis of PsA or plaque psoriasis, Patient is not receiving Cosentyx in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS (Initial): Prescribed by or in consultation with a rheumatologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

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<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## COTELLIC

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### Products Affected

- COTELLIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of unresectable or metastatic malignant melanoma with BRAF V600E OR V600K mutation, and documentation of combination therapy with vemurafenib (Zelboraf)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### CYSTARAN

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#### Products Affected

- CYSTARAN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Demonstrated cysteamine hypersensitivity or penicillamine hypersensitivity
<b>Required Medical Information</b>	Diagnosis of cystinosis and patient has corneal cystine crystal accumulation
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### DALIRESP

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#### Products Affected

- DALIRESP

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Moderate to severe liver impairment (Child-Pugh B or C)
<b>Required Medical Information</b>	Diagnosis of severe chronic obstructive pulmonary disease (COPD) (defined as FEV1 less than or equal to 50% of predicted and FEV1/forced vital capacity [FVC] less than 0.7) associated with chronic bronchitis and a history of COPD exacerbations
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### DAPTOMYCIN

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#### Products Affected

- *daptomycin*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Staphylococcus aureus bacteremia, B.) complicated skin and skin structure infections, including infections caused by methicillin-resistant Staphylococcus aureus (MRSA), or C.) endocarditis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### DAURISMO

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#### Products Affected

- DAURISMO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of newly diagnosed acute myeloid leukemia (AML) and used in combination with cytarabine in patients 75 years of age or older OR in patients that have comorbidities that preclude use of intensive induction chemotherapy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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### DEFERASIROX

#### Products Affected

- *deferasirox oral tablet 360 mg, 90 mg*
- *deferasirox oral tablet soluble*
- JADENU ORAL TABLET 180 MG
- JADENU SPRINKLE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Creatinine clearance less than 40 mL/min, B.) Poor performance status, C.) Platelet count less than 50 x 10 <sup>9</sup> /L, D.) Advanced malignancy, E.) High-risk myelodysplastic syndrome (MDS)
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic iron overload in patients with non-transfusion-dependent thalassemia syndromes who have liver iron concentrations of at least 5 mg Fe/g dry weight AND serum ferritin level greater than 300 mcg/L, or B.) Chronic iron overload due to blood transfusions (transfusion hemosiderosis) as evidenced by transfusion of at least 100 mL/kg packed red blood cells AND serum ferritin level greater than 1000 mcg/L
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### DEPEN

#### Products Affected

- DEPEN TITRATABS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Breastfeeding, B.) During Pregnancy (except for treatment of Wilson's disease), C.) Hypersensitivity to penicillamine products, D.) Penicillamine-related aplastic anemia/agranulocytosis, E.) Rheumatoid arthritis patients with history or evidence of renal insufficiency
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Cystinuria, B.) Rheumatoid arthritis, or C.) Wilson's disease
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## DICLOFENAC TOPICAL

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**Products Affected**

- *diclofenac sodium transdermal gel 3 %*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Actinic keratosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary

## Prior Authorization Criteria

### DRONABINOL

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#### Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Anorexia associated to AIDS, or B.) Chemotherapy-induced nausea and vomiting
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	N/A
Off-Label Uses	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### DUPIXENT

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#### Products Affected

- DUPIXENT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Moderate to severe atopic dermatitis and patient has trial and failure, contraindication, or intolerance to two medium to high potency topical corticosteroids (e.g., mometasone, triamcinolone, fluocinolone, betamethasone, etc), or B.) Eosinophilic phenotype or oral corticosteroid- dependent moderate to severe asthma and used as an adjunct treatment, or C.) Chronic rhinosinusitis with nasal polyposis and used as an adjunct treatment
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### EMSAM

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#### Products Affected

- EMSAM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant use with any of the following: SSRIs, SNRIs, clomipramine, imipramine, meperidine, tramadol, methadone, pentazocine, propoxyphene, dextromethorphan, carbamazepine, B.) Pheochromocytoma
<b>Required Medical Information</b>	Diagnosis of major depressive disorder
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## ENBREL

### Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Moderate to severe rheumatoid arthritis, B.) Moderate to severe polyarticular juvenile idiopathic arthritis, C.) Psoriatic arthritis, D.) Ankylosing spondylitis, or E.) Moderate to severe chronic plaque psoriasis in patients who are candidates for systemic therapy or phototherapy. Screening for latent tuberculosis infection is required prior to initiation of treatment.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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### ENDARI

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#### Products Affected

- ENDARI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of acute sickle cell disease AND patient must have trial history of Hydroxyurea. Otherwise Endari requires documentation of (1) history of inadequate treatment with Hydroxyurea OR (2) history of adverse event with Hydroxyurea OR (3) Hydroxyurea is contraindicated.
<b>Age Restrictions</b>	5 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ENTRESTO

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#### Products Affected

- ENTRESTO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) History of angioedema related to previous ACE inhibitor or ARB therapy, B.) Concomitant use or use within 36 hours of ACE inhibitors, or C.) Concomitant use of aliskiren in patients with diabetes
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic heart failure, NYHA Class II to IV, or B.) Symptomatic heart failure with systemic left ventricular systolic dysfunction
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## EPIDIOLEX

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### Products Affected

- EPIDIOLEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Lennox-Gastaut syndrome, or B.) Severe myoclonic epilepsy in infancy (Dravet syndrome)
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ERIVEDGE

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#### Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Metastatic basal cell carcinoma, or B.) Diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## ERLEADA

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### Products Affected

- ERLEADA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Nonmetastatic, castration-resistant prostate cancer, or B.) Metastatic, castration-sensitive prostate cancer
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or urologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ERLOTINIB

#### Products Affected

- *erlotinib hcl*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) locally advanced, unresectable, or metastatic pancreatic cancer and erlotinib (Tarceva) will be used in combination with gemcitabine, or B.) locally advanced or metastatic non-small cell lung cancer with one of the following: 1.) failure with at least one prior chemotherapy regimen, 2.) no evidence of disease progression after four cycles of first-line platinum-based chemotherapy and Tarceva will be used as maintenance treatment, or 3.) Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ESBRIET

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**Products Affected**

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 801 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of idiopathic pulmonary fibrosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ESRD THERAPY

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#### Products Affected

- EPOGEN INJECTION SOLUTION                      UNIT/ML, 3000 UNIT/ML, 4000  
10000 UNIT/ML, 2000 UNIT/ML, 20000      UNIT/ML
- RETACRIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### FARYDAK

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#### Products Affected

- FARYDAK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Multiple Myeloma (MM) Used in combination with both of the following: Velcade (bortezomib) and dexamethasone. Patient has received at least two prior treatment regimens which included both of the following: Velcade (bortezomib) and an immunomodulatory agent [eg, Revlimid (lenalidomide), Thalomid (thalidomide)].
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## FASENRA

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### Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of severe asthma with an eosinophilic phenotype
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### FEBUXOSTAT

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#### Products Affected

- *febuxostat*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use of azathioprine or mercaptopurine
<b>Required Medical Information</b>	Diagnosis of Gout and all of the following 1.) documented inadequate treatment response, adverse event, or contraindication to maximally titrated dose of Allopurinol, and 2.) patients with established cardiovascular disease, prescriber attests that benefit of treatment outweighs the risk of treatment
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### FENTANYL ORAL

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#### Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Management of acute or postoperative pain (including headache/migraine, dental pain, and use in the emergency room), B.) Use in opioid non-tolerant patients
<b>Required Medical Information</b>	Must meet all of the following 1.) Diagnosis of cancer-related breakthrough pain, 2.) Patient is currently receiving/tolerant to around-the-clock opioid therapy for persistent cancer pain, and 3.) Patient and prescriber are enrolled in the TIRF REMS Access Program
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### FENTANYL TD

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#### Products Affected

- *fentanyl*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Management of acute or postoperative pain (including headache/migraine, dental pain, and use in the emergency room), B.) Use in opioid non-tolerant patients
<b>Required Medical Information</b>	Must meet all of the following 1.) Patient is opioid tolerant (taking for one week or longer at least 60mg of morphine or equivalent daily), and 2.) Patient has tried two extended release oral opioids or is unable to take extended release oral opioids secondary to allergy, adverse events, swallowing difficulty, or uncontrollable nausea/vomiting
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### FERRIPROX

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#### Products Affected

- FERRIPROX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Must meet all of the following 1.) Diagnosis of transfusional iron overload due to thalassemia syndromes, 2.) Patient has failed prior chelation therapy, and 3.) Patient has an absolute neutrophil count greater than $1.5 \times 10^9/L$
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## FIRDAPSE

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### Products Affected

- FIRDAPSE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	History of seizures
<b>Required Medical Information</b>	Treatment of Lambert-Eaton myasthenic syndrome
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## FIRMAGON

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### Products Affected

- FIRMAGON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of advanced or metastatic prostate cancer
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### FORTEO

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#### Products Affected

- FORTEO SUBCUTANEOUS SOLUTION 600 MCG/2.4ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following and trial of generic formulary bisphosphonate A.) Osteoporosis in postmenopausal female patient with high risk for fracture, B.) Primary or hypogonadal osteoporosis in male patient with high risk for fracture, or C.) Osteoporosis due to associated sustained systemic glucocorticoid therapy in patient with high risk for fracture
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 12 months, Renewal: 12 months, max treatment 24 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## FYCOMPA

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### Products Affected

- FYCOMPA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Partial-onset seizures with or without secondary generalization, or B.) Primary generalized tonic-clonic seizure disorder
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### GILENYA

#### Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) 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, B.) History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker, C.) Baseline QTC interval greater than or equal to 500 milliseconds, D.) Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (quinidine, procainamide, amiodarone, sotalol)
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### GILOTRIF

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#### Products Affected

- GILOTRIF

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test, or B.) Metastatic squamous NSCLC, progressing after platinum-based chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### GLATIRAMER

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#### Products Affected

- *glatiramer acetate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### GLEOSTINE

#### Products Affected

- GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Secondary therapy of Hodgkin's disease in combination with other agents and who have relapsed during or failed to respond to primary therapy, B.) Intracranial tumor primary and metastatic who have already received surgical or radiotherapeutic procedures, C.) Carcinoma of the breast, D.) Colorectal cancer, E.) Lung cancer, F.) Malignant melanoma, G.) Malignant tumor of the thymus, H.) Multiple myeloma, I.) Non-Hodgkin's lymphoma, or J.) Small cell carcinoma of lung AND monitoring of blood counts for evidence of Bone Marrow Suppression (thrombocytopenia or leukopenia).
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### GOCOVRI

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#### Products Affected

- GOCOVRI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Patients with end-stage renal disease (ESRD, CrCl below 15 ml/min/m <sup>2</sup> )
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Parkinsons disease and patient is experiencing dyskinesia, receiving levodopa based therapy, and has documented trial and failure to amantadine immediate release, or B.) Extrapyrmidal disease and has documented trial and failure to amantadine immediate release
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## GROWTH HORMONE

### Products Affected

- OMNITROPE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) growth promotion in pediatric patients with closed epiphyses, B.) acute critical illness caused by complications following open-heart or abdominal surgery, multiple accidental trauma, or acute respiratory failure, C.) active malignancy, D.) active proliferative or severe nonproliferative diabetic retinopathy
<b>Required Medical Information</b>	Diagnosis of pediatric indication: A.) GHD and bone age at least 1 year or 2 standard deviations (SD) delayed compared with chronological age and 2 stim tests with peak GH secretion below 10 ng/mL or IGF-1/IGFBP3 level more than 2 SD below mean if CNS pathology, h/o irradiation, or proven genetic cause, B.) SGA and birth weight or length 2 or more SD below mean for gestational age and fails to manifest catch up growth by age 2 (height 2 or more SD below mean for age and gender), C.) CRI and nutritional status has been optimized, metabolic abnormalities have been corrected, and patient has not had renal transplant, D.) SHOX deficiency or Noonan syndrome, E.) PWS confirmed by genetic testing, F.) Turner Syndrome confirmed by chromosome analysis. Diagnosis of GHD, CRI, SHOX deficiency, Noonan syndrome, and PWS one of the following: 1.) height more than 3 SD below mean for age and gender, 2.) height more than 2 SD below mean with GV more than 1 SD below mean, or 3.) GV over 1 year 2 SD below mean. Diagnosis of adult indication: A.) childhood or adult-onset GHD confirmed by 2 standard GH stim tests (provide assay): 1 test must be insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L). If contraindicated, use a standardized stim test (i.e. arginine plus GH releasing hormone, glucagon, arginine), B.) GHD with at least 1 other pituitary hormone deficiency and failed at least 1 GH stim test (ITT preferred), C.) GHD with panhypopituitarism (3 or more pituitary hormone deficiencies), D.) GHD with irreversible hypothalamic-pituitary structural lesions due to tumors, surgery or radiation of pituitary or hypothalamus region, a subnormal IGF-1 (after at least 1 month off GH therapy), objective evidence of GHD complications, such as: low bone

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<b>PA Criteria</b>	<b>Criteria Details</b>
	density, increased visceral fat mass, or cardiovascular complications, completed linear growth (GV less than 2 cm/year), and GH has been discontinued for at least 1 month (if previously receiving GH).
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### HEPATITIS B

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#### Products Affected

- *adefovir dipivoxil*
- BARACLUDGE ORAL SOLUTION
- *entecavir*
- VEMLIDY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of chronic hepatitis B and all of the following: 1.) Patient has evidence of viral replication, 2.) Patient has evidence of persistent elevations in serum aminotransferase (ALT or AST) or histologically active disease, and 3.) Patient is receiving anti-retroviral therapy if the patient has HIV co-infection
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### HEPATITIS C

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#### Products Affected

- *sofosbuvir-velpatasvir*
- VOSEVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis 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: CBC, INR, hepatic function panel, and GFR. Must document cirrhosis status, prior treatment history (if any), and planned duration of treatment. All genotypes will require trial/failure, contraindication to, or intolerance to Sofosbuvir-Velpatasvir prior to the approval of Vosevi.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in conjunction with gastroenterologist, hepatologist, or infectious disease specialist
<b>Coverage Duration</b>	Duration of approval per AASLD Guidelines
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### HRM-ANALGESICS

#### Products Affected

- *meperidine hcl injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml*
- *meperidine hcl oral tablet*
  - *pentazocine-naloxone hcl*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary 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 alternative(s) - See OTHER criteria for alternatives.
<b>Age Restrictions</b>	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.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Analgesics: APAP/codeine,hydrocodone/APAP,hydrocodone/IBU,hydromorphone,met hadone,morphine sulfate,oxycodone,oxycodone/APAP,oxycodone/ASA,oxycodone/ibuprofen,oxymorphone IR,tramadol, tramadol/APAP
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### HRM-SKELETAL MUSCLE RELAXANTS

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#### Products Affected

- *chlorzoxazone oral tablet 375 mg, 500 mg, 750 mg*
- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*
- *orphenadrine citrate er*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration.
<b>Age Restrictions</b>	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.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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### HUMIRA

#### Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER
- HUMIRA PEN-PS/UV/ADOL HS START
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Moderate to severe rheumatoid arthritis, B.) Moderate to severe polyarticular juvenile idiopathic arthritis, C.) Psoriatic arthritis, D.) Ankylosing spondylitis, E.) Moderate to severe chronic plaque psoriasis in patients who are candidates for systemic therapy or phototherapy and when other systemic therapies are medically less appropriate, F.) Moderate to severe Crohn's disease in patients who have had an inadequate response to conventional therapy, G.) Moderate to severe ulcerative colitis in patients who have had an inadequate response to immunosuppressants (e.g. corticosteroids, azathioprine), H.) Non-infectious uveitis (including intermediate, posterior, and panuveitis), or I.) Moderate to severe hidradenitis suppurativa. Screening for latent tuberculosis infection is required prior to initiation of treatment.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A

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<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### IBRANCE

#### Products Affected

- IBRANCE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer used in combination with Faslodex (fulvestrant) and disease has progressed following endocrine therapy, or B) Advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer used in combination with an aromatase inhibitor AND One of the following 1) patient is a postmenopausal woman, 2) patient is a man, or 3) both of the following: patient is a premenopausal or perimenopausal woman and patient is receiving a luteinizing hormone-releasing hormone (LHRH) agonist [eg, Zoladex (goserelin)].
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ICLUSIG

**Products Affected**

- ICLUSIG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) 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 B.) 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.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary

## Prior Authorization Criteria

### IDHIFA

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#### Products Affected

- IDHIFA

PA Criteria	Criteria Details
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	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None
Indications	N/A
Off-Label Uses	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### IMATINIB

#### Products Affected

- *imatinib mesylate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B.) Ph+ acute lymphoblastic leukemia (ALL), C.) Gastrointestinal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy, D.) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, E.) hypereosinophilic syndrome or chronic eosinophilic leukemia, F.) myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, or G.) aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### IMBRUVICA

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#### Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Mantle cell lymphoma (MCL) who have received at least one prior therapy, B.) Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL), C.) Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) with 17p deletion, D.) Waldenstrom's macroglobulinemia (WM), E.) Marginal zone lymphoma who require systemic therapy and have received at least one prior anti-CD20-based therapy, or F.) Graft vs host disease after failure of a least one first-line corticosteroid therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### INCRELEX

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#### Products Affected

- INCRELEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) active or suspected malignancy, B.) use for growth promotion in patients with closed epiphyses, C.) Intravenous administration
<b>Required Medical Information</b>	Diagnosis of one of the following A.) growth failure in children with severe primary IGF-1 deficiency, or B.) growth hormone (GH) gene deletion in children who have developed neutralizing antibodies to GH
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## **INHALED TOBRAMYCIN**

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**Products Affected**

- *tobramycin inhalation*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Must meet all of the following 1.) Diagnosis of cystic fibrosis and 2.) Patient has evidence of P. aeruginosa in the lungs
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary

## Prior Authorization Criteria

### INLYTA

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#### Products Affected

- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced renal cell carcinoma and patient failed one or more systemic therapies for renal cell carcinoma (e.g., sunitinib-, bevacizumab-, temsirolimus-, or cytokine-containing regimens)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	N/A
Off-Label Uses	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### INREBIC

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#### Products Affected

- INREBIC

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF).
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## INTRAROSA

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### Products Affected

- INTRAROSA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, B.) Known or suspected estrogen-dependent neoplasia
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Moderate to severe dyspareunia due to menopause, or B.) Atrophic vaginitis due to menopause.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 3 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### INTRON A

#### Products Affected

- INTRON A

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Autoimmune hepatitis, or B.) Decompensated liver disease
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Hairy cell leukemia, B.) Diagnosis of condylomata acuminata involving external surfaces to the genital or perianal areas, C.) Diagnosis of AIDS-related Kaposi's sarcoma, D.) Clinically aggressive follicular lymphoma and the medication will be used concurrently with anthracycline-containing chemotherapy or is not a candidate for anthracycline-containing chemotherapy, E.) Malignant melanoma and the request for coverage is within 56 days of surgery and the patient is at high risk of disease recurrence, F.) Diagnosis of chronic hepatitis B with compensated liver disease and patient has evidence of hepatitis B viral replication and patient has been serum hepatitis B surface antigen-positive for at least 6 months, or G.) Diagnosis of chronic hepatitis C with compensated liver disease and is receiving combination therapy with ribavirin, unless ribavirin is contraindicated, and the medication will not be used as part of triple therapy with a protease inhibitor and patient has a clinical reason for not using peginterferon
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Condylomata: 3 mos, HBV: E antigen pos: 16 wks, E antigen neg: 48 wks, KS: 16 wks, Other: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## IRESSA

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### Products Affected

- IRESSA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic Non-small cell lung cancer (NSCLC) and Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ITRACONAZOLE

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#### Products Affected

- *itraconazole oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF), B.) Concurrent therapy with a CYP3A4 substrate (e.g., methadone, lovastatin, simvastatin, etc.)
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis), B.) Onychomycosis confirmed by one of the following: positive potassium hydroxide (KOH) preparation, fungal culture, or nail biopsy, or C.) Candidiasis (esophageal or oropharyngeal) that is refractory to treatment with fluconazole (ORAL SOLUTION ONLY)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## IVIG

### Products Affected

- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA
- 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
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Acute corn or maltose hypersensitivity, B.) Hereditary fructose intolerance, C.) Hyperprolinemia, D.) IgA deficiency with antibody formation and a history of hypersensitivity, E.) History of anaphylaxis or severe systemic reaction to human immune globulin
<b>Required Medical Information</b>	Supporting statement of diagnosis from the physician
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### JAKAFI

#### Products Affected

- JAKAFI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Intermediate or high-risk myelofibrosis, or B.) Polycythemia vera: Diagnosis of polycythemia vera, AND history of failure, contraindication, or intolerance to hydroxyurea, or C.) Acute Graft Versus Host Disease (GVHD): Diagnosis of Acute GVHD, AND disease is refractory to steroid therapy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### JYNARQUE

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#### Products Affected

- JYNARQUE ORAL TABLET THERAPY  
PACK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) use in patients unable to sense or respond to thirst, B.) anuria, C.) history, signs, or symptoms of significant liver impairment or injury, D.) uncorrected abnormal blood sodium concentrations, E.) uncorrected urinary outflow obstruction
<b>Required Medical Information</b>	Diagnosis of autosomal dominant polycystic kidney disease (ADPKD)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## KALYDECO

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### Products Affected

- KALYDECO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis AND the patient has 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### KISQALI

#### Products Affected

- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)
- KISQALI FEMARA(200 MG DOSE)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	KISQALI: Breast Cancer: Diagnosis of one of the following A.) Metastatic or advanced, HER-2 negative, hormone receptor-positive, postmenopausal women in combination with fulvestrant as initial endocrine based therapy or following disease progression on endocrine therapy, or B.) Metastatic or advanced, HER-2 negative, hormone receptor-positive, premenopausal, perimenopausal or postmenopausal women, in combination with an aromatase inhibitor for initial endocrine-based treatment. KISQALI FEMARA: Diagnosis of HER-2 negative, hormone receptor-positive, advanced or metastatic breast cancer in premenopausal, perimenopausal, or postmenopausal women, as initial endocrine based therapy.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### KORLYM

#### Products Affected

- KORLYM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) pregnancy, B.) coadministration with simvastatin, lovastatin, or CYP3A substrates with narrow therapeutic ranges, C.) concomitant treatment with systemic corticosteroids for serious medical conditions or illnesses, D.) history of unexplained vaginal bleeding, E.) endometrial hyperplasia with atypia or endometrial carcinoma
<b>Required Medical Information</b>	Diagnosis of endogenous Cushing syndrome in patients with type 2 diabetes mellitus or glucose intolerance and one of the following A.) Used to control hyperglycemia secondary to hypercortisolism and patient has failed surgery, or B.) Used to control hyperglycemia secondary to hypercortisolism and patient is not a candidate for surgery
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## KUVAN

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### Products Affected

- KUVAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hyperphenylalaninemia (HPA) caused by tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### LENVIMA

#### Products Affected

- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer, B.) Advanced renal cell carcinoma following one prior anti-angiogenic therapy in combination with everolimus, C.) Unresectable liver carcinoma, or D.) Advanced endometrial carcinoma that is not microsatellite instability-high or mismatch repair deficient, in a patient which has disease progression following prior systemic therapy and is not a candidate for curative surgery or radiation
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### LEUKINE

#### Products Affected

- LEUKINE INJECTION SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with myelosuppressive chemotherapy or radiation or excessive (greater than or equal to 10%) leukemic myeloid blasts in bone marrow or peripheral blood
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Patient has undergone allogeneic or autologous bone marrow transplant (BMT) and engraftment is delayed or failed, B.) Patient is undergoing autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis, C.) Medication will be used for myeloid reconstitution after an autologous or allogeneic BMT, D.) Patient has acute myeloid leukemia and administration will be after completion of induction chemotherapy, or E.) Hematopoietic subsyndrome of acute radiation syndrome (H-ARS)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### LEUPROLIDE

#### Products Affected

- ELIGARD
- *leuprolide acetate injection*
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) advanced or metastatic prostate cancer and patient with have trial of/contraindication to Eligard prior to approval of Lupron, B.) Diagnosis of central precocious puberty and patient had early onset of secondary sexual characteristics (male: earlier than 9 years of age. female: earlier than 8 years of age) and advanced bone age of at least one year compared with chronological age and has undergone gonadotropin-releasing hormone agonist (GnRHa) testing with peak luteinizing hormone (LH) level above pre-pubertal range or random LH level in pubertal range and Patient had the following diagnostic evaluations to rule out tumors, when suspected: diagnostic imaging of the brain (MRI or CT scan), Pelvic/testicular/adrenal ultrasound, Human chorionic gonadotropin levels, Adrenal steroids to rule out congenital adrenal hyperplasia, C.) the medication will be used for stimulation testing to confirm the diagnosis of central precocious puberty, D.) management of endometriosis, or E.) anemia caused by uterina leiomyomata
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A

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<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### LIDOCAINE EXT

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**Products Affected**

- *lidocaine external ointment*
- *lidocaine hcl external solution*
- *lidocaine hcl urethral/mucosal external gel*
- *lidocaine-prilocaine external cream*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Amide hypersensitivity
<b>Required Medical Information</b>	For topical anesthesia of skin and mucous membranes
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## LIDOCAINE PATCH

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**Products Affected**

- *lidocaine external patch 5 %*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) pain associated with diabetic neuropathy, B.) pain associated with cancer-related neuropathy, C.) post-herpetic neuralgia
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### LONSURF

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#### Products Affected

- LONSURF

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) 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, or B.) Metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least 2 prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan and if appropriate, HER2/neu-targeted therapy if appropriate
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### LORBRENA

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#### Products Affected

- LORBRENA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with strong CYP3A4 inducers
<b>Required Medical Information</b>	Diagnosis of metastatic, anaplastic lymphoma kinase (ALK) positive non-small cell lung cancer with disease progression on either alectinib or ceritinib as the first ALK inhibitor for metastatic disease, or disease progression on crizotinib and at least one other ALK inhibitor for metastatic disease
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### LYNPARZA

#### Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) HER2- negative, deleterious or suspected deleterious germline BRCA mutated metastatic breast cancer AND patient has been previously treated with chemotherapy in neoadjuvant, adjuvant, or metastatic setting, B.) Advanced ovarian cancer with known or suspected BRCA mutation as detected by an FDA-approved test AND patient has trial and failure, contraindication, or intolerance to 3 or more prior lines of chemotherapy, C.) Recurrent epithelial ovarian cancer, recurrent fallopian tube cancer, or recurrent primary peritoneal cancer AND used for maintenance treatment in patients who are in complete or partial response to platinum-based chemotherapy (e.g. cisplatin, carboplatin), D.) Deleterious or suspected deleterious germline or somatic BRCA-mutated (gBRCAm or sBRCAm) epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients with complete or partial response to first-line platinum-based chemotherapy, or E.) Deleterious or suspected deleterious germline BRCA-mutated metastatic pancreatic adenocarcinoma and disease has not progressed on at least 16 weeks of a first-line platinum-based chemotherapy regimen
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.

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<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### MATULANE

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#### Products Affected

- MATULANE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Hodgkin's Disease, Stages III and IV in combination with other anticancer drugs, B.)Malignant intracranial tumor including but not limited to medulloblastoma, C.) Multiple myeloma, D.) Non-Hodgkin's lymphona, or E.) Malignant glioma
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### MAYZENT

#### Products Affected

- MAYZENT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) CYP2C9*3/*3 genotype, B.) In the last 6 months experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization, Class III-IV heart failure, or C.) Presence of Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, unless patient has a functioning pacemaker
<b>Required Medical Information</b>	Diagnosis of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, or active secondary progressive disease and the following A.) Patients with relapsing forms of multiple sclerosis have history of/or contraindication to Avonex, Betaseron, Copaxone, or Gilenya
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### MEKINIST

#### Products Affected

- MEKINIST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and used in combination with dabrafenib and no locoregional treatment options, B.) Malignant melanoma with lymph node involvement and following complete resection with BRAF V600E or V600K mutations and used in combination with dabrafenib, C.) Unresectable or metastatic malignant melanoma with BRAF V600E or V600K mutations and used in combination with dabrafenib or as monotherapy , or D.) Metastatic non-small cell lung cancer, with BRAF V600E mutation, in combination with dabrafenib.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### MEKTOVI

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#### Products Affected

- MEKTOVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of unresectable or metastatic malignant melanoma with documented BRAF V600E or V600K mutation as detected by an FDA approved test AND used in combination with encorafenib
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### METHOTREXATE SC

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#### Products Affected

- OTREXUP SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.4ML, 12.5 MG/0.4ML, 15 MG/0.4ML, 17.5 MG/0.4ML, 20 MG/0.4ML, 22.5 MG/0.4ML, 25 MG/0.4ML
- RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	A.) Pregnancy, B.) Breastfeeding, C.) Alcoholism or liver disease, D.) Immunodeficiency syndromes, E.) Preexisting blood dyscrasias
<b>Required Medical Information</b>	Diagnosis of one of the following: A.) Severe rheumatoid arthritis in patients who are intolerant of or had an inadequate response to first-line therapy, B.) Polyarticular juvenile idiopathic arthritis in patients who are intolerant of or had an inadequate response to first-line therapy, C.) Severe, recalcitrant, disabling psoriasis in patients who are not adequately responsive to other forms of therapy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### METHOXSALEN

#### Products Affected

- *methoxsalen rapid*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Aphakia, B.) Melanoma or a history of melanoma, C.) Invasive squamous cell carcinomas, or D.) History of a light sensitive disease/skin photosensitivity disorder such systemic lupus erythematosus (SLE), porphyria cutanea tarda, erythropoietic protoporphyria, variegate porphyria, xeroderma pigmentosum or albinism
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Psoriasis, B.) Cutaneous T-cell lymphoma, or C.) Vitiligo
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, immunologist, or dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## MIGLUSTAT

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### Products Affected

- *miglustat*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of mild to moderate type 1 Gaucher disease and patient is not a candidate for enzyme replacement therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	N/A
Off-Label Uses	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### MS INTERFERONS

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#### Products Affected

- AVONEX PEN INTRAMUSCULAR  
AUTO-INJECTOR KIT
- AVONEX PREFILLED  
INTRAMUSCULAR PREFILLED  
SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., clinically isolated syndrome, relapsing-remitting MS, active secondary progressive disease, or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### MYTESI

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#### Products Affected

- MYTESI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of non-infectious diarrhea associated with HIV/AIDS in patients receiving anti-retroviral therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist or gastroenterologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## NATPARA

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### Products Affected

- NATPARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hypoparathyroidism and used to control hypocalcemia
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## NERLYNX

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### Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of early stage HER2- overexpressed breast cancer and used after trastuzumab therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None
Indications	N/A
Off-Label Uses	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### NEXAVAR

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#### Products Affected

- NEXAVAR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Squamous cell lung cancer being treated with carboplatin and paclitaxel
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Advanced renal cell carcinoma, B.) Diagnosis of locally recurrent or metastatic, progressive, differentiated thyroid carcinoma that is refractory to radioactive iodine treatment, or C.) Diagnosis of unresectable hepatocellular carcinoma
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## NINLARO

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### Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma and documentation of combination therapy with lenalidomide and dexamethasone, used in patients with history of 1 prior therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	N/A
Off-Label Uses	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### NORTHERA

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#### Products Affected

- NORTHERA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of symptomatic neurogenic orthostatic hypotension (nOH) caused by primary autonomic failure (e.g., Parkinson disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### NOXAFIL

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#### Products Affected

- NOXAFIL ORAL SUSPENSION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant treatment with sirolimus, B.) Concomitant use of CYP3A4 substrates that prolong QT interval (pimozide, quinidine), C.) Concomitant use of HMG-CoA Reductase inhibitors primarily metabolized through CYP3A4, or D.) Concomitant use of ergot alkaloids
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Oropharyngeal candidiasis, or B.) Patient is severely immunocompromised and requires prophylaxis of invasive aspergillosis or candidiasis due to high risk of infection
<b>Age Restrictions</b>	13 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## NUBEQA

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### Products Affected

- NUBEQA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of non-metastatic, castration-resistant prostate cancer
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or urologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### NUCALA

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#### Products Affected

- NUCALA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Severe asthma with eosinophilic phenotype, or B.) Eosinophilic granulomatosis with polyangiitis (EGPA)
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist, rheumatologist, or immunologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### NUEDEXTA

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#### Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) History of prolonged QT interval, congenital long QT syndrome or Torsades de pointes, B.) Heart failure, C.) Complete AV block without an implanted pacemaker or high risk of complete AV block, D.) Concomitant use with quinidine, quinine, mefloquine, or drugs that prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozide), E.) Concomitant use with MAOIs or within 14 days of MAOI therapy
<b>Required Medical Information</b>	Diagnosis of pseudobulbar affect
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### OCTREOTIDE

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#### Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) acromegaly and patient has inadequate response to or is ineligible for surgery, radiation, or bromocriptine mesylate, B.) metastatic carcinoid syndrome, C.) vasoactive intestinal peptide-secreting tumors (VIPomas) with associated diarrhea
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ODOMZO

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#### Products Affected

- ODOMZO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of locally advanced basal cell carcinoma of the skin and one of the following A.) Cancer has recurred following surgery or radiation therapy, B.) Patient is not a candidate for surgery or radiation therapy.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### OPSUMIT

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#### Products Affected

- OPSUMIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension WHO group I AND diagnosis was confirmed by right heart catheterization AND female patients are enrolled in the OPSUMIT REMS program
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## ORFADIN

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### Products Affected

- ORFADIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of tyrosinemia type 1
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ORKAMBI

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#### Products Affected

- ORKAMBI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### OSPHENA

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#### Products Affected

- OSPHENA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) undiagnosed abnormal genital bleeding, B.) known or suspected estrogen-dependent neoplasia, C.) active or history of DVT, D.) active or history of pulmonary embolism, E.) active or history of arterial thromboembolic disease F.) pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause, or B.) moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### OXANDROLONE

#### Products Affected

- *oxandrolone oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Breast or prostate cancer in men, B.) Breast cancer in women with hypercalcemia, C.) Pregnancy, D.) Nephrosis or nephrotic phase of nephritis, E.) Hypercalcemia
<b>Required Medical Information</b>	Diagnosis one of the following and receiving treatment as an adjunct therapy to promote weight gain A.) Extensive surgery, B.) Chronic infections, C.) Severe trauma, or D.) Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons, E.) Chronic corticosteroid administration, F.) Bone pain associated with osteoporosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## PANRETIN

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### Products Affected

- PANRETIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Kaposi sarcoma cutaneous lesions in patient with AIDS-related Kaposi sarcoma (KS)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or HIV specialist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### PCSK9 INHIBITOR

#### Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	<p>PRALUENT: Must meet criteria #1, #2 or #3. REPATHA: Must meet criteria #1, #2, #3 or #4. 1.) Diagnosis of primary hyperlipidemia including heterozygous familial hypercholesterolemia (HeFH). 2.) Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in pts with established CVD. 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. 4.) Primary hyperlipidemia 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. <b>REQUIRED DOCUMENTATION FOR INITIAL THERAPY:</b> A.) Baseline and current LDL-C, LDL-C greater than or equal to 70 mg/dL, AND used in combination with maximally tolerated high-intensity statin OR patient is statin intolerant and LDL-C greater than or equal to 70 mg/dL. <b>FOR CONTINUING THERAPY:</b> Will continue to be used in combination with maximally tolerated statin (unless statin intolerant).</p>
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist
<b>Coverage Duration</b>	Initial: 8 weeks, Renewal: 12 months

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<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### PEGYLATED INTERFERON

#### Products Affected

- PEGASYS PROCLICK  
SUBCUTANEOUS SOLUTION 180  
MCG/0.5ML
- PEGASYS SUBCUTANEOUS  
SOLUTION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon, B.) Uncontrolled depression
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic hepatitis B infection, or B.) Chronic hepatitis C and required criteria will be applied consistent with current AASLD-IDS A guidance with compensated liver disease
<b>Age Restrictions</b>	Hepatitis B: 3 years of age and older. Hepatitis C: 5 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist
<b>Coverage Duration</b>	HBV: 12 months, HCV: based on current AASLD guidelines
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### PENICILLAMINE

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#### Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Breastfeeding, B.) During Pregnancy (except for treatment of Wilson's disease), C.) Hypersensitivity to penicillamine products, D.) Penicillamine-related aplastic anemia/agranulocytosis, E.) Rheumatoid arthritis patients with history or evidence of renal insufficiency
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Cystinuria, B.) Rheumatoid arthritis, or C.) Wilson's disease
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### PIQRAY

#### Products Affected

- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hormone receptor (HR) positive, HER2-negative, PIK3CA-mutated, advanced or metastatic breast cancer and used in combination with fulvestrant for postmenopausal women, and men following progression on or after endocrine- based regimen.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### POMALYST

#### Products Affected

- POMALYST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Must meet all of the following 1.) Disease has progressed on or within 60 days of completion of the last therapy, 2.) If female of reproductive potential ALL of the below: Two negative pregnancy tests obtained prior to initiating therapy with Pomalyst, monthly negative pregnancy tests during therapy, 3.) Patient has been counseled about the use of 2 forms of reliable contraception before, during, and 1 month after discontinuing therapy with Pomalyst, 4.) Patient assessment to determine if prophylactic aspirin or antithrombic treatment (warfarin, clopidogrel) will need to be taken to reduce the risk of VTE (embolism, stroke), and 5.) Registered and certified to be compliant with Pomalyst REMS program
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### POSACONAZOLE

#### Products Affected

- *posaconazole*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant treatment with sirolimus, B.) Concomitant use of CYP3A4 substrates that prolong QT interval (pimozide, quinidine), C.) Concomitant use of HMG-CoA Reductase inhibitors primarily metabolized through CYP3A4, or D.) Concomitant use of ergot alkaloids
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Oropharyngeal candidiasis, or B.) Patient is severely immunocompromised and requires prophylaxis of invasive aspergillosis or candidiasis due to high risk of infection
<b>Age Restrictions</b>	13 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### PROMACTA

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#### Products Affected

- PROMACTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic idiopathic thrombocytopenic purpura (ITP), B.) Chronic hepatitis C infection associated thrombocytopenia, or C.) Severe aplastic anemia with insufficient response to immunosuppressive therapy or in combination with standard immunosuppressive therapy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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**PULMONARY FIBROSIS**

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**Products Affected**

- OFEV

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Idiopathic pulmonary fibrosis (IPF), or B.) Systemic sclerosis-associated interstitial lung disease (ILD)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## QUININE SULFATE

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**Products Affected**

- *quinine sulfate oral*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Prolongation of QT interval. Glucose-6-phosphate dehydrogenase deficiency. Myasthenia gravis. Known hypersensitivity to mefloquine or quinidine. Optic neuritis. Diagnosis of Blackwater fever
<b>Required Medical Information</b>	Diagnosis of one of the following A.) uncomplicated Plasmodium falciparum malaria, B.) uncomplicated Plasmodium vivax malaria, or C.) babesiosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## RAVICTI

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### Products Affected

- RAVICTI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of urea cycle disorders
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## REGRANEX

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### Products Affected

- REGRANEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Known neoplasm at the site of application
<b>Required Medical Information</b>	Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply
<b>Age Restrictions</b>	16 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### REVLIMID

#### Products Affected

- REVLIMID

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Multiple myeloma and medication will be used in combination with dexamethasone, B.) Autologous hematopoietic stem-cell transplantation (HSCT) in multiple myeloma patients, C.) Transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndrome (MDS) associated with a deletion 5q cytogenetic abnormality or without additional cytogenetic abnormalities, D.) Mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib, E.) Follicular lymphoma and used in combination with rituximab, or F.) Marginal zone lymphoma and used in combination with rituximab
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## RILUTEK

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### Products Affected

- *riluzole*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of amyotrophic lateral sclerosis (ALS)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## RINVOQ

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### Products Affected

- RINVOQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of moderate to severe rheumatoid arthritis and patient has had an inadequate response or intolerance to methotrexate
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ROZLYTREK

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#### Products Affected

- ROZLYTREK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following: A) ROS1-positive metastatic non-small cell lung cancer (NSCLC), OR B) Solid tumors that 1) have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, AND 2) are metastatic or where surgical resection is likely to result in severe morbidity, AND 3) have either progressed following treatment or have no satisfactory alternative therapy
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### RUBRACA

#### Products Affected

- RUBRACA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of 1. deleterious BRCA mutation (germline and/or somatic)-associated ovarian, fallopian tube, or primary peritoneal cancer and all of the following criteria (A-E): A.) BRCA mutation positive as detected by an approved FDA laboratory test, B.) Previous trial/failure with two or more chemotherapy regimens, C.) Used as monotherapy, D.) Agreement of provider to perform a complete blood count (CBC) at baseline and monthly thereafter, E.) Women of reproductive potential must use an effective method of contraception during therapy and for 6 months after the last dose. Diagnosis of 2. Diagnosis of recurrent ovarian, fallopian tube, or primary peritoneal cancer and all of the following (A-D): A.) Complete or partial response to platinum-based chemotherapy B.) Used as monotherapy C.) Agreement of provider to perform a complete blood count (CBC) at baseline and monthly thereafter, D.) 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.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A

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<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### RUCONEST

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#### Products Affected

- RUCONEST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Known allergy to rabbits or rabbit-derived products (leporine protein hypersensitivity)
<b>Required Medical Information</b>	Diagnosis of Hereditary angioedema (HAE)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist, immunologist, or allergist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## RYDAPT

### Products Affected

- RYDAPT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) 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 B.) systemic mastocytosis or mast cell leukemia
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### SAMSCA

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#### Products Affected

- SAMSCA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) use in patients unable to sense or respond to thirst, B.) anuria, C.) hypovolemic hyponatremia, D.) urgent need to raise serum sodium acutely
<b>Required Medical Information</b>	Diagnosis of clinically significant hypervolemic and euvoletic hyponatremia (serum sodium less than 125 mEq/L or less marks hyponatremia that is symptomatic and has resisted correction with fluid restriction), including in patients with heart failure and syndrome of inappropriate antidiuretic hormone (SIADH)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## SIGNIFOR

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### Products Affected

- SIGNIFOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Cushing disease and patient has inadequate response to or is not a candidate for surgery
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### SILDENAFIL

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#### Products Affected

- sildenafil citrate oral tablet 20 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Nitrate therapy
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) and Patient has WHO Group I PAH
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## SKYRIZI

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### Products Affected

- SKYRIZI (150 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of moderate to severe plaque psoriasis
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist
Coverage Duration	12 months
Other Criteria	None
Indications	N/A
Off-Label Uses	N/A

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## Prior Authorization Criteria

### SOLTAMOX

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#### Products Affected

- SOLTAMOX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant coumarin-type anticoagulant therapy, B.) history of thromboembolic disease such as DVT or PE
<b>Required Medical Information</b>	Diagnosis of breast cancer and documentation of inability to swallow tablet formulation
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### SOMATULINE

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#### Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) acromegaly in patient with inadequate response to or is ineligible for surgery or radiotherapy, B.) carcinoid syndrome, or C.) gastroenteropancreatic neuroendocrine tumors (GEP-NETs)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## SOMAVERT

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### Products Affected

- SOMAVERT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of acromegaly and patient has inadequate response to or is ineligible for surgery or radiation therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### SPRYCEL

#### Products Affected

- SPRYCEL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) that is newly diagnosed in the chronic phase, B.) Ph+ CML in chronic, accelerated, or lymphoid blast phase with resistance or intolerance to prior therapy, C.) Diagnosis of Ph+ acute lymphoblastic leukemia with resistance or intolerance to prior therapy, or D.) Newly diagnosed Ph+ acute lymphoblastic leukemia in combination with chemotherapy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### STELARA

#### Products Affected

- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) moderate to severely active Crohn disease and patient has trial and failure or intolerance or contraindication to Humira, B.) moderate to severe plaque psoriasis and patient has trial and failure or intolerance or contraindication to Humira and Enbrel, C.) active psoriatic arthritis and patient has trial and failure or intolerance or contraindication to Humira and Enbrel, or D.) moderate to severe active ulcerative colitis and patient has trial and failure or intolerance or contraindication to Humira
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a rheumatologist or gastroenterologist or dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### STIVARGA

#### Products Affected

- STIVARGA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) metastatic colorectal cancer in patients previously treated with ALL of the following per the indication: 1. (fluoropyrimidine-, oxaliplatin-, and irinotecan)-based chemotherapy 2. anti-VEGF bevacizumab 3. anti-EGFR panitumumab OR cetuximab (for KRAS mutation-negative patients only), B.) liver carcinoma in patients previously treated with sorafenib, or C.) locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib and sunitinib
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### SUTENT

#### Products Affected

- SUTENT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) gastrointestinal stromal tumor after disease progression on or intolerance to imatinib, B.) pancreatic neuroendocrine tumors in a patient with unresectable locally advanced or metastatic disease, C.) advanced renal cell carcinoma, or D.) renal cell carcinoma and used as adjuvant therapy following nephrectomy in patients who are at high risk for recurrence
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### SYLATRON

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#### Products Affected

- SYLATRON SUBCUTANEOUS KIT  
200 MCG, 300 MCG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Autoimmune hepatitis or B.) Hepatic decompensation (Child-Pugh score greater than 6 [Class B or C])
<b>Required Medical Information</b>	Diagnosis of melanoma with microscopic or gross nodal involvement and prescribed medication will be used as adjuvant therapy within 84 days of definitive surgical resection, including complete lymphadenectomy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### **SYMDEKO**

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#### **Products Affected**

- SYMDEKO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis and One of the following A.) Patient is homozygous for the F508del mutation, or B.) Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by an FDA-cleared CF mutation test
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### SYMLIN

#### Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) confirmed diagnosis of gastroparesis, B.) hypoglycemia unawareness
<b>Required Medical Information</b>	Diagnosis of one of the following A.) type 1 diabetes mellitus and patient uses mealtime insulin therapy and has failed to achieve desired glucose control, or B.) type 2 diabetes mellitus and patient uses mealtime insulin therapy and has failed to achieve desired glucose control
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### SYNAREL

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#### Products Affected

- SYNAREL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) pregnancy, B.) breastfeeding, C.) undiagnosed abnormal vaginal bleeding
<b>Required Medical Information</b>	Diagnosis of one of the following A.) central precocious puberty, or B.) endometriosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## SYNRIBO

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### Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic or accelerated phase chronic myeloid leukemia (CML) and patient has tried and failed or has a contraindication or intolerance to 2 tyrosine kinase inhibitors
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	N/A
Off-Label Uses	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## SYPRINE

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### Products Affected

- *trientine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of Wilson's disease in patients that are intolerant to penicillamine
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	N/A
Off-Label Uses	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TAFINLAR

#### Products Affected

- TAFINLAR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	A.) Diagnosis of locally advanced or metastatic anaplastic thyroid carcinoma with BRAF V600E mutation, in combination with trametinib and no satisfactory locoregional treatment options OR B.) Diagnosis of metastatic non-small cell lung cancer with BRAF V600E mutation, in combination with trametinib OR in patients previously treated as monotherapy OR C.) Diagnosis of unresectable or metastatic malignant melanoma with BRAF V600E or V600K mutation AND 1) used as monotherapy OR 2) in combination with trametinib OR 3) used as adjuvant therapy following complete resection in patients with lymph node involvement AND used in combination with trametinib.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TAGRISSO

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#### Products Affected

- TAGRISSO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) metastatic, non-small cell lung cancer (NSCLC) with EGFR exon 19 deletion or exon 21 L858R mutation and used as first line therapy, or B.) Metastatic, non-small cell lung cancer with confirmed presence of T790M EGFR mutation AND whose disease has progressed on or after EGFR tyrosine kinase inhibitor based therapy (Diagnosis should be confirmed by an FDA-approved test)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TALZENNA

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#### Products Affected

- TALZENNA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of deleterious or suspected deleterious germline BRCA-mutated (gBRCAm), HER2-negative locally advanced or metastatic breast cancer
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## TASIGNA

### Products Affected

- TASIGNA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Long QT syndrome, B.) Uncorrected hypokalemia, C.) Uncorrected hypomagnesemia, or D.) Concomitant use with a drug known to prolong the QT interval or strong cytochrome P450 3A4 inhibitors
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Newly diagnosed Philadelphia chromosome-positive chronic myelogenous leukemia (CML) in chronic phase, B.) Chronic-phase and accelerated-phase Philadelphia chromosome-positive CML in patients resistant or intolerant to prior therapy that include imatinib, or C.) Chronic phase Philadelphia chromosome-positive CML in patients with resistance or intolerance to prior tyrosine-kinase inhibitor therapy
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TAVALISSE

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#### Products Affected

- TAVALISSE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of thrombocytopenia in patient with chronic idiopathic thrombocytopenic purpura (ITP) and an insufficient response to one previous treatment
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TAZORAC

#### Products Affected

- *tazarotene external*
- TAZORAC EXTERNAL GEL
- TAZORAC EXTERNAL CREAM 0.05 %

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) acne vulgaris and patient has trial with at least one generic topical acne product, or B.) stable moderate to severe plaque psoriasis with 20% or less body surface area involvement and patient has trial with at least one other topical psoriasis product (e.g., medium to high potency corticosteroid and/or vitamin D analogs)
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TECFIDERA

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#### Products Affected

- TECFIDERA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Relapsing forms of multiple sclerosis (e.g., relapsing-remitting MS or progressive-relapsing MS), or B.) Patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TEFLARO

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#### Products Affected

- TEFLARO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Known serious hypersensitivity to cephalosporin class
<b>Required Medical Information</b>	Diagnosis of one of the following A.) acute bacterial skin and skin structure infection and patient has documented culture and sensitivity to teflaro, or B.) community acquired pneumonia and patient has documented culture and sensitivity to teflaro
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	2 weeks
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TEGSEDI

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#### Products Affected

- TEGSEDI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Platelet count less than 100,000 per microliter, B.) urinary protein to creatinine ratio (UPCR) of 1000 mg/g or higher
<b>Required Medical Information</b>	Diagnosis of Polyneuropathy of hereditary transthyretin-mediated amyloidosis
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TESTOSTERONE

#### Products Affected

- *methyltestosterone oral*
- *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)*
- *testosterone enanthate intramuscular solution*
- *testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Carcinoma of the breast (males only) or prostate, B.) Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Hypogonadotropic hypogonadism, B.) Inoperable metastatic breast cancer in women who are postmenopausal, C.) Primary hypogonadism. Diagnosis of hypogonadism must be confirmed by a low-for-age serum testosterone (total or free) level defined by the normal laboratory reference value, or D.) Delayed puberty (testosterone enanthate)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TETRABENAZINE

#### Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Actively suicidal, B.) Untreated or inadequately treated depression, C.) Impaired hepatic function, D.) Concomitant use of monoamine oxidase inhibitors, E.) Concomitant use of reserpine or within 20 days of discontinuing reserpine
<b>Required Medical Information</b>	Diagnosis of chorea associated with Huntington's disease
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### THALOMID

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#### Products Affected

- THALOMID

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Multiple myeloma that is newly diagnosed, or B.) Erythema nodosum leprosum (ENL)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or infectious disease specialist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TIBSOVO

#### Products Affected

- TIBSOVO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Acute myeloid leukemia in relapsed or refractory patients, with susceptible isocitrate dehydrogenase-1 mutation, or B.) Acute myeloid leukemia in newly-diagnosed patients, with susceptible isocitrate dehydrogenase-1 mutation AND one of the following 1.) patient is 75 years or older , or 2.) patient has comorbidities that preclude intensive induction chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## TIGLUTIK

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### Products Affected

- TIGLUTIK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of amyotrophic lateral sclerosis (ALS)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TOPICAL RETINOIDS

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**Products Affected**

- *adapalene external cream*
- *adapalene external gel*
- AVITA
- *tretinoin external cream*
- *tretinoin external gel 0.01 %, 0.025 %*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of mild to moderate acne vulgaris
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TOREMIFENE

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#### Products Affected

- *toremifene citrate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic breast cancer and patient must have previous inadequate response or intolerance to tamoxifen
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TRACLEER

#### Products Affected

- TRACLEER ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Receiving concomitant cyclosporine A or glyburide therapy, B.) Aminotransferase elevations are accompanied by signs or symptoms of liver dysfunction or injury or increases in bilirubin at least 2 times the upper limit of normal, or C.) Pregnancy
<b>Required Medical Information</b>	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND all of the following: A.) Patient has WHO Group I PAH, B.) Patient has New York Heart Association (NYHA) Functional Class II-IV, and C.) Female patients of reproductive potential must use two forms of reliable contraception
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 6 months, Renewal: 12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## TRELSTAR

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### Products Affected

- TRELSTAR MIXJECT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of advanced prostate cancer and used in palliative treatment
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TRIKAFTA

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#### Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis and patient has at least 1 F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene verified by an FDA-cleared CF mutation test
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or prescribing practitioner is from a CF center accredited by the Cystic Fibrosis Foundation
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## TURALIO

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### Products Affected

- TURALIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TYKERB

#### Products Affected

- TYKERB

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of breast cancer with tumors that overexpress human epidermal growth factor receptor 2 (HER2) and One of the following A.) used in combination with capecitabine in a patient who has received prior therapy including an anthracycline, a taxane and trastuzumab, or B.) used in combination with letrozole in postmenopausal women for whom hormonal therapy is indicated
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### TYMLOS

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#### Products Affected

- TYMLOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of postmenopausal osteoporosis and one of the following A.) osteoporotic fracture or multiple risk factors for fracture, or B.) previous trial of/or contraindication to bisphosphonate
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 12 months, Renewal: 12 months, max treatment 24 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### UPTRAVI

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#### Products Affected

- UPTRAVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### VALCHLOR

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#### Products Affected

- VALCHLOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cutaneous T-cell lymphoma (stage IA and IB mycosis fungoides-type) and patient has received prior skin-directed therapy (e.g. Topical corticosteroids, phototherapy, or topical nitrogen mustard)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### VARIZIG

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#### Products Affected

- VARIZIG INTRAMUSCULAR SOLUTION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	History of hypersensitivity (including anaphylaxis or severe systemic reaction) to immune globulin or any component of the preparation
<b>Required Medical Information</b>	Diagnosis of post-exposure varicella (chickenpox) infection prophylaxis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### VENCLEXTA

#### Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use with strong CYP3A inhibitor during the initial and titration phase in patients with CLL or SLL
<b>Required Medical Information</b>	Diagnosis of one of the following A.) chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL), or B.) Newly-diagnosed acute myeloid leukemia (AML) and used in combination with azacitidine, decitabine or low-dose cytarabine in patients 75 years or older or who have comorbidities that preclude use of intensive induction chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### VERZENIO

#### Products Affected

- VERZENIO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of advanced or metastatic, HER2-negative, hormone receptor-positive breast cancer AND One of the following: A.) For postmenopausal women must be used in combination with fulvestrant for the treatment of disease progression following endocrine therapy and patient has trial and failure or contraindication to Ibrance or Kisqali, B). For premenopausal or perimenopausal women must be used in combination with fulvestrant for the treatment of disease progression following endocrine therapy and patient has trial and failure or contraindication to Ibrance, C.) used as monotherapy for treatment of disease progression following endocrine therapy and patient has already received at least one prior chemotherapy regimen of Ibrance or Kisqali, D.) For postmenopausal women used as initial endocrine- based treatment in combination with an aromatase inhibitor and patient has trial and failure or contraindication to Kisqali or Ibrance, or E.) For premenopausal or perimenopausal women used as initial endocrine- based treatment in combination with an aromatase inhibitor and patient has trial and failure or contraindication to Kisqali
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A

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<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### VIGABATRIN

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**Products Affected**

- *vigabatrin*
- VIGADRONE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Infantile spasms, or B.) Refractory complex partial seizures and the drug is being used as adjunctive therapy in patients who have responded inadequately to several alternative treatments
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### VITRAKVI

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#### Products Affected

- VITRAKVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic or surgically unresectable neurotrophic receptor tyrosine kinase (NTRK) gene fusion-positive solid tumors and used in patients with unsatisfactory alternative treatments or who have progressed following treatment
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### VIZIMPRO

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#### Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	First line treatment of metastatic non-small cell lung cancer with confirmed epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### VOTRIENT

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#### Products Affected

- VOTRIENT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) advanced renal cell carcinoma, or B.) advanced soft tissue sarcoma and patient received at least one prior chemotherapy (e.g., doxorubicin, dacarbazine, ifosfamide, epirubicin, docetaxel, or vinorelbine)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## VYNDAMAX

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### Products Affected

- VYNDAMAX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of wild type or hereditary transthyretin related familial amyloid cardiomyopathy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## XALKORI

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### Products Affected

- XALKORI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive or ROS1-positive as detected by an FDA-approved test
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### XELJANZ

**Products Affected**

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following: A.) Moderate to severe rheumatoid arthritis (RA), B.) Active psoriatic arthritis, or C.) Moderate to severe ulcerative colitis (UC).
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

## Tribute 2020 Formulary Prior Authorization Criteria

### XGEVA

#### Products Affected

- XGEVA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Hypocalcemia (calcium less than 8.0 mg/dL)
<b>Required Medical Information</b>	Diagnosis of one of the following A.) bone metastases from a solid tumor, B.) giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity, C.) hypercalcemia of malignancy refractory to bisphosphonate therapy, or D.) multiple myeloma used for the prevention of skeletal related events
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### XOLAIR

#### Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic idiopathic urticaria in patients who remain symptomatic despite H1 antihistamine therapy, or B.) Moderate to severe persistent asthma in patients with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms are inadequately controlled with inhaled corticosteroids
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## XOSPATA

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### Products Affected

- XOSPATA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of relapsed or refractory acute myeloid leukemia, with presence of FLT3 mutation as detected by an FDA-approved test
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### XPOVIO

#### Products Affected

- XPOVIO (100 MG ONCE WEEKLY)
- XPOVIO (60 MG ONCE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY)
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of relapsed or refractory multiple myeloma being used in combination with dexamethasone in patient who has received at least 4 prior therapies and is refractory to at least 2 proteasome inhibitors, at least 2 immunomodulatory agents, and an anti-CD38 monoclonal antibody.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### XTANDI

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**Products Affected**

- XTANDI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) castration-resistant prostate cancer (CRPC), or B) metastatic castration-sensitive prostate cancer
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or urologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### XYREM

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#### Products Affected

- XYREM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Concomitant treatment with sedative hypnotic agents, B.) Succinic semialdehyde dehydrogenase deficiency
<b>Required Medical Information</b>	Diagnosis of cataplexy and excessive daytime sleepiness in patients with narcolepsy
<b>Age Restrictions</b>	7 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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### YONSA

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#### Products Affected

- YONSA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Any of the following A.) Pregnancy, or B.) Patients with severe baseline hepatic impairment (Child-Pugh Class C)
<b>Required Medical Information</b>	Diagnosis of metastatic castration-resistant prostate cancer and All of the following 1.) used in combination with methylprednisolone, and 2.) documented history of trial with, inadequate treatment response, adverse event, or contraindication to Zytiga (Abiraterone)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## ZARXIO

### Products Affected

- ZARXIO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	<p>Diagnosis of one of the following: A) congenital, cyclic, or idiopathic neutropenia, B) severe febrile neutropenia (FN) with the following: Has not received prophylactic pegfilgrastim and Used as adjunct to appropriate antibiotics in high-risk patients and any one of the following: 65 years or older, Uncontrolled primary disease, Pneumonia, Hypotension and multiorgan dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalization when developed fever, Prior FN, Severe (ANC less than 100/mcL) or anticipated prolonged (more than 10 days) neutropenia, C) Autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis, D) Undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT, E) Acute myeloid leukemia and will be given after completion of induction or consolidation chemotherapy, F) Acute lymphoblastic leukemia and will be given after completion of the first few days of chemotherapy of the initial induction or first post-remission course, G) Myelodysplastic syndrome with severe neutropenia and recurrent infection, H) Receiving radiation therapy, not on chemotherapy, and expected to have prolonged delays in treatment due to neutropenia, I) Neutropenia associated with HIV infection and antiretroviral therapy, J) Aplastic anemia, K) Primary prophylaxis of FN in one of the following patients: 20% or higher risk of FN based on chemotherapy regimen OR Less than 20% risk of FN based on chemotherapy regimen with one of the following: 65 years or older, Poor performance status, Poor nutritional status, Previous FN, Extensive prior treatment including large radiation ports, Cytopenias due to bone marrow involvement by tumor, Administration of combined chemoradiotherapy, Presence of open wounds or active infections, Other serious comorbidities (including renal or liver dysfunction) or Receiving</p>

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<b>PA Criteria</b>	<b>Criteria Details</b>
	dose-dense chemotherapy regimen in breast or small cell lung cancer or non-Hodgkins lymphoma.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ZEJULA

#### Products Affected

- ZEJULA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) recurrent epithelial ovarian cancer, recurrent fallopian tube cancer, or recurrent primary peritoneal cancer and used for maintenance therapy in patients who are in a complete or partial response to platinum-based chemotherapy (e.g., cisplatin, carboplatin), or B.) advanced ovarian, fallopian tube, or primary peritoneal cancer and patient has been treated with 3 or more prior chemotherapy regimens, and cancer is associated with homologous recombination deficiency positive status defined by either a deleterious or suspected deleterious BRCA mutation, or genomic instability, and disease has progressed more than 6 months after response to the last platinum-based chemotherapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or gynecologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ZELBORAF

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#### Products Affected

- ZELBORAF

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Unresectable or metastatic melanoma and patient has positive BRAF-V600E mutation documented by an FDA-approved test, or B.) Erdheim-Chester disease and patient has documented BRAF V600 mutation
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## ZOLINZA

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### Products Affected

- ZOLINZA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of primary cutaneous T-cell lymphoma (CTCL) in patients who have progressive, persistent or recurrent disease on or following two systemic therapies (e.g., bexarotene, romidepsin, etc)
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ZYDELIG

#### Products Affected

- ZYDELIG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of one of the following A.) Chronic lymphocytic leukemia and all of the following: Used in combination with rituximab, patient has relapsed on at least one prior therapy (e.g., purine analogues [fludarabine, pentostatin, cladribine], alkylating agents [chlorambucil, cyclophosphamide], or monoclonal antibodies [rituximab]), and patient does not have any co-morbidities that prevents the use of cytotoxic chemotherapy (i.e. severe neutropenia or thrombocytopenia, creatinine clearance less than 60 mL/minute), B.) Non-Hodgkins lymphoma (Follicular, B-Cell) and the patient has relapsed on at least two prior systemic therapies (e.g., rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine]), or C.) Small lymphocytic lymphoma and the patient has relapsed on at least two prior systemic therapies(e.g., rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine])
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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# Tribute 2020 Formulary Prior Authorization Criteria

## ZYKADIA

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### Products Affected

- ZYKADIA ORAL TABLET

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC)
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None
<b>Indications</b>	N/A
<b>Off-Label Uses</b>	N/A

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## Tribute 2020 Formulary Prior Authorization Criteria

### ZYTIGA

#### Products Affected

- *abiraterone acetate*
- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following A.) Castration-resistant metastatic prostate cancer and used in combination with prednisone, or B.) High risk, castration-sensitive metastatic prostate cancer and used in combination with prednisone
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None
Indications	N/A
Off-Label Uses	N/A

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# Tribute 2020 Formulary

## Prior Authorization Criteria

### PART B VERSUS PART D

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#### Products Affected

- ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml, 2.5 mg/0.5ml*
- AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG
- AMINOSYN II INTRAVENOUS SOLUTION 10 %
- AMINOSYN-PF INTRAVENOUS SOLUTION 10 %, 7 %
- *amphotericin b intravenous solution reconstituted 50 mg*
- *aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg*
- AZASAN ORAL TABLET 100 MG, 75 MG
- *azathioprine oral tablet 50 mg*
- *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml*
- *calcitonin (salmon) nasal solution 200 unit/act*
- *calcitriol oral capsule 0.25 mcg, 0.5 mcg*
- *calcitriol oral solution 1 mcg/ml*
- *cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg*
- CLINIMIX E/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION 2.75 %
- CLINIMIX E/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %
- CLINIMIX E/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (4.25/10) 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 %
- CLINISOL SF INTRAVENOUS SOLUTION 15 %
- *cromolyn sodium inhalation nebulization solution 20 mg/2ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml*
- ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML
- ENVARUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG
- ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG

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## Tribute 2020 Formulary Prior Authorization Criteria

- FREAMINE HBC INTRAVENOUS SOLUTION 6.9 %
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- GENGRAF ORAL SOLUTION 100 MG/ML
- *granisetron hcl oral tablet 1 mg*
- HEPATAMINE INTRAVENOUS SOLUTION 8 %
- IMOVAX RABIES INTRAMUSCULAR INJECTABLE 2.5 UNIT/ML
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- IONOSOL-MB IN D5W INTRAVENOUS SOLUTION
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
- ISOLYTE-P IN D5W INTRAVENOUS SOLUTION
- ISOLYTE-S INTRAVENOUS SOLUTION
- *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml*
- *methotrexate oral tablet 2.5 mg*
- *methotrexate sodium (pf) injection solution 50 mg/2ml*
- *methotrexate sodium injection solution 50 mg/2ml*
- *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*
- NEPHRAMINE INTRAVENOUS SOLUTION 5.4 %
- NORMOSOL-M IN D5W INTRAVENOUS SOLUTION
- NORMOSOL-R IN D5W INTRAVENOUS SOLUTION
- NORMOSOL-R PH 7.4 INTRAVENOUS SOLUTION
- *nutrilipid intravenous emulsion 20 %*
- *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*
- *paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg*
- *penicillin g sodium injection solution reconstituted 5000000 unit*
- *pentamidine isethionate inhalation solution reconstituted 300 mg*
- *piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm*
- PLASMA-LYTE 148 INTRAVENOUS SOLUTION
- PLASMA-LYTE A INTRAVENOUS SOLUTION
- PLENAMINE INTRAVENOUS SOLUTION 15 %
- *potassium chloride intravenous solution 10 meq/100ml, 2 meq/ml, 2 meq/ml (20 ml), 20 meq/100ml, 40 meq/100ml*
- PREMASOL INTRAVENOUS SOLUTION 10 %
- PROCALAMINE INTRAVENOUS SOLUTION 3 %
- PROGRAF ORAL PACKET 0.2 MG, 1 MG
- PROSOL INTRAVENOUS SOLUTION 20 %

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- PULMOZYME INHALATION SOLUTION 1 MG/ML
- RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED
- RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 10 MCG/ML (1ML SYRINGE), 40 MCG/ML, 5 MCG/0.5ML
- SANDIMMUNE ORAL SOLUTION 100 MG/ML
- *sirolimus oral solution 1 mg/ml*
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- *sodium chloride intravenous solution 3 %, 5 %*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML
- TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU
- TPN ELECTROLYTES INTRAVENOUS SOLUTION
- TRAVASOL INTRAVENOUS SOLUTION 10 %
- TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG
- TROPHAMINE INTRAVENOUS SOLUTION 10 %
- XATMEP ORAL SOLUTION 2.5 MG/ML
- ZERBAXA INTRAVENOUS SOLUTION RECONSTITUTED 1.5 (1-0.5) GM
- ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG, 1 MG
- ZOSYN INTRAVENOUS SOLUTION 2-0.25 GM/50ML, 3-0.375 GM/50ML

### 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.

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levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml.....	346	mycophenolate mofetil oral capsule 250 mg .....	347
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