

PA Criteria

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| Prior Authorization Group | ACNE |
| Drug Names | TRETINOIN |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Cosmetic use |
| Required Medical Information | |
| Age Restrictions | 12 years of age and older |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | |

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| Prior Authorization Group | ACTEMRA |
| Drug Names | ACTEMRA |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D plus patients already started on tocilizumab. Systemic-onset juvenile idiopathic arthritis (JIA). |
| Exclusion Criteria | Tocilizumab should not be given in combination with tumor necrosis factor (TNF) antagonists (adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), abatacept, anakinra, or rituximab. Other uses excluded from coverage include JIA types other than systemic onset, Crohn's disease, and Castleman's disease. |
| Required Medical Information | |
| Age Restrictions | For indication of systemic-onset JIA, may approve for children and adolescents 18 years of age or younger. For rheumatoid arthritis (RA), approve for adults. |
| Prescriber Restrictions | Adults with RA, tocilizumab is to be prescribed by a rheumatologist or in consultation with a rheumatologist. Systemic-onset JIA, tocilizumab is to be prescribed by a rheumatologist. |
| Coverage Duration | Authorization will be for 12 months. |
| Other Criteria | COVERAGE POLICY: Adults with RA, approve for patients who have tried one of the following TNF antagonists for at least 2 months, adalimumab, certolizumab pegol, etanercept, golimumab, or infliximab. Systemic-onset JIA, approve for patients who have tried a systemic corticosteroid, and either MTX or sulfasalazine or another DMARD such as etanercept. |

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| Prior Authorization Group | ADAGEN |
| Drug Names | ADAGEN |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Adagen is NOT covered for members with the following criteria: A. Patient has diagnosis of severe thrombocytopenia B. Patient with bone marrow transplantation |

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| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation showing patient has failed bone marrow transplantation or is not a suitable candidate for bone marrow transplantation. |
| Age Restrictions | |
| Prescriber Restrictions | Endocrinologist |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Adagen is covered for members who meet the following criteria: A. Documented diagnosis of Adenosine Deaminase (ADA) deficiency B. AND patient has failed bone marrow transplantation or is not a suitable candidate for bone marrow transplantation C. AND is being used for direct replacement for deficient enzyme (no benefit achieved in patients with immunodeficiency due to other causes) |
| Prior Authorization Group | ADCIRCA |
| Drug Names | ADCIRCA |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Adcirca is NOT covered for members with the following criteria: A. Using any form of organic nitrate, regularly and/or intermittently B.Unstable angina C.Heart failure in last 6 months D.Uncontrolled arrhythmias E.Hypotension (less than 90/50 mm Hg), or uncontrolled hypertension (more than 170/100 mm Hg) F.Stroke within the last 6 months G. Clinically significant aortic and mitral valve disease, pericardial constriction, restrictive or congestive cardiomyopathy, significant left ventricular dysfunction, life-threatening arrhythmias, or symptomatic coronary artery diseasefered a myocardial infarction (MI), stroke the last 90 days. H.Hereditary degenerative retinal disorders like retinitis pigmentosa. I.Receiving combination therapy with Flolan, Ventavis, Remodulin, Tracleer, Viagra,Cialis, or Letairis. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation verifying: 1. Blood pressue.2 .The dose does not exceed 40 mg daily. |
| Age Restrictions | Patient is age 18 years or older. |
| Prescriber Restrictions | Pulmonologist and Cardiologist |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Adcirca is covered for members who meet the following criteria: A. Diagnosis for the treatment of pulmonary arterial hypertension to improve exercise ability. |
| Prior Authorization Group | ALDURAZYME |
| Drug Names | ALDURAZYME |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Aldurazyme is NOT covered for members with the following criteria: A. The patient has laronidase hypersensistivity. |

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation showing patient has at least two of the listed moderate-to-severe symptoms. a. Impaired vision b. Recurrent otitis media c. Recurrent sinopulmonary infections d. Impaired hearing e. Upper airway obstruction f. Malaise and reduced endurance g. Corneal clouding h. Macrocephaly i. Reduced joint range of motion j. Progressively coarse facial features k. Umbilical and inguinal hernias l. Carpal tunnel syndrome m. Delayed or regressed mental development n. Hepatosplenomegaly o. Cardiac abnormalities and valvular disease p. Communicating hydrocephalus q. Spinal cord compression r. Sleep apnea s. Short stature t. Reduced pulmonary function u. Bone deformities B. Documentation showing diagnosis has been confirmed by diagnostic method (measurement of alpha-iduronidase activity) or antenatal diagnosis (enzymatic assay). C. Documentation showing patient has previously received at least 26 weeks of Aldurazyme therapy, they must show an improvement in lung function (forced vital capacity [FVC] from when therapy was started.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Endocrinologist

1 Year

COVERAGE POLICY Aldurazyme is covered for members who meet the following criteria: A. Diagnosis is documented as Hurler syndrome (MPS 1H) or Hurler-Scheie syndrome (MPS IS). B. OR the diagnosis is documented as Scheie syndrome (MPS IS). " AND the patient has at least two of the listed moderate-to-severe symptoms. Impaired vision Recurrent otitis media Recurrent sinopulmonary infections Impaired hearing Upper airway obstruction Malaise and reduced endurance Corneal clouding Macrocephaly Reduced joint range of motion Progressively coarse facial features Coarse facial features Umbilical and inguinal hernias Carpal tunnel syndrome Delayed or regressed mental development Hepatosplenomegaly Cardiac abnormalities and valvular disease Communicating hydrocephalus Spinal cord compression Sleep apnea Short stature Reduced pulmonary function Bone deformities C. AND diagnosis has been confirmed by diagnostic method (measurement of alpha-iduronidase activity) or antenatal diagnosis (enzymatic assay). D. AND if the patient has previously received at least 26 weeks of Aldurazyme therapy, they must show an improvement in lung function (forced vital capacity [FVC] from when therapy was started

Prior Authorization Group

Drug Names

Covered Uses

AMPYRA

AMPYRA

All FDA-approved indications not otherwise excluded from Part D. Plus patient already started on dalfampridine extended-release for Multiple Sclerosis (MS).

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

Age Restrictions

The patient is 18 years of age or older

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| Prescriber Restrictions | MS. If prescribed by, or in consultation with, an MS specialist. |
| Coverage Duration | Initial approval for MS, 90 days. Subsequent authorization for 12 mos if patient had a response. |
| Other Criteria | For initial approval for MS, authorize for 90 days. After up to 90 days of dalfampridine extended-release therapy, if MS patient has had a response to therapy as determined by prescribing physician (eg, increased walking distance, improved leg/limb strength, improvement in activities of daily living), then an additional authorization is allowed. |
| Prior Authorization Group | ANAGRELIDE |
| Drug Names | ANAGRELIDE HYDROCHLORIDE |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Anagrelide is NOT covered for members with the following criteria: A. Severe hepatic impairment. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. If the diagnosis is Chronic Myelogenous Leukemia a. Documentation showing persistent granulocyte count greater than or equal to 50,000/mcL without infection b. Documentation showing absolute basophil count greater than or equal to 100/mcL c. Documentation of granulocytic line in the bone marrow d. Documentation showing presence of Philadelphia chromosome e. Leukocyte alkaline phosphatase less than or equal to lower limit of the lab range B. If the diagnosis is Polycythemia Vera f. Documentation showing increased red cell mass g. Documentation showing normal arterial oxygen saturation h. Documentation showing splenomegaly i. Documentation showing platelet count greater than or equal to 400,000/mcL without iron deficiency or bleeding j. Documentation showing leukocytosis greater than or equal to 12,000/mcL without infection k. Documentation showing elevated leukocyte alkaline phosphatase l. Documentation showing elevated serum B12 C. If the diagnosis is thrombocytosis m. Documentation showing platelet count greater than or equal to 900,000/mcL n. Documentation showing profound megakaryocytic hyperplasia in bone marrow o. Documentation showing normal red cell mass p. Documentation showing normal serum iron and ferritin and normal marrow iron stores D. Documentation showing a pre-treatment cardiovascular examination. |
| Age Restrictions | |
| Prescriber Restrictions | Oncologist or Hematologist |
| Coverage Duration | 6 months |
| Other Criteria | COVERAGE POLICY Anagrelide is covered for members who meet the following criteria: A. Being used for Thrombocytosis, Secondary to myeloproliferative disorders. |
| Prior Authorization Group | ANDROGEL |
| Drug Names | ANDROGEL |

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| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON-COVERAGE Androgel is NOT covered if indicated or reference to sexual dysfunction diagnosis or to enhance athletic ability. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Current lab results measuring Testosterone levels (less than 250ng/dL) if new start. |
| Age Restrictions | 13 years or older |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Androgel is covered for members who meet the following criteria:A. Sexual dysfunction or ED is NOT the primary diagnosis. |
| Prior Authorization Group | ARALAST |
| Drug Names | ARALAST NP |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Aralast is NOT covered for members with the following criteria: A. Selective IgA deficiencies (IgA level less than 15 mg/dL) who have known antibody against IgA, because they may experience severe reactions, including anaphylaxis, to IgA that may be present. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Office visit notes to verify FDA approved diagnosis and verify yearly physician appointments B.Lab report measuring elevations in serum and lung fluid levels of alpha-1 antitrypsin. |
| Age Restrictions | 18 years or older |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Aralast is covered for members who meet the following criteria: A.Congenital alpha1-PI deficiency has been established. |
| Prior Authorization Group | ARCALYST |
| Drug Names | ARCALYST |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Active or chronic infection. Concurrent therapy with other biologics such as live vaccines or tumor necrosis factor (TNF) inhibitors. |
| Required Medical Information | |
| Age Restrictions | 12 years and older |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | |
| Prior Authorization Group | AVONEX |

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| Drug Names | AVONEX |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D worded as patients with a diagnosis of multiple sclerosis (MS) or have experienced an attack and who are at risk of MS. |
| Exclusion Criteria | Concurrent use of Rebif, Betaseron, Extavia, Copaxone or Tysabri. Coverage not recommended for anything not listed under Covered Uses |
| Required Medical Information | |
| Age Restrictions | |
| Prescriber Restrictions | Prescribed by or after consultation with a neurologist or an MS specialist. |
| Coverage Duration | Authorization will be for 12 months, unless otherwise specified. |
| Other Criteria | |
| Prior Authorization Group | B VS. D |

Drug Names

A-METHAPRED, ABILIFY, ACETYLCYSTEINE, ACTIMMUNE, ACYCLOVIR SODIUM, ALBUTEROL SULFATE, ALIMTA, AMINOSYN, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 4.25/DEXTROSE, AMINOSYN II 8.5%/ELECTROL, AMINOSYN II M 3.5%/DEXTRO, AMINOSYN-HBC, AMINOSYN-HF, AMINOSYN-PF, AMINOSYN-PF 7%, AMIODARONE HCL, AMPHOTERICIN B, ARZERRA, ATGAM, AVASTIN, AZATHIOPRINE, AZATHIOPRINE SODIUM, BICNU, BLEOMYCIN SULFATE, BOTOX, BUDESONIDE, BUSULFEX, CALCITRIOL, CAMPATH, CAPASTAT SULFATE, CARBOPLATIN, CEFAZOLIN SODIUM, CEFEPIME, CELLCEPT, CELLCEPT INTRAVENOUS, CISPLATIN, CLADRIBINE, COLISTIMETHATE SODIUM, CROMOLYN SODIUM, CUBICIN, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE, DACOGEN, DAUNORUBICIN HCL, DEXTROSE 10%, DEXTROSE 10%/NACL 0.2%, DEXTROSE 2.5%/SODIUM CHLO, DEXTROSE 5%, DEXTROSE 5%/NACL 0.2%, DEXTROSE 5%/NACL 0.225%, DEXTROSE 5%/NACL 0.33%, DEXTROSE 5%/NACL 0.45%, DEXTROSE 5%/NACL 0.9%, DIHYDROERGOTAMINE MESYLAT, DOCETAXEL, DOXORUBICIN HCL, ELITEK, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FLUDARABINE PHOSPHATE, FOSPHENYTOIN SODIUM, FUROSEMIDE, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE HCL, GRANISETRON HCL, HALAVEN, HECTOROL, HEPARIN SODIUM, HEPARIN SODIUM/NACL 0.45%, HEPARIN SODIUM/SODIUM CHL, HERCEPTIN, HYDRALAZINE HCL, HYDROMORPHONE HCL, IFOSFAMIDE, INTRALIPID, INTRON-A, INTRON-A W/DILUENT, INVANZ, INVEGA SUSTENNA, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTODAX, IXEMPRA KIT, JEVTANA, KCL 0.3%/D5W/LR IV LAC RI, KEPIVANCE, LACTATED RINGERS, LANOXIN, LEUCOVORIN CALCIUM, LEUPROLIDE ACETATE, LEVALBUTEROL, LEVETIRACETAM, LIDOCAINE HCL, LINCOCIN, LUPRON DEPOT, LUPRON DEPOT-PED, MELPHALAN HYDROCHLORIDE, MESNA, METHADONE HCL, METHOTREXATE SODIUM, METHYLPREDNISOLONE SODIUM, METOCLOPRAMIDE HCL, MIACALCIN, MITOXANTRONE HCL, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, MYFORTIC, NALOXONE HCL, NEBUPENT, NORMOSOL-R, ONTAK, ORTHOCLONE OKT3, OXALIPLATIN, PIPERACILLIN SODIUM/TAZOB, PROLEUKIN, PROMETHAZINE HCL, PROTONIX, RANITIDINE HCL, RAPAMUNE, SIMULECT, SODIUM BICARBONATE, SODIUM CHLORIDE, SODIUM CHLORIDE 0.45% VIA, STREPTOMYCIN SULFATE, TACROLIMUS, TAXOTERE, TOBI, TOPOTECAN HCL, TORISEL, TPN ELECTROLYTES, TRAVASOL, TREANDA, TRIMETHOBENZAMIDE HCL, TRISENOX, TYGACIL, VANCOMYCIN HCL, VELCADE, VENTAVIS, VIDAZA, VIMPAT, ZEMPLAR, ZOMETA, ZORTRESS

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| Covered Uses | 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. |
| Exclusion Criteria | |
| Required Medical Information | |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | |
| Other Criteria | |
| Prior Authorization Group | BUPHENYL |
| Drug Names | BUPHENYL |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Buphenyl is NOT covered for members with the following criteria: A. To treat acute hyperammonemia. |
| Required Medical Information | |
| Age Restrictions | |
| Prescriber Restrictions | Endocrinologist |
| Coverage Duration | 1 Year |
| Other Criteria | "COVERAGE POLICY Buphenyl is covered for members who meet the following criteria: A. Diagnosis of Cycle disorders: As an adjunctive therapy in the chronic management of urea cycle disorders involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamoylase (OTC), or argininosuccinic acid synthetase (AAS). It is indicated in all patients with neonatal-onset deficiency (complete enzymatic deficiency, presenting within the first 28 days of life). It is also indicated in patients with late-onset disease (partial enzymatic deficiency, presenting after the first month of life) who have a history of hyperammonemic encephalopathy. |
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| Prior Authorization Group | BYETTA |
| Drug Names | BYETTA |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |

Required Medical Information The following copies of chart notes/laboratory reports are required: A. The patient is diagnosed as having type-2 diabetes with an HbA1c level greater than 7. B. The patient has a creatinine clearance of greater than 30mL/minute or normal kidney function. C. The patient has had an inadequate treatment response, intolerance or contraindication to metformin and a sulfonylurea medication. D. If the patient has received previous Byetta therapy, the patient demonstrated a reduction in HbA1c since initiating Byetta therapy.

Age Restrictions

Prescriber Restrictions

Coverage Duration

1 Year

Other Criteria

Prior Authorization Group

CAMPRAL

Drug Names

CAMPRAL

Covered Uses

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

Exclusion Criteria

NON COVERAGE Campral delayed-release tablets are NOT covered for members with the following criteria: A. If the patient has renal failure.

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation showing patient will receive psychosocial treatment concurrently.

Age Restrictions

Prescriber Restrictions

Coverage Duration

6 months

Other Criteria

COVERAGE POLICY Campral delayed-release tablets are covered for members who meet the following criteria: A. Clinical diagnosis for alcohol dependence "

Prior Authorization Group

CANCIDAS

Drug Names

CANCIDAS

Covered Uses

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

Exclusion Criteria

NON COVERAGE Cancidas is NOT covered for members with the following criteria: A. Initial therapy for invasive aspergillosis UNLESS refractory to or intolerant of other therapies such as amphotericin B, lipid formulations of amphotericin B, and/or itraconazole. B. If patient has endocarditis, osteomyelitis, or meningitis caused by Candida.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

6 months

Other Criteria

Prior Authorization Group

CAYSTON

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| Drug Names | CAYSTON |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Cayston is NOT covered for members with the following criteria: A. Hypersensitivity to aztreonam or any other component in the formulation. B. Must have a FEV1 less than 25% or greater than 75% predicted. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documented FDA approved indication (Cystic Fibrosis) B. Documentation of FEV1 C. Confirm patient does not have Burkholderia cepacia. |
| Age Restrictions | 7 years or older |
| Prescriber Restrictions | |
| Coverage Duration | 28 days |
| Other Criteria | COVERAGE POLICY Cayston is covered for members who meet the following criteria:A.Cayston is approved for the diagnosis of Cystic Fibrosis B. Perform B vs. D determination to ensure Part D.C.Must try fail conventional treatment (e.g.TOBI). |
| Prior Authorization Group | CEREDASE |
| Drug Names | CEREDASE |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation showing the patient cannot tolerate Imiglucerase therapy (Cerezyme) |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Ceredase is covered for members who meet the following criteria: A. Patient has documented diagnosis of Gauchers disease B. AND can not tolerate Imiglucerase therapy (Cerezyme) C. AND B vs. D criteria is determined that this medication should be paid for by Medicare Part D |
| Prior Authorization Group | CEREZYME |
| Drug Names | CEREZYME |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Cerezyme is NOT covered for members with the following criteria: A. If the patient is taking Miglustat (Zavesca) oral capsule |

Required Medical Information The following copies of chart notes/laboratory reports are required: A. Documentation showing diagnosis as mild-to-moderate type-1 Gaucher disease. B. Documentation that diagnosis has been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%. C. Documentation showing the patient has at least one of the following conditions: Anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly. D. Documentation if the patient has previously received 24 months of Cerezyme therapy, they must show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration since starting therapy.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Endocrinologist

1 Year

COVERAGE POLICY Cerezyme is covered for members who meet the following criteria: A. Diagnosis is documented as long-term enzyme replacement therapy with a confirmed diagnosis of Type 1 Gaucher disease that results in 1 or more of the following conditions: anemia, bone disease, hepatomegaly or splenomegaly, and thrombocytopenia. B. If the patient has previously received 24 months of Cerezyme therapy, they must show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration since starting therapy.

Prior Authorization Group

Drug Names

Covered Uses

CHANTIX

CHANTIX

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

Exclusion Criteria

NON COVERAGE Chantix is NOT covered for members who meet the following criteria: A. Concurrent use with bupropion or other nicotine replacement products

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation of the stop smoking date. Varenicline dosing should start 1 week before targeted quit date. B. Documentation verifying the patient is enrolled in a smoking cessation program.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

18 years or older

Treatment course is 12 weeks with an additional 12 weeks if needed.

COVERAGE POLICY Chantix is covered for members who meet the following criteria: A. The patient is diagnosed with nicotine addiction or withdrawal following cessation of smoking B. AND the patient is enrolled in a smoking cessation program.

Prior Authorization Group

Drug Names

Covered Uses

CIMZIA

CIMZIA

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

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| Exclusion Criteria | NON COVERAGE Cimzia is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: Tuberculosis, recurring infections, invasive fungal infections B. If the patient is taking/receiving any of the following: Abatacept, Adalimumab, Anakinra, Etanercept, Infliximab, Riloncept, Live Vaccines. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. If the diagnosis is Crohns' Disease: a. Documentation showing the diagnosis is Crohns Disease b. Documentation showing previous trial/failure of At least one (1) oral corticosteroid B. If the diagnosis is rheumatoid arthritis: 1. Documentation the patient has at least four (4) of the following symptoms: i. Morning stiffness. ii. Arthritis of three (3) or more joint areas. iii. Arthritis of hand joints. iv. Symmetric arthritis. v. Rheumatoid nodules. vi. Serum rheumatoid factor. vii. Radiographic changes. 2. Documentation the patient has had at least an 8-week maximum tolerated dose trial and failure to at least one (1) of the following DMARDS listed: methotrexate, cyclosporine, azathioprine, sulfasalazine, leflunomide, aurothioglucose, auranofin, hydroxychloroquine. C. Documentation that the patient will NOT receive combination therapy with other biologic and/or retinoid therapy. (Eg. Enbrel, Humira, Remicade, Kineret, Orencia, Soriatane Tysabri, Raptiva and Rituxan. D. For retreatment,documentation if the patient has received previous Cimzia therapy, the patient must see an improvement. |
| Age Restrictions | 18 years or older |
| Prescriber Restrictions | Gastroenterologist, Rheumatologist |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Cimzia is covered for members who meet the following criteria: A.Verification of B vs D criteria per CMS guidelines B. AND if the diagnosis is documented as Crohns disease: a. The patient has tried, failed and/or had an inadequate response to the following: i.At least one (1) oral corticosteroid ii.Humira C. OR if the diagnosis is documented as rheumatoid arthritis: a. The patient has tried, failed and/or had an inadequate response to at least one (1) of the following: i. Methotrexate ii. Cyclosporine iii. Azathioprine iv. Sulfasalazine v. Leflunomide vi. hydroxychloroquine b. AND the patient has tried, failed and/ore had an inadequate response to at lease one (1) of the following: i. Enbrel ii. Humira D. OR if the patient has received previous Cimzia therapy, the patient must see an improvement in clinical symptoms. |
| Prior Authorization Group | CLARAVIS |
| Drug Names | CLARAVIS |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |

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| Exclusion Criteria | NON COVERAGE Claravis is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: breast-feeding, papilledema, paraben hypersensitivity, pregnancy or retinoid hypersensitivity B. If the patient is taking/receiving Retinoids, Vitamin A. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation showing failure of any oral antibiotic(ex: erythromycin, doxycycline, tetracycline) B. Documentation showing failure of any topical acne preparations (ex: benzoyl peroxide, topical tretinoin cream, topical antibiotics) C. Documentation in female patients a negative pregnancy test or mother is not breast feeding. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Claravis is covered for members who meet the following criteria: A. For the treatment of Acne Vulgaris and Cystic Acne B. Failure of any oral antibiotic (ex: erythromycin, doxycycline, tetracycline) C. AND failure of any topical acne preparation (ex: benzoyl peroxide, topical tretinoin cream, topical antibiotics). |
| Prior Authorization Group | COPAXONE |
| Drug Names | COPAXONE |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D worded as patients with a diagnosis of multiple sclerosis (MS) or have experienced an attack and who are at risk of MS. |
| Exclusion Criteria | Concurrent use of Rebif, Betaseron, Extavia, Avonex, or Tysabri. Coverage not recommended for anything not listed under Covered Uses. |
| Required Medical Information | |
| Age Restrictions | |
| Prescriber Restrictions | Prescribed by or after consultation with a neurologist or an MS specialist. |
| Coverage Duration | Authorization will be for 12 months, unless otherwise specified. |
| Other Criteria | |
| Prior Authorization Group | CYKLOKAPRON |
| Drug Names | CYKLOKAPRON |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Cyklokapron is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: Subarachnoid hemorrhage, acquired defective color vision, active intravascular clotting processes or Thromboembolic disease B. If the patient is taking/receiving any of the following: Anti-inhibitor coagulant complex, Chlorpromazine, clotting factors: disseminated intravascular coagulation, Estrogens, Thrombolytic agents or Tretinoin. |
| Required Medical Information | |
| Age Restrictions | |

Prescriber Restrictions

Coverage Duration

Other Criteria

1 month

COVERAGE POLICY Cyklokapron is covered for members who meet the following criteria: A. Patient is diagnosed with an FDA approved indication. B. AND the patient meets B vs. D determination that requires Medicare Part D payment

Prior Authorization Group

Drug Names

Covered Uses

DALIRESP

DALIRESP

All FDA approved indications not otherwise excluded from Part D. Daliresp is indicated as a treatment to reduce the risk of COPD exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations.

Exclusion Criteria

Required Medical Information

A. Moderate to severe liver impairment (Child-Pugh B or C)

"A. Confirmation of diagnosis of COPD where exacerbations not controlled by a long acting beta agonist and/or muscarinic agents

B. History of exacerbations not otherwise controlled C. Current history of consistent use of long-acting beta agonist and muscarinic agents

D. Documentation that patient does not have Moderate to Severe Liver Impairment (Child-Plugh B or C)"

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

18 years or older

Pulmonologist or other qualified provider

One Year

Prior Authorization Group

Drug Names

Covered Uses

DRONABINOL

DRONABINOL

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

Exclusion Criteria

NON COVERAGE Dronabinol is NOT covered for members w/ the following criteria:

A.If the member has any of the following contraindications: breast-feeding or sesame oil hypersensitivity. B. If the patient is taking/receiving any of the following: Nabilone.

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation showing a trial of 2 or more formulary drugs prior to approval (Zofran,Kytril, promethazine, ect.)

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

6 months

COVERAGE POLICY for Dronabinol - 1. Confirm approved diagnosis, and 2. Confirm whether Part B or Part D (If Dronabinol is used as a full replacement of IV antiemetic administration and the tx is or will be w/in 48 hours of CA tx, Medicare Part B will pay for the tx.) 3. Trial of ONE of the following formulary drugs prior to approval: ondansetron, granisetron, promethazine.

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| Prior Authorization Group | ELAPRASE |
| Drug Names | ELAPRASE |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | |
| Age Restrictions | |
| Prescriber Restrictions | Endocrinologist |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Elaprasedipyrone is covered for members who meet the following criteria: A. Approve only for patients diagnosed with mucopolysaccharidosis II (Hunter Syndrome) |
| Prior Authorization Group | ELIDEL |
| Drug Names | ELIDEL |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation of previous trial/failure to at least two high potency topical steroids B. Documentation of patient not being immunocompromised |
| Age Restrictions | 2 years or older |
| Prescriber Restrictions | Dermatologist |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Elidel is covered for members who meet the following criteria: A. The documented diagnosis is a FDA approved indication.B. Documented trial and failure of at least two (2) first-line agents including high potency topical steroids (Amcinonide, Bethamethasone, Clobetasol, Desoximetasone, Diflorasone, Fluocinonide, Halcinonide, Halobetasol, Triamcinolone) or have documented intolerance or unresponsiveness to high potency topical steroids. C. The patient is not immunocompromised |
| Prior Authorization Group | EMEND |
| Drug Names | EMEND |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Emend is NOT covered for members with the following criteria: A. If the patient is taking/receiving any of the following: Astemizole, Cisapride, Pimozide or Terfenadine. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. If patient is diagnosed with cancer: a. Documentation of what chemotherapy agent the patient is receiving |

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| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 6 months |
| Other Criteria | <p>COVERAGE POLICY Emend is covered for members who meet the following criteria:</p> <p>A. Is prescribed for 1. Chemotherapy-induced nausea and vomiting, Due to highly to moderately emetogenic chemotherapy 2. Postoperative nausea and vomiting B. Determine Part B or Part D drug status.</p> |
| Prior Authorization Group | ENBREL |
| Drug Names | ENBREL |
| Covered Uses | <p>All FDA-approved indications not otherwise excluded from Part D plus patient already on etanercept. Active juvenile spondyloarthritis. Undifferentiated spondyloarthritis (undifferentiated arthritis). Reactive arthritis (Reiter's disease). Still's disease. Uveitis (noninfectious). Scleritis or sterile corneal ulceration. Chronic inflammatory demyelinating polyneuropathy. Myasthenia gravis. Acute or chronic graft versus host disease. Behcet's disease. Giant cell arteritis. Hidradenitis suppurativa. Polymyalgia rheumatica. Pyoderma gangrenosum. Autoimmune mucocutaneous blistering diseases (pemphigus vulgaris, mucous membrane pemphigoid [cicatricial pemphigoid]). Systemic sclerosis (scleroderma) with inflammatory joint involvement. Tumor necrosis factor receptor-associated periodic syndrome (TRAPS).</p> |
| Exclusion Criteria | <p>Concurrent use with anakinra, abatacept, certolizumab pegol, ustekinumab, infliximab, rituximab, or golimumab. Intra-articular injection of etanercept. Use in the management of alopecia areata, alopecia totalis, alopecia universalis, asthma, Crohn's disease, dermatomyositis/polymyositis, inclusion body myositis, Graves ophthalmopathy, hepatitis C, alcoholic hepatitis, idiopathic pulmonary fibrosis, immune-mediated cochleovestibular disorders, immune thrombocytopenic purpura, myelodysplastic syndrome, prevention of peri-prosthetic osteolysis, primary sclerosing cholangitis, recurrent spontaneous pregnancy loss, ocular sarcoidosis, pulmonary sarcoidosis, sciatica, Sjogren's syndrome, Takayasu's arteritis, Wegener's granulomatosis, cancer anorexia/weight loss syndrome, new-onset diabetes mellitus type 1, keloids, and Alzheimer's disease. Coverage not recommended for anything not listed under Covered Uses.</p> |
| Required Medical Information | For patients with systemic sclerosis, the patient must have inflammatory joint involvement. |
| Age Restrictions | For use in Still's disease and RA, approve for adults. For uveitis (non-infectious), approve for children aged less than 18 years. For JIA approve for children aged 2 years and older. |
| Prescriber Restrictions | |
| Coverage Duration | Authorization will be for 12 months, unless otherwise specified. |

Other Criteria

RA, pt tried one DMARD for at least 2 months (includes other biologic DMARDs for at least 2 months), or the pt is concurrently receiving methotrexate (MTX). JIA or JRA, polyarticular course, patient has tried MTX or will be starting on etanercept concurrently with MTX. Approve without trying MTX if the pt has an absolute contraindication to MTX. Plaque psoriasis (PP). Pt has a minimum body surface area (BSA) of 5% or more, exceptions allowed for patients with less than 5% BSA if they have PP of palms, soles, head and neck, nails, intertriginous areas or genitalia. Pt has a minimum BSA of 5% or more, exceptions allowed for patients with less than 5% BSA if they have had an inadequate response to a 2-month trial of either topical therapy OR localized phototherapy (with ultraviolet B [UVB] or oral methoxsalen plus UVA light [PUVA]), and had an inadequate response to a 2-month trial of systemic therapy (with one of the following - MTX, cyclosporine (CSA), acitretin, adalimumab, alefacept, infliximab, or ustekinumab) or has contraindications to all of these, and has significant disability or impairment in physical or mental functioning according to the treating physician. Pt has tried a systemic therapy (MTX, CSA, acitretin, adalimumab, alefacept, infliximab, or ustekinumab) or phototherapy with UVB or PUVA for psoriasis for 2 months. Rarely, a pt may have contraindications to nearly all of these other therapies and exceptions can be made on a case-by-case basis. Juvenile spondylarthropathy. Tried at least one other DMARD. Reactive arthritis. Tried an NSAID and at least one DMARD. Still's disease. Tried one DMARD or is currently receiving MTX for at least 2 months. Uveitis (non-infectious). Tried topical (ophthalmic) or systemic corticosteroids (SCs), MTX, or CSA. Scleritis/corneal ulcer. Tried one other therapy for these conditions. CIDP. Tried two of the following- IVIG, SC, plasmapheresis, azathioprine, CSA, cyclophosphamide, interferon alfa. Myasthenia gravis. Approve if receiving corticosteroids and have received at least one other immunosuppressive agent. GVHD. Approve if managed by a transplant center and has tried or currently is receiving with etanercept one conventional GVHD txment (high-dose SC, CSA, tacrolimus, etc.). Behcet's. Have not responded to at least one conventional therapy (eg, SCs, immunosuppressives, etc). Giant cell arteritis. Tried corticosteroids but are unable to withdraw systemic steroid therapy. HS. Tried one other therapy (eg, intralesional/oral corticosteroids, topical/systemic antibiotics, isotretinoin). PMR. Tried corticosteroids but unable to reduce dose or withdraw steroid therapy. PG. Tried one other systemic therapy (eg, intralesional corticosteroids or CSA, SCs or immunosuppressives, etc.) AMBD. Tried conventional therapy (SCs AND immunosuppressive agent) or has contraindications to conventional tx. Systemic sclerosis. Tried an NSAID AND at least one DMARD. TRAPS. Tried corticosteroids.

Prior Authorization Group Drug Names

EPLERENONE
EPLERENONE

Covered Uses

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

Exclusion Criteria

NON COVERAGE EPLERENONE is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: hyperkalemia or renal failure B. If the patient is taking/receiving any of the following: Itraconazole, Ketoconazole, Nefazodone, Nelfinavir, Potassium Salts, Potassium-sparing diuretics.

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation of previous trial/failure of Spironolactone therapy B. Documentation showing creatine clearance is greater than 30 mL/min

Age Restrictions

Prescriber Restrictions

Coverage Duration

1 Year

Other Criteria

COVERAGE POLICY EPLERENONE is covered for members who meet the following criteria: A. The patient has had a serum potassium level taken within 10 days of initiation of therapy and the level is Less than 5.5 mEq/L. B. C. AND the diagnosis is documented as hypertension. " AND the patient has tried and failed maximum tolerated doses of a 60-day trial or had unacceptable toxicity to spironolactone (Aldactone, Spirono). (Please review the patient s drug history or chart to verify a trial to spironolactone). " AND the patient does NOT have type-2 diabetes with microalbuminuria. " AND the patient does NOT have a serum creatinine Greater than 2 mg/dL in males or Greater than 1.8 mg/dL in females. " AND the patient does NOT have a creatinine clearance Less than or equal to 50 mL/min. AND if the patient has had previous Inspra therapy, he/she must show a decrease in systolic and diastolic blood pressure since initiating Inspra therapy. D. AND/OR the diagnosis is documented as a patient with left ventricular systolic dysfunction and/or congestive heart failure after an acute myocardial infarction. " AND the patient has tried and failed maximum tolerated doses of a 60-day trial or had unacceptable toxicity to spironolactone (e.g. Aldactone, Spirono). (Please review the patient s drug history or chart to verify a trial to spironolactone). " AND the patient does NOT have a creatinine clearance Less than or equal to 30 mL/ min. " AND if the patient has had previous Inspra therapy, he/she must show an improvement in left ventricular systolic dysfunction and/or congestive heart failure symptoms (e.g. fatigue, edema, shortness of breath) since initiating Inspra therapy.

Prior Authorization Group

ERAXIS

Drug Names

ERAXIS

Covered Uses

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

Exclusion Criteria

Required Medical Information The following copies of chart notes/laboratory reports are required: A. Documentation of previous trial/failure of Fluconazole

Age Restrictions 2 years or older

Prescriber Restrictions Infectious Disease

Coverage Duration 6 Months

Other Criteria COVERAGE POLICY Eraxis is covered for members who meet the following criteria: A. The diagnosis is documented as candidemia or another Candida infection B. AND the patient has completed a documented trial and failure of Fluconazole B C. AND verification of all B vs. D criteria indicate coverage by Part D

Prior Authorization Group ETHYOL

Drug Names AMIFOSTINE

Covered Uses FDA approved indications A. All FDA approved indications not otherwise excluded from Part D

Exclusion Criteria NON COVERAGE Amifostine is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: dehydration, exfoliative dermatitis, hypotension or mannitol hypersensitivity.

Required Medical Information

Age Restrictions

Prescriber Restrictions Oncologist

Coverage Duration 6 months

Other Criteria COVERAGE POLICY Amifostine is covered for members who meet the following criteria: A. Patient is being treated for FDA indication. B. AND B vs. D criteria indicates coverage should be through Medicare Part D

Prior Authorization Group EXJADE

Drug Names EXJADE

Covered Uses FDA approved indications A. All FDA approved indications not otherwise excluded from Part D

Exclusion Criteria NON COVERAGE Exjade is NOT covered for members with the following criteria A. If the patient is taking/receiving any of the following: Deferoxamine, Iron Dextran, Iron Salts, Iron Sucrose, Polysaccharide-Iron Complex or Sodium Ferric Gluconate Complex.

Required Medical Information The following copies of chart notes/laboratory reports are required: A. Documentation of ferritin levels within the last 60 days of at least 1000 ng/mL

Age Restrictions

Prescriber Restrictions Hematologist

Coverage Duration 3 months

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| Other Criteria | COVERAGE POLICY Exjade is covered for members who meet the following criteria: A. Patient has a diagnosis of transfusion-dependent anemia (-thalassemia, sickle cell disease, Diamond-Blackfan anemia, or myelodysplastic syndrome) and chronic iron overload due to blood transfusions, evidenced by serum ferritin 1,000-8,000ng/mL. B. Patient failed Desferal therapy due to compliance or is unable to use it (documentation of noncompliance, adverse effects, and/or contraindications). |
| Prior Authorization Group | EXTAVIA |
| Drug Names | EXTAVIA |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D worded as patients with a diagnosis of multiple sclerosis (MS) or have experienced an attack and who are at risk of MS. |
| Exclusion Criteria | Concurrent use of Avonex, Rebif, Copaxone or Tysabri. Coverage not recommended for anything not listed under Covered Uses. |
| Required Medical Information | |
| Age Restrictions | |
| Prescriber Restrictions | Prescribed by or after consultation with a neurologist or an MS specialist. |
| Coverage Duration | Authorization will be for 12 months, unless otherwise specified. |
| Other Criteria | |
| Prior Authorization Group | FABRAZYME |
| Drug Names | FABRAZYME |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation of alpha-galactosidase enzyme deficiency |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Fabrazyme is covered for members who meet the following criteria: A. Diagnosis is documented as a patient with Fabry disease. B. AND the diagnosis has been confirmed with an enzyme assay measuring a deficient activity of alpha-galactosidase enzyme. |
| Prior Authorization Group | FOMEPIZOLE |
| Drug Names | FOMEPIZOLE |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Fomepizole is NOT covered for members with the following criteria: A. Known hypersensitivity to fomepizole or other pyrazoles. B. The patient is receiving Ethanol. |

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

up to 30 days

COVERAGE POLICY Fomepizole is covered for members who meet the following criteria: A. Patient is suffering from acute methanol or ethylene glycol poisoning B. AND verification of all B vs. D criteria indicate coverage by Part D

Prior Authorization Group

Drug Names

Covered Uses

FORTEO

FORTEO

All FDA-approved indications not otherwise excluded from Part D. For the treatment of osteoporosis in patients (women and men) who are at high risk for fracture. Patients at high risk include those with a history of osteoporotic fracture, those with a medical condition that has resulted in bone loss significantly greater than would be expected for the patient's age (eg, chronic liver disease), patients with a very low BMD (defined as (ie, BMD T-score below -2.0), or those using medicine that resulted in bone loss (eg, steroids [prednisone]). For use in hypoparathyroidism (primary or secondary). Prevention of osteoporosis (women and men). Coverage not recommended for anything not listed under Covered Uses.

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

For hypoparathyroidism, the patient must be under the care of an endocrinologist. Authorization will be for up to 12 months. Not to exceed 24 months of life-time therapy. COVERAGE POLICY: Forteo may be approved for the covered osteoporosis indications if the patient has tried an oral or intravenous bisphosphonate (eg, alendronate, risedronate, ibandronate, zoledronic acid [Reclast]), or if the patient has severe renal impairment (eg, creatinine clearance less than 30 mL/min) or chronic kidney disease, or if the patient has multiple vertebral fractures in the setting or vertebral T-scores less than -2.5.

Prior Authorization Group

Drug Names

Covered Uses

GILENYA

GILENYA

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

Exclusion Criteria

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| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documented FDA approved indication (Multiple sclerosis, Relapsing forms) B. Confirm before initiation of fingolimod, that baseline transaminase and bilirubin concentrations in those without recent (for example, within the last 6 months) levels are documented D. Confirm varicella zoster virus has been administer at least one month prior to start of drug or confirm history of chickenpox E. Before initiating fingolimod or if fingolimod was discontinued for more than 2 weeks and will be restarted, confirm an electrocardiogram (ECG) in patients without a recent ECG (for example, within 6 months) was obtained F. Confirm ophthalmologic exam at baseline. |
| Age Restrictions | 18 years or older |
| Prescriber Restrictions | Neurologist |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Gilenya is covered for members who meet the following criteria: A. Gilenya is approved for the diagnosis of Multiple sclerosis, Relapsing forms B. Tried, failed or intolerant to at least two conventional treatments (Rebif, Betaseron, Avonex, Extavia) C. REMS protocol must be followed. |
| Prior Authorization Group | GONADOTROPIN |
| Drug Names | CHORIONIC GONADOTROPIN |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Gonadotropin is NOT covered for the following criteria: A. If the patient meets any of the following contraindications: benzyl alcohol hypersensitivity, hamster protein hypersensitivity, pituitary adenoma, precocious puberty, pregnancy or prostate cancer. B. If the patient is taking/receiving Chasteberry, Chaste tree fruit or Vitex agnus-castus. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis |
| Age Restrictions | |
| Prescriber Restrictions | Endocrinologist |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Gonadotropin is covered for members who meet either of the following criteria: A. In a Male patient 1. If the patient has a diagnosis of prepubertal cryptochidism not due to anatomic obstruction or hypogonadism secondary to a pituitary deficiency. 2. AND If the patient does not have any signs of the following diagnoses: a. Precocious puberty, or b. Prostatic carcinoma or other androgen dependent neoplasm 3. And is not being used in the treatment of obesity. |
| Prior Authorization Group | GRANISETRON |
| Drug Names | GRANISETRON HCL |

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| <i>Covered Uses</i> | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | NON COVERAGE Granisetron is NOT covered for members who meet the following criteria: A. Concomitant use of apomorphine. |
| <i>Required Medical Information</i> | The following copies of chart notes/laboratory reports are required: A. Documentation showing patient is experiencing Chemotherapy-induced, Postoperative or Radiation-induced nausea and vomiting. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | up to 6 months |
| <i>Other Criteria</i> | COVERAGE POLICY Granistron is covered for members who meet the following criteria: A. Verification of B vs D criteria as per CMS regulations B. Used as a antiemetic: For the prevention of nausea and vomiting in patients receiving moderately and/or highly emetogenic chemotherapy regimens of up to 5 consecutive days' duration. |
| <i>Prior Authorization Group</i> | HEPSERA |
| <i>Drug Names</i> | HEPSERA |
| <i>Covered Uses</i> | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | The following copies of chart notes/laboratory reports are required: A. Documentation of positive HBsAg OR liver biopsy showing chronic hepatitis B. Documentation of Hepatitis B viral load greater than 100000 copies/mL C. Documentation of elevated liver enzymes showing AST greater than 69 units/L AND ALT greater than 71 units/L |
| <i>Age Restrictions</i> | 12 years or older |
| <i>Prescriber Restrictions</i> | Gastroenterologist or Infectious Disease |
| <i>Coverage Duration</i> | 1 Year |

Other Criteria

COVERAGE POLICY Hepsera is covered for members who meet the following criteria: A. Diagnosed with chronic hepatitis B. B. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis. (Please verify that the patient has a HBsAg serological marker for greater than 6 months or a positive liver biopsy by reviewing the patients drug history or chart). C. AND the patient has a Hepatitis B viral load greater than 100,000 copies per ml. D. AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal. E. AND the patient has been tested for HIV. (Hepsera therapy can cause HIV resistance in untreated HIV infection). AND if the patient has received previous Hepsera treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patients liver aminotransferases. (Please verify patients chart notes to verify drop in viral load or reduction in liver aminotransferases from their starting level). F. AND the patient is not receiving duplicate therapy that includes Baraclude, Tyzeka, Epivir, Intron A and/or Infergen. (Please verify that the patient does not have duplicate therapy by reviewing the patients drug history or chart). G. AND evidence of diagnosis, serological markers, liver biopsy, viral load, and liver aminotransferases is documented in patients chart.

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES

HYDROXYZINE PAMOATE, PROMETHAZINE HCL

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

Coverage not recommended for anything not listed under Covered Uses.

Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.

Prescriber Restrictions

Coverage Duration

Other Criteria

Authorization will be for 12 months, unless otherwise specified.

Hydroxyzine and Promethazine hydrochloride tablets or syrup: Not covered for those who are 65 years of age and older.

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

HIGH RISK MEDICATIONS - SKELETAL MUSCLE RELAXANTS

CARISOPRODOL, CHLORZOXAZONE, CYCLOBENZAPRINE HCL,

CYPROHEPTADINE HCL, METAXALONE, METHOCARBAMOL

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

Coverage not recommended for anything not listed under Covered Uses.

Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.

Prescriber Restrictions

Coverage Duration

Authorization will be for 1 month.

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| Other Criteria | Musculoskeletal conditions/disorders, approve if the patient has tried two other therapies for the current condition. |
| Prior Authorization Group | HUMIRA |
| Drug Names | HUMIRA, HUMIRA PEN-CROHNS DISEASE |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D plus patients already started on adalimumab for non-Crohn's disease uses. Crohn's disease (CD) patients already on adalimumab. Undifferentiated spondylarthritis (undifferentiated arthritis). Crohn's disease (induction/remission) in adolescents (15 up to 18 yrs). Uveitis (noninfectious). Behcet's disease. Sarcoidosis. Pyoderma gangrenosum. Hidradenitis suppurativa. |
| Exclusion Criteria | Concurrent use with anakinra, abatacept, rituximab, ustekinumab, certolizumab pegol, etanercept, infliximab, or golimumab. Use in the management of osteoarthritis, ulcerative colitis, recurrent spontaneous pregnancy loss, in vitro fertiliation (IVF). Intra-articular injection of adalimumab. Coverage not recommended for anything not listed under Covered Uses. |
| Required Medical Information | |
| Age Restrictions | RA, adults. Crohn's disease adults and adolescents aged 15 to up to 18 yrs. |
| Prescriber Restrictions | Rheumatologist, Dermatologist and Gastroenterology |
| Coverage Duration | Crohn's disease=12 wks for induction.All other conds=12mos. |

Other Criteria

RA, pt has tried one DMARD (brand or generic, oral or injectable) for at least 2 months (this includes patients who have tried other biologic DMARDs for at least 2 months), or the pt is concurrently receiving methotrexate (MTX). JIA/JRA polyarticular course. Tried MTX or will be starting on adalimumab concurrently with MTX. Approve without trying MTX if pt has absolute contraindication to MTX. Plaque psoriasis (PP). Pt has a minimum body surface area (BSA) of 5% or more, exceptions allowed for patients with less than 5% BSA if they have PP of palms, soles, head and neck, nails, intertriginous areas or genitalia. Pt has a minimum BSA of 5% or more, exceptions allowed for patients with less than 5% BSA if they have had an inadequate response to a 2-month trial of either topical therapy OR localized phototherapy (with ultraviolet B [UVB] or oral methoxsalen plus UVA light [PUVA]), and had an inadequate response to a 2-month trial of systemic therapy (with one of the following - MTX, cyclosporine (CSA), acritretin, etanercept, alefacept, infliximab, or ustekinumab) or has contraindications to all of these, and has significant disability or impairment in physical or mental functioning according to the treating physician. Pt has tried a systemic therapy (MTX, CSA, acritretin, etanercept, alefacept, infliximab, or ustekinumab) for 2 months or phototherapy with UVB or PUVA for psoriasis for 2 months. Rarely, a pt may have contraindications to nearly all of these other therapies and exceptions can be made on a case-by-case basis. CD to induce remission. Tried corticosteroids or if corticosteroids are contraindicated or if patient currently on corticosteroids (adolescents with CD must also have tried infliximab). CD to maintain remission. Pt has received 2 doses or 12 wks of adalimumab and has responded or if has not received adalimumab for induction of remission then authorize if pt tried azathioprine, 6-mercaptopurine, or MTX or has tried infliximab (or certolizumab pegol for adults). Uveitis (non-infectious). Tried periocular/intraocular corticosteroids, immunosuppressants, or etanercept or infliximab. Behcet's. Pt has not responded to at least one conventional tx (eg, systemic corticosteroids, immunosuppressants, interferon alfa, or infliximab). Sarcoidosis. Tried corticosteroid and immunosuppressive agent, or infliximab, or chloroquine, or thalidomide. PG. Tried one other systemic therapy (eg, systemic corticosteroids, immunosuppressives, cyclophosphamide, chlorambucil, infliximab, or intralesional corticosteroids or CSA). HS. Tried one other therapy (eg, intralesional/oral corticosteroids, antibiotics, isotretinoin).

Prior Authorization Group

Drug Names

Covered Uses

IMMUNE GLOBULIN

CARIMUNE NANOFILTERED, GAMMAGARD LIQUID, GAMUNEX

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

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| Exclusion Criteria | NON COVERAGE Immune globulin is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: IgA deficiency. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation of the patient s diagnosis. B. For a diagnosis of Chronic inflammatory demyelinating polyneuropathy (CIDP) a. documentation showing the patient s baseline neurological exam. b. Documentation showing weakness in all four (4) limbs accompanied by numbness, impaired proprioception, and ataxia. Cranial nerves may also be involved. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Immune Globulin is covered for members who meet the following criteria: A. Verify B vs. D criteria per CMS guidelines B. Treatment of a FDA approved diagnosis C. For the treatment of chronic inflammatory demyelinating polyneuropathy (CIDP) a. And a baseline neurological exam has been provided. b. And the patient has weakness in all 4 limbs accompanied by numbness, impaired proprioception, and ataxia. Cranial nerves may also be involved. |
| Prior Authorization Group | INCRELEX |
| Drug Names | INCRELEX |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Increlex is not covered for members who meet the following criteria: A. If the patient has any of the following contraindications: benzyl alcohol hypersensitivity, epiphyseal closure, intravenous administration, neonates or neoplastic disease. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation showing patients epiphyses are NOT closed B. Documentation showing patient has NO active malignancy C. Documentation of IGF-1 standard deviation score of less than -2.9 based on lab reference for age and sex D. If requesting retreatment: a. Documentation of an increase in height velocity greater than 2.5 cm total growth in one year b. Documentation patient has NOT met final expected adult height based on mid-parental height calculation |
| Age Restrictions | Between 2 and 20 years old |
| Prescriber Restrictions | Endocrinologist |
| Coverage Duration | 1 Year |

Other Criteria

COVERAGE POLICY Increlex is covered for members who meet the following criteria: A. Patient is not being treated with chronic anti-inflammatory steroids. B. AND the diagnosis is documented as the treatment of growth failure in a child with severe primary IGF-1 deficiency or with growth hormone gene deletion who have developed neutralizing antibodies to growth hormone. " C. AND the patient has a basal IGF-1 standard deviation score Less than or equal to -3 based on lab reference for age and sex. (Please verify the IGF-1 level in the patient s chart notes and ensure the test was performed within 3 months of the initial request). " D. AND the patient has a normal or elevated growth hormone level that has been confirmed with at least one growth hormone stimulation test. (Please verify the stimulation test result in the patient s chart notes). " E. AND the patient has severe growth retardation with a height standard deviation (SDS) score more than 3 SDS below the mean for chronological age and sex and their target height based on mid-parental height calculation. (Please verify the SDS score in the patient s chart notes). " F. AND all indications of secondary IGF-1 have been ruled out such as growth hormone deficiency, hypothyroidism and malnutrition. " G. AND the patient is not taking or has no plans to receive growth hormone therapy in combination with Increlex therapy. " H. AND if the patient has received previous mescasermin therapy, the patient must meet all of the following criteria: 1. There has been an increase in height velocity Greater than 2.5 cm total growth in one year of therapy. 2. There is no evidence of epiphyseal closure. 3. The patient has NOT met their expected final adult height or targeted height based on mid-parental height calculation or their current absolute height is Less than or equal to 25th percentile (defined as 68 inches in males and 63 inches in females).

Prior Authorization Group

Drug Names

Covered Uses

ITRACONAZOLE

ITRACONAZOLE

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

Exclusion Criteria

NON COVERAGE Itraconazole is NOT covered for members with the following criteria: A. pregnant women or women contemplating pregnancy do not use for the treatment of onychomycosis (capsules) B. Ventricular dysfunction (eg, congestive heart failure (CHF) or history of CHF) except for life-threatening or serious infections (oral solution) do not use for the treatment of onychomycosis (capsules).

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation that patient is not pregnant (if female) B. Documentation of diagnosis C. If the diagnosis is Candidiasis: a. Documentation of previous trial/failure to Fluconazole

Age Restrictions

Prescriber Restrictions

Coverage Duration

12 weeks

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| Other Criteria | COVERAGE POLICY Itraconazole is covered for members who meet the following criteria: A. Diagnosis is FDA approved indication B. AND if the diagnosis is oropharyngeal candidiasis the patient is unresponsive or refractory to fluconazole therapy. |
| Prior Authorization Group | KETEK |
| Drug Names | KETEK |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Ketek is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: macrolide hypersensitivity, history of macrolide induced hepatitis/jaundice, myasthenia gravis, QT prolongation, torsade de pointes. B. If the patient is taking/receiving any of the following: Astemizole, Atorvastatin, Bepridil, Cisapride, Class IA antiarrhythmics, Class III antiarrhythmics, Droperidol, Ergot Alkaloids, Grepafloxacin, Levomethadyl, Lovastatin, Pimozide, Probutol, Red Yeast Rice, Rifampin, Simvastatin, Sirolimus, Terfenadine or Ziprasidone. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis B. Documentation of previous trial/failure on Azithromycin AND a Fluoroquinolone. (including length of therapy of both agents) |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 10 days |
| Other Criteria | COVERAGE POLICY Ketek is covered for members who meet the following criteria: A. The patient is diagnosed with community-acquired pneumonia B. AND the patient has had previous failed therapy on BOTH of the following: a. Azithromycin b. Fluoroquinolone |
| Prior Authorization Group | KINERET |
| Drug Names | KINERET |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D plus patient already started on anakinra. Juvenile idiopathic arthritis (JIA) or juvenile rheumatoid arthritis (JRA), polyarticular course (regardless of type of onset). Systemic onset JIA. Ankylosing spondylitis. Adult with Still's disease. Muckle-Wells syndrome (MWS). Familial cold autoinflammatory syndrome (FCAS). Neonatal Onset Multisystem Inflammatory disease (NOMID) or Chronic infantile neurological cutaneous and articular (CINCA) syndrome. Schnitzler's syndrome. Acute gout. Familial Mediterranean fever. Tumor necrosis factor (TNF) receptor-associated periodic syndrome (TRAPS). |

Exclusion Criteria

Use in the management of symptomatic osteoarthritis, lupus arthritis, or type 2 diabetes mellitus. Anakinra should not be given in combination with TNF blocking agents (etanercept, adalimumab, infliximab, certolizumab pegol, and golimumab), or abatacept, or rituximab. Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

Age Restrictions

RA and Still's disease, adults.

Prescriber Restrictions

Coverage Duration

Other Criteria

Acute gout, approve 3 doses. Approve 12 months for all other conditions/uses. Adults with RA. Approve if the patient has tried adalimumab, etanercept, or infliximab for at least 2 months. JIA, JRA (regardless of onset), approve if patient has tried etanercept, adalimumab, or abatacept. Systemic onset of JIA, approve if patient has tried a systemic corticosteroid. Ankylosing spondylitis, approve if the patient has tried etanercept, infliximab, golimumab, or adalimumab. Adult with Still's disease, approve if patient has tried one DMARD or is currently receiving MTX. MWS, approve if patient has tried two other drugs (rilonacept, canakinumab, colchicine, corticosteroids, chlorambucil, antihistamines, dapsone, azathioprine, mycophenolate mofetil) for MWS. FCAS, approve if patient has tried two other drugs (eg, colchicine, corticosteroids, antihistamines, azathioprine, mycophenolate mofetil, rilonacept, or canakinumab) for FCAS. Schnitzler's syndrome, approve if patient has tried one other prescription medication used in Schnitzler's syndrome (eg, NSAIDs, antihistamines, colchicine, corticosteroids, immunosuppressive drugs). Acute gout, patient has tried 2 standard therapies for acute gout (eg, NSAIDs, colchicine, corticosteroid) or patient cannot tolerate or has contraindications to standard therapies. FMF, approve in patients who have tried colchicine. TRAPS, approve in patients who have tried corticosteroids.

Prior Authorization Group

KUVAN

Drug Names

KUVAN

Covered Uses

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

Exclusion Criteria

NON COVERAGE Kuvan is NOT covered for members with the following criteria: A. Dosing that exceeds 20 mg/kg/day.

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Confirm approved diagnosis. B.For initial therapy confirm phenylalanine levels are greater than 10mg/dl. C.Reauthorization: confirm 20 percent reduction from initial baseline. D.Documentation of phenylalanine (Phe) restricted diet

Age Restrictions

Prescriber Restrictions

Coverage Duration

One month, then eval response, then may approve up to 1 year

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| Other Criteria | COVERAGE POLICY: Kuvan is covered for members who meet the following criteria: A. To reduce blood phenylalanine (Phe) levels in patients with hyperphenylalaninemia caused by tetrahydrobiopterin (BH4)-responsive phenylketonuria. |
| Prior Authorization Group | LETAIRIS/TRACLEER |
| Drug Names | LETAIRIS, TRACLEER |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. Patients currently on Letairis or Tracleer for treatment of pulmonary arterial hypertension. Digital ulcers (Tracleer). Chronic thromboembolic pulmonary hypertension (CTEPH) (Tracleer). |
| Exclusion Criteria | Coverage is not recommended for circumstances not listed in the Covered Uses. |
| Required Medical Information | For the FDA-approved indication of pulmonary arterial hypertension, patients not currently on Letairis or Tracleer are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. For the FDA-approved indication of pulmonary arterial hypertension, patients currently on Letairis or Tracleer may continue therapy if they have a diagnosis of PAH. |
| Age Restrictions | |
| Prescriber Restrictions | For treatment of pulmonary arterial hypertension, Letairis or Tracleer must be prescribed by or in consultation with a cardiologist or a pulmonologist. |
| Coverage Duration | Authorization will be for 12 months, unless otherwise specified. |
| Other Criteria | Digital ulcers, approve Tracleer if the patient has tried two other therapies for this condition such as calcium channel blockers (eg, amlodipine, felodipine, isradipine, nifedipine), alpha-adrenergic blockers (eg, prazosin), nitroglycerin, phosphodiesterase-5 inhibitors (eg, sildenafil, vardenafil), or angiotensin-converting enzyme inhibitors (ACE inhibitors), or the patient has tried one vasodilator product (eg, intravenous epoprostenol, intravenous alprostadil). |
| Prior Authorization Group | LIDODERM |
| Drug Names | LIDODERM |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Lidoderm is NOT covered for members who meet the following criteria: A. If the patient has a known history of sensitivity to local anesthetics (amide type). |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation of trial and failure of the following: gabapentin OR capsaicin |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 3 months |

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| Other Criteria | COVERAGE POLICY Lidoderm is covered for members who meet the following criteria: A. Diagnosis is documented as postherpetic neuralgia B. Patient has completed a documented trial and failure of the either medications: Gabapentin OR capsaicin. |
| Prior Authorization Group | LOTRONEX |
| Drug Names | LOTRONEX |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Lotronex is NOT covered for members who meet the following criteria:A. If the patient is a Male. B. Concurrently has ischemic colitis, Crohn disease or ulcerative colitis, diverticulitis. C.If patient is constipated.D. Concurrent use of fluvoxamine. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation of IBS symptoms generally lasting 6 months or longer. B. Documentation of severe IBS to include diarrhea and 1 or more of the following: frequent and severe abdominal pain/discomfort, frequent bowel urgency or fecal incontinence, and/or disability or restriction of daily activities because of IBS. C. Confirmation of the prescriber be specially certified in the Prescribing Program for Lotronex (PPL). |
| Age Restrictions | 18 years or older |
| Prescriber Restrictions | |
| Coverage Duration | May approve 4 weeks, then may approve up to 1 year |
| Other Criteria | COVERAGE POLICY Lotronex is covered for members who meet the following criteria: A. Only physicians enrolled in the Prometheus Prescribing Program for Lotronex(R) may prescribe alosetron B.For women with severe diarrhea-predominant IBS who have chronic IBS symptoms (generally lasting 6 months or longer), have had anatomic or biochemical abnormalities of the GI tract excluded, and who have not responded adequately to conventional therapy (ex: loperamide, diphenoxylate). |
| Prior Authorization Group | LYRICA |
| Drug Names | LYRICA |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documented FDA approved indication. |
| Age Restrictions | 18 years or older |
| Prescriber Restrictions | |
| Coverage Duration | May approve up to 8 weeks initially then may approve up to 1 year |

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| Other Criteria | COVERAGE POLICY Lyrica is covered for members who meet the following criteria: A. For the management of fibromyalgia. B.For the management of neuropathic pain associated with diabetic peripheral neuropathy. C. Adjunctive therapy for adult patients with partial-onset seizures. D.For the management of postherpetic neuralgia. E. Maximum dose of 600 mg/day |
| Prior Authorization Group | MEPRON |
| Drug Names | MEPRON |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Meproin is NOT covered for members with the following criteria: A. Concurrent pulmonary conditions such as bacterial, viral, or fungal pneumonia or mycobacterial diseases. B. Coadministration of rifampin. |
| Required Medical Information | |
| Age Restrictions | 13 years or older |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Meproin is covered for members who meet the following criteria:A. For the prevention of Pneumocystis carinii pneumonia (PCP) in patients who are intolerant to trimethoprim-sulfamethoxazole (TMP-SMZ). B.For the acute oral treatment of mild-to-moderate PCP in patients who are intolerant to TMP-SMZ. |
| Prior Authorization Group | MESNEX |
| Drug Names | MESNEX |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation that the patient is being administered with ifosfamide or cyclophosphamide |
| Age Restrictions | |
| Prescriber Restrictions | Oncologist |
| Coverage Duration | 3 months |
| Other Criteria | COVERAGE POLICY Mesnex is covered for members who meet the following criteria: A. Patient is diagnosed with an FDA approved indication. B. AND patient is being administered with ifosfamide or cyclophosphamide C. AND B vs. D criteria indicates that coverage should be through Medicare Part D |
| Prior Authorization Group | METHADONE |
| Drug Names | METHADONE HCL |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |

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| Exclusion Criteria | NON COVERAGE Methadone is NOT covered when prescribed for Opioid Dependence. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation showing methadone is being prescribed for pain management. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 6 months |
| Other Criteria | |
| Prior Authorization Group | MOZOBIL |
| Drug Names | MOZOBIL |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 6 Months |
| Other Criteria | COVERAGE POLICY Colony Stimulating Factor is covered for members who meet the following criteria: A. Patient is diagnosed with leukemia, non-Hodgkin's lymphoma, OR multiple myeloma B. AND B vs. D criteria indicates that coverage should be through Medicare Part D D. Mozobil will be used to mobilize hematopoietic stem cells for collection prior to autologous transplantation |
| Prior Authorization Group | NAGLAZYME |
| Drug Names | NAGLAZYME |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation that diagnosis has been confirmed by an enzymatic assay showing a deficiency in N-acetylgalactosamine activity. B. If the patient has previously received Naglazyme therapy, documentation that they have shown an improvement in walking and/or stair-climbing capacity since initiating therapy |
| Age Restrictions | |
| Prescriber Restrictions | Endocrinologist |
| Coverage Duration | 1 Year |

Other Criteria

COVERAGE POLICY Naglazyme is covered for members who meet the following criteria: A. Diagnosis is documented as mucopolysaccharidosis VI (MPS VI). B. AND diagnosis has been confirmed by an enzymatic assay showing a deficiency in N-acetylgalactosamine activity. C. AND the patient has at least one of the listed MPS VI symptoms. Impaired vision Recurrent otitis media. Recurrent sinopulmonary infections Impaired hearing Upper airway obstruction Malaise and reduced endurance Corneal clouding Macrocephaly Reduced joint range of motion Progressively coarse facial features Short stature Umbilical and inguinal hernias Carpal tunnel syndrome Communicating hydrocephalus Hepatosplenomegaly Cardiac abnormalities and valvular disease Spinal cord compression Sleep apnea Reduced pulmonary function Hepatosplenomegaly Dysostosis mutiplex D. AND if the patient has previously received Naglazyme therapy, they must show an improvement in walking and/or stair-climbing capacity since initiating therapy.

Prior Authorization Group

Drug Names

NEULASTA

Covered Uses

NEULASTA

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

Exclusion Criteria

NON COVERAGE Neulasta is NOT covered for members with the following criteria: A. Hypersensitivity to pegfilgrastim or filgrastim B. Do not administer pegfilgrastim in the period between 14 days before and 24 hours after administration of cytotoxic chemotherapy because of the potential for an increase in sensitivity of rapidly dividing myeloid cells to cytotoxic chemotherapy.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Oncologist

Coverage Duration

3 months

Other Criteria

COVERAGE POLICY Neulasta is covered for members who meet the following criteria: A. Patient is diagnosed with an FDA or compendia approved indication B. Determine if Part B or Part D drug status.

Prior Authorization Group

Drug Names

NEUMEGA

Covered Uses

NEUMEGA

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

Exclusion Criteria

NON COVERAGE Neumega is NOT covered for members with the following criteria: A. Hypersensitivity to oprelvekin B. Indication of myeloablative chemotherapy.

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| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. For thrombocytopenia following chemotherapy 1. Verification that the cancer is a non-myeloid malignancy AND 2. Platelet count is less than 50,000 cells/microliter AND 3. Patients with one or more of the following risk factors: a. Extensive prior cytotoxic chemotherapy b. Prior severe chemotherapy-induced thrombocytopenia c. Receiving chemotherapy regimens associated with high risk for thrombocytopenia. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | up to 6months |
| Other Criteria | COVERAGE POLICY Neumega is covered for members who meet the following criteria: A. Patient is diagnosed with an FDA or compendia approved indication B. Determine Part B or Part D drug status C. Patient will be receiving myelosuppressive chemotherapy but not being treated with Neumega at least two days before chemotherapy treatment. |
| Prior Authorization Group | NEUPOGEN |
| Drug Names | NEUPOGEN |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Neupogen is NOT covered for members with the following criteria: A. Hypersensitivity to E. coli-derived proteins, filgrastim, or any component of the product B. Use of filgrastim in the period 24 hours before through 24 hours after the administration of cytotoxic chemotherapy. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. For Cancer patients receiving myelosuppressive chemotherapy documentation showing post nadir ANC is less than 10,000/mm ³ |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 3 months |
| Other Criteria | COVERAGE POLICY Neupogen is covered for members who meet the following criteria: A. Determine Part B or Part D drug status. |
| Prior Authorization Group | NICOTROL |
| Drug Names | NICOTROL NS |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Nicotrol is NOT covered for members who meet the following criteria: Nonsmokers during immediate post-MI period life-threatening arrhythmias severe or worsening angina pectoris |

Required Medical Information The following copies of chart notes/laboratory reports are required: A. Documentation that the patient has stopped smoking previous to receiving medication B. Documentation verifying the patient is enrolled in a smoking cessation program

Age Restrictions

Prescriber Restrictions

Coverage Duration 3 months

Other Criteria COVERAGE POLICY Nicotrol is covered for members who meet the following criteria: A. The patient is diagnosed with nicotine addiction or withdrawal following cessation of smoking B. AND the patient has stopped smoking previous to receiving medication. C. AND the patient is enrolled in a smoking cessation program.

Prior Authorization Group

Drug Names OCTREOTIDE

Covered Uses OCTREOTIDE ACETATE
FDA approved indications A. All FDA approved indications not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information The following copies of chart notes/laboratory reports are required: A. Acromegaly: 1. Inadequate response to surgery and/or radiotherapy or patients who are not a surgical and/or radiotherapy candidate 2. Diagnosis of acromegaly by one of the following: a. Serum growth hormone (GH) level greater than 1 ng/mL after a 2-hour oral glucose tolerance test b. Elevated serum IGF-1 levels as compared to normal reference values by age and gender B. Carcinoid Tumors: Diagnosis of metastatic carcinoid tumor for symptomatic treatment of severe diarrhea or flushing C. Vasoactive Intestinal Peptide Tumors: Diagnosis of metastatic vasoactive peptide tumor, for symptomatic treatment of diarrhea associated with vasoactive peptide tumor D. Cancer Chemotherapy Induced Diarrhea: 1. Diagnosis of diarrhea due to concurrent cancer chemotherapy OR 2. Diagnosis of complicated diarrhea due to concurrent cancer chemotherapy E. AIDS-related Diarrhea: 1. Diagnosis of AIDS-related diarrhea

Age Restrictions

Prescriber Restrictions

Coverage Duration Endocrinologist, Gastroenterologist and Oncologist

Other Criteria 6 months

COVERAGE POLICY Octreotide is covered for members who meet either of the following criteria: 1. The patient has ONE of the following diagnoses: a. Acromegaly b. Vasoactive intestinal peptide-secreting tumor, or c. Carcinoid syndrome

Prior Authorization Group

Drug Names ONDANSETRON

Covered Uses ONDANSETRON HCL, ONDANSETRON ODT
FDA approved indications A. All FDA approved indications not otherwise excluded from Part D

Exclusion Criteria

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| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation showing FDA labeled indication. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | up to 1 year |
| Other Criteria | COVERAGE POLICY Ondansetron is covered for members who meet the following criteria: A. Determine Part B vs D drug status B. Prevention of nausea and vomiting associated with highly or moderately emetogenic cancer chemotherapy C. Prevention of nausea and vomiting associated with radiotherapy in patients receiving either total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen D. Prevention of postoperative nausea and/or vomiting |
| Prior Authorization Group | ORENCIA |
| Drug Names | ORENCIA |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Orencia is NOT covered for members who meet the following criteria: A. If the patient is taking/receiving any of the following: Anakinra, Actemra, Retuxan, or Tumor necrosis factor (TNF) modifiers. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. For Adult RA, documentation verifying that the patient must has a minimum of 3 of the following symptoms in accordance with American College of Rheumatology: 1. Morning stiffness 2. Arthritis of 3 or more joint areas 3. Arthritis of hand joints 4. symmetric arthritis 5. Rheumatoid nodules 6. Serum rheumatoid factor 7. Radiographic changes B. For Adult RA, documentation verifying that the patient has tried, failed or intolerant to Humira or Enbrel. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Orencia is covered for members who meet the following criteria: A. For RA, the patient must have a minimum of 3 of the following symptoms in accordance with American College of Rheumatology: 1. Morning stiffness 2. Arthritis of 3 or more joint areas 3. Arthritis of hand joints 4. Symmetric arthritis 5. Rheumatoid nodules 6. Serum rheumatoid factor 7. Radiographic changes B. AND the patient must have tried, failed or intolerant to Humira or Enbrel. |
| Prior Authorization Group | ORFADIN |
| Drug Names | ORFADIN |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |

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| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation verifying the patient is on a protein-restricted diet that is low in phenylalanine B. Lab reports verifying that the patients baseline liver function tests (LFTs) are within normal limits |
| Age Restrictions | |
| Prescriber Restrictions | Endocrinologist |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Orfadin is covered for members who meet the following criteria: A. Patient must be diagnosed with hereditary tyrosinemia type I. B. AND the patient must have documented treatment protocol of protein-restricted diet that is low in phenylalanine. C. AND the patients baseline liver function tests (LFTs) must be within normal limits. |
| Prior Authorization Group | OXANDROLONE |
| Drug Names | OXANDROLONE |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation verifying the patient has cachexia due to chronic infections B. Documentation verifying the patient has bone pain due to osteoporosis |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Oxandrolone is covered for members who meet the following criteria: a. Patient is diagnosed with bone pain associated with osteoporosis |
| Prior Authorization Group | OXSORALEN |
| Drug Names | OXSORALEN, OXSORALEN ULTRA |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Oxsoralen is NOT covered for members who meet the following criteria:A.Idiosyncratic reactions to psoralen compounds B.Aphakia C. Invasive squamous cell carcinomas, melanoma, or a history of melanoma. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. If the diagnosis is psoriasis, documentation verifying the patient has completed a trial and failure or is adverse to at least 1 topical steroid AND Dovonex |
| Age Restrictions | |
| Prescriber Restrictions | Dermatologist and Oncologist |
| Coverage Duration | 1 Year |

Other Criteria

COVERAGE POLICY Oxsoalolen is covered for members who meet the following criteria: A. Patient must be diagnosed with T-cell lymphoma OR psoriasis OR vitiligo. B. AND if the diagnosis is psoriasis the patient must have previous trial/failure or contraindication to ALL of the following: a. At least 1 topical steroid b. Dovonex.

Prior Authorization Group

Drug Names

Covered Uses

PEG-INTRON

PEG-INTRON, PEG-INTRON REDIPEN

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

Exclusion Criteria

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis B. If patient is diagnosed with Hepatitis C: a. Documentation showing Hepatitis C genotype b. Documentation showing baseline HCV RNA levels that are dated within the last 90 days C. If request is for treatment for Hepatitis C beyond initial 12 weeks: a. Documentation of Early Viral Response (EVR) showing at least a 2 log reduction from baseline HCV RNA levels D. If request is for Hepatitis B: a. Documentation of positive HBsAg OR liver biopsy showing chronic hepatitis b. Documentation of Hepatitis B viral load greater than 100000 copies/mL c. Documentation of elevated liver enzymes showing AST greater than 69 units/L AND ALT greater than 71 units/L

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Infectious Disease and Gastroenterology

12 weeks

COVERAGE POLICY Peg-Intron is covered for members who meet the following criteria: A. Chronic Hepatitis C Virus (HCV) with Genotype 1 or 4. Initial authorization will be given for 12 weeks. At 12 weeks, an early viral response (EVR) must be shown with greater than 2 log reduction in viral load, therapy may be continued up to a total of 48 weeks treatment. For patients who fail to achieve a 2log reduction, treatment should be discontinued B. HCV with Genotype 2,3, 5, or 6. Initial authorization will be given for 12 weeks. At 12 weeks, an EVR must be shown with greater than 2 log reduction in viral load, therapy may be continued up to a total of 24 weeks treatment. For patients who fail to achieve a 2 log reduction, treatment should be discontinued C. Retreatment allowed in those who did not receive optimal HCV treatment.

Prior Authorization Group

Drug Names

Covered Uses

PEGASYS

PEGASYS

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

Exclusion Criteria

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis B. If patient is diagnosed with Hepatitis C: a. Documentation showing Hepatitis C genotype b. Documentation showing baseline HCV RNA levels that are dated within the last 90 days C. If request is for treatment for Hepatitis C beyond initial 12 weeks: a. Documentation of Early Viral Response (EVR) showing at least a 2 log reduction from baseline HCV RNA levels D. If request is for Hepatitis B: a. Documentation of positive HBsAg OR liver biopsy showing chronic hepatitis b. Documentation of Hepatitis B viral load greater than 100000 copies/mL c. Documentation of elevated liver enzymes showing AST greater than 69 units/L AND ALT greater than 71 units/L

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Infectious Disease and Gastroenterology

12 weeks

COVERAGE POLICY Pegasys is covered for members who meet the following criteria: A. Chronic Hepatitis C Virus (HCV) with Genotype 1 or 4. Initial authorization will be given for 12 weeks. At 12 weeks, an early viral response (EVR) must be shown with greater than 2 log reduction in viral load, therapy may be continued up to a total of 48 weeks treatment. For patients who fail to achieve a 2log reduction, treatment should be discontinued B. HCV with Genotype 2,3, 5, or 6. Initial authorization will be given for 12 weeks. At 12 weeks, an EVR must be shown with greater than 2 log reduction in viral load, therapy may be continued up to a total of 24 weeks treatment. For patients who fail to achieve a 2 log reduction, treatment should be discontinued C. Retreatment allowed in those who did not receive optimal HCV treatment.

Prior Authorization Group

Drug Names

Covered Uses

PRADAXA

PRADAXA

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

Exclusion Criteria

NON COVERAGE PRADAXA is NOT covered for members who meet the following criteria: A. Patients with active pathological bleeding B. Patients on Dialysis C. 2011 ACCF/AHA/HRS atrial fibrillation guidelines: Not recommended for patients with coexisting prosthetic heart valve or hemodynamically significant valve disease, severe renal failure (Clcr < 15 mL/minute), or advanced liver disease (impaired baseline clotting function)

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Confirm diagnosis of non- valvular atrial fibrillation. Confirm creatinine clearance of greater than 15 L/min (If CRCL is not available, eGFR > 59) within past year Oral: 150 mg twice daily Oral: 75mg twice daily if CRCL is (15L/min to 30L/min) QLL of 60 tablets per 30 days 18 years or older

Age Restrictions

Prescriber Restrictions

| | |
|-------------------------------------|---|
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY An FDA-approved patient medication guide, which is available with the product information and at http://www.fda.gov/downloads/Drugs/DrugSafety/UCM231720.pdf , must be dispensed with this medication. |
| Prior Authorization Group | PRIMAXIN |
| Drug Names | PRIMAXIN I.M., PRIMAXIN IV |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Primaxin is NOT covered for members who meet the following criteria: A. IM: Hypersensitivity to local anesthetics of the amide type and in patients with severe shock or heart block due to the use of lidocaine HCl diluent. B. IV: Patients with meningitis |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Culture Sensitivity Results |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 6 months |
| Other Criteria | COVERAGE POLICY Confirm Part D vs. Part B evaluation. |
| Prior Authorization Group | PROCRIT |
| Drug Names | PROCRIT |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Procrit is NOT covered for members who meet the following criteria: 1.Excluded from Part D if meets coverage criteria from Part B. 2.Patients with uncontrolled hypertension 3. Anemia due to folate, B-12 or iron deficiency, hemolysis, bleeding, or bone marrow fibrosis 4. Anemia associated with CML, AML or erythroid cancers 5. Anemia of cancer not related to cancer treatment |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Must have current documented Hemoglobin (HGB) levels of less than or equal to 10g/dl or Hematocrit levels of less than or equal to 30% within 30 days prior to initiation of therapy except for Preoperative use in anemic patients scheduled for elective hip or knee surgery in which HGB should be between 10 and 13 g/dL. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 12 weeks |

Other Criteria

COVERAGE POLICY Procrit is covered for members who meet the following criteria: A. Treatment of Anemia in Chronic Renal Failure (CRF) -Procrit may be covered under Part B B. For use in an anemic patient prior to surgery, the patient must also receive concomitant iron supplementation. C. For other indications, all of the following criteria are required: 1) The pretreatment Hgb is less than or equal to 10 g/dL for initial authorization. 2) The patient is receiving concomitant iron supplementation if iron stores are inadequate. 3) The Hgb is maintained at or below 12 g/dL once on therapy. 4) Once on therapy for 12 weeks, the hemoglobin must increase at least 1 g/dL in response to epoetin alfa.

Prior Authorization Group

Drug Names

PROLASTIN

Covered Uses

PROLASTIN, PROLASTIN-C

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

Exclusion Criteria

NON COVERAGE Prolastin is NOT covered for members with the following criteria: A. Use in patients other than those with PiZZ, PiZ(null), or Pi(null)(null) phenotypes

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Office visit notes to verify FDA approved diagnosis and verify yearly physician appointments B. Lab report measuring elevations in serum and lung fluid levels of alpha-1 antitrypsin.

Age Restrictions

18 years or older

Prescriber Restrictions

Coverage Duration

1 Year

Other Criteria

COVERAGE POLICY Prolastin is covered for members who meet the following criteria: A. Congenital alpha1-proteinase inhibitor (alpha1-PI alpha1-antitrypsin) deficiency.

Prior Authorization Group

Drug Names

PROLIA

Covered Uses

PROLIA

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

Exclusion Criteria

NON COVERAGE Prolia is not covered for members with the following criteria: Experimental or investigational use for the following indications: A. Bone loss associated with hormone-ablation therapy in breast or prostate cancer B. Giant cell tumor of bone C. Multiple Myeloma D. Osteogenesis imperfect E. Primary bone sarcomas (Ewing's Sarcoma and Osteosarcoma) F. Rheumatoid arthritis G. Hypocalcemia

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Medical records that confirm treatment of women with post-menopausal osteoporosis who are at high risk of fracture or those who have had a osteoporotic fracture, or have multiple risk factors for fracture, documented Failure or inability to tolerate alendronate, risedronate and/or raloxifene

Age Restrictions

18 years or older

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|--|---|
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | 1 Year |
| <i>Other Criteria</i> | COVERAGE POLICY PROLIA is covered for members who meet the following criteria: 1. Administered by a healthcare provider every 6 months 2. Part B v.D determination |
| <i>Prior Authorization Group</i> | PROMACTA |
| <i>Drug Names</i> | PROMACTA |
| <i>Covered Uses</i> | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | NON COVERAGE Promacta is NOT covered for members with the following criteria: A. To normalize platelet counts. B.If ALT levels are 3 times the upper limit of normal (ULN) and are progressive. |
| <i>Required Medical Information</i> | The following copies of chart notes/laboratory reports are required: A. Platlet Count less than 50 x 10(9)/L. B. ALT, AST and Bilirubin within normal limits of the lab performing the test. |
| <i>Age Restrictions</i> | 18 years or older |
| <i>Prescriber Restrictions</i> | Physicians enrolled in Promacta Cares program |
| <i>Coverage Duration</i> | 6 months |
| <i>Other Criteria</i> | COVERAGE POLICY Promacta is covered for members who meet the following criteria: A.For the treatment of thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who have had an insufficient response to corticosteroids |
| <i>Prior Authorization Group</i> | PULMOZYME |
| <i>Drug Names</i> | PULMOZYME |
| <i>Covered Uses</i> | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | |
| <i>Required Medical Information</i> | |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | Pulmonologist |
| <i>Coverage Duration</i> | 1 Year |

Other Criteria

COVERAGE POLICY Pulmozyme is covered for members who meet the following criteria: A. The patient is a cystic fibrosis patient and medication is being used to improve pulmonary function and/or reduce the frequency of respiratory infections. B. AND the patient will be using one of the following nebulizers: Hudston T UP-draft II, Marquest Acorn II, PARI LC Jet+, Pari BABY, Durable Sidestream. (Safety and efficacy have only been shown with these nebulizers). C. AND the patient will be using one of the following compressors: Pulmo-Aide, PARI PRONEB, Mobilair, Porta-Neb. (Safety and efficacy have only been shown with these compressors). D. AND the patient is being treated in a hospital or long-term care facility (LTC) or a skilled-nursing facility (SNF). " AND the payer of the stay is NOT Medicare Part A. ((Medicare Part A can pay for the first 110 days and Pulmozyme would be paid by Medicare Part B. Please verify payer). E. AND/OR the patient is being treated at home. " THEN Pulmozyme is NOT covered. (Patients using a medication with a nebulizer are covered under Medicare Part B). F. AND if the patient has previously received Pulmozyme, he/she must show an improvement in pulmonary function and/or reduction in the frequency of respiratory infections since initiating therapy.

Prior Authorization Group

RANEXA

Drug Names

RANEXA

Covered Uses

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

Exclusion Criteria

NON COVERAGE Ranexa is NOT covered for members with the following criteria: A. If the patient is taking/receiving strong CYP3A inhibitors (eg. ketoconazole, clarithromycin, nelfinavir) B. If the patient is taking/receiving strong CYP3A inducers (eg. rifampin, phenobarbital) C. In patients with clinically significant hepatic impairment.

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation verifying the patient has tried, failed and/or been intolerant (continues to have angina that limits daily activities) to a 30-day trial of a) a nitrate AND either b) a beta blocker OR c) a calcium channel blocker. . a. Betablockers: (eg. Toprol XL, atenolol, Coreg, propranolol, bisoprolol, metoprolol, timolol, acebutolol, nadolol, propranolol). b. Calcium Channel Blocker: (eg. amlodipine, nifedipine, nisoldipine, isradipine, diltiazem, nifedipine, felodipine, verapamil, Norvasc, Exforge, Caduet, Lotrel, Azor). c. Nitrate: (eg. isosorbide, Isordil, Dilatrate SR, Monoket, Ismo, Imdur, nitroglycerin, Nitro-Time).

Age Restrictions

Prescriber Restrictions

Coverage Duration

1 Year

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|-------------------------------------|---|
| Other Criteria | COVERAGE POLICY Ranexa is covered for members who meet the following criteria: A. The diagnosis documented as chronic angina B. patient is NOT currently taking CYP3A inducers (eg, rifampin, rifabutin, rifapentine, phenobarbital, phenytoin, carbamazepine, and St. John's wort) C. Patient is not currently taking strong CYP3A inhibitors (eg, ketoconazole, itraconazole, clarithromycin, nefazodone, nelfinavir, ritonavir, indinavir, and saquinavir) D. Significant Hepatic Impairment is not present (ALT greater than 60 IU/L). |
| Prior Authorization Group | REBIF |
| Drug Names | REBIF, REBIF TITRATION PACK |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D worded as patients with a diagnosis of multiple sclerosis (MS) or have experienced an attack and who are at risk of MS. |
| Exclusion Criteria | Concurrent use of Avonex, Betaseron, Extavia, Copaxone or Tysabri. Coverage not recommended for anything not listed under Covered Uses. |
| Required Medical Information | |
| Age Restrictions | |
| Prescriber Restrictions | Prescribed by or after consultation with a neurologist or an MS specialist. |
| Coverage Duration | Authorization will be for 12 months, unless otherwise specified. |
| Other Criteria | |
| Prior Authorization Group | REGRANEX |
| Drug Names | REGRANEX |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Regranex is NOT covered for members who meet the following criteria: A. Hypersensitivity to any component of the product, including parabens B. Neoplasm at the application site. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation verifying the ulcer extends into subcutaneous tissue and the tissue has adequate blood supply B. Documentation verifying the patient has concurrent good ulcer treatment practices including: a. Debridement b. Pressure relief c. Infection relief C. Documentation verifying the ulcer is less than 10cm ² in size |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 10 weeks |

Other Criteria

COVERAGE POLICY Regranex is covered for members who meet the following criteria: A. Must be used for treatment of lower-extremity diabetic ulcers B. AND the ulcer must extend into subcutaneous tissue C. AND the tissue must have an adequate blood supply D. AND the patient must have concurrent good ulcer treatment practices including ALL of the following: a. Debridgement b. Pressure relief c. Infection relief E. AND the above good ulcer treatment practices must be documented through chart notes F. AND the ulcer must be less than 10 cm² in size G.

Prior Authorization Group

Drug Names

Covered Uses

REMICADE

REMICADE

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

Exclusion Criteria

NON COVERAGE Remicade is NOT covered for members who meet the following criteria: A. Administration of doses greater than 5 mg/kg to patients with moderate to severe heart failure B. Readministration to patients who have experienced a severe hypersensitivity reaction to infliximab C. Known hypersensitivity to inactive components of the product or to any murine proteins.

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. For rheumatoid arthritis 1. Documentation showing the pt has RA 2. Documentation showing that the pt has has tried, failed or intolerant to at least one of the following: Methotrexate, cyclosporine, azathioprine, leflunomide. B. For psoriatic arthritis 1. Documentation showing the pt has at least one of the following symptoms: i. Three (3) or more swollen joints. ii. Three (3) or more tender joints. C. For active ankylosing spondylitis: 1. Documentation showing the pt has tried, failed or intolerant to at least one NSAIDs. D. For plaque psoriasis: 1. Documentation showing the involvement of plaque psoriasis is 10% or greater of the pts total body surface area (BSA) OR the plaque psoriasis must involve areas that will prevent the pt from performing crucial daily functions such as walking (eg. feet). 2. Documentation showing the pt has tried, failed or intolerant to one of the following: High potency topical steroid treatment, Calcipotriene, Phototherapy, Retinoids, Methotrexate, Cyclosporine. E. For Ulcerative Colitis: 1. Documentation showing the pt has tried, failed or intolerant to at least one of the following: mesalamine, methotrexate, mercaptopurine.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Rheumatologist, Dermatologist and Gastroenterology

1 Year

Other Criteria

COVERAGE POLICY Remicade is covered for members who meet the following criteria: 1. Rheumatoid /Psoriatic Arthritis in patients that have tried, failed or intolerant to methotrexate (MTX) OR at least 1 alternative disease modifying antirheumatic drugs (DMARDs) (ex: plaquenil, sulfasalzine, Arava). 2. Juvenile Rheumatoid Arthritis in patients that have tried and failed at least 1 DMARDs (ex: plaquenil, sulfasalzine, Arava). Approve without trying MTX if the patient has an absolute contraindication to MTX (ex: pregnancy, alcoholic liver disease, immunodeficiency syndrome) 3. Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drugs (ex:Ibuprofen, diclofenac), corticosteroids (ex:prednisone), OR sulfasalazine. 4. Plaque Psoriasis in patients that have had chronic conditions for at least 1 year , minimum body surface area (BSA) involvement of greater than or equal to 10% OR involvement of the palms, soles, head, neck or genitalia, tried and failed a topical agent (ex:calcipotriene, tazarotene) AND tried and failed 1 systemic therapy (ex: MTX, azathioprine, cyclosporine, Soriatane) OR phototherapy (UVB, OR oral methoxsalen plus UVA light [PUVA]). 5.Moderate to severe Crohn's Disease or Ulcerative colitis in patients that have tried and failed at least 1 of the following: immunomodulators (ex:MTX, azathioprine), corticosteroids (ex:5-ASA, prednisone), or aminosalicylates(ex:Asacol, Pentasa).

Prior Authorization Group

REMODULIN

Drug Names

REMODULIN

Covered Uses

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

Exclusion Criteria

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis

Age Restrictions

Prescriber Restrictions

Pulmonologist and Cardiologist

Coverage Duration

1 Year

Other Criteria

COVERAGE POLICY Treatment of pulmonary arterial hypertension (PAH) in patients with NYHA Class II-IV symptoms, to diminish symptoms associated with exercise

Prior Authorization Group

RESTASIS

Drug Names

RESTASIS

Covered Uses

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

Exclusion Criteria

NON COVERAGE RESTASIS is NOT covered for members who meet the following criteria: 1.Chronic dry eye as a result of ocular surgical procedures or active ocular infection 2. concurrent use of punctal plugs or ophthalmic anti-inflammatory drugs.

Required Medical Information

Age Restrictions

16 years or older

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|-------------------------------------|--|
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | |
| Prior Authorization Group | REVATIO |
| Drug Names | REVATIO |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Revatio is NOT covered for members with the following criteria: A. IF the patient has any of the following contraindications: current therapy with organic nitrates or known hypersensitivity to sildenafil. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation verifying: a. the patient does NOT have pulmonary veno-occlusive disease (PVOD), (contraindicated). b. the patient will NOT receive combination therapy with a prostacyclin (Ventavis, Remodulin) or an endothelin antagonist (Tracleer) or a phosphodiesterase type-5 inhibitor (Viagra or Letairis) agent. Combination therapy has not been approved by the FDA. (Please verify that the patient is not on duplicate therapy by reviewing the patients drug history or chart). c. the diagnosis is documented as pulmonary arterial hypertension class I-IV defined by the World Health Organization (WHO). d. therapy is being prescribed to improve exercise ability. e. the dose does not exceed 20 mg three times a day. |
| Age Restrictions | 18 years or older |
| Prescriber Restrictions | Pulmonologist and Cardiologist |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Revatio is covered for members who meet the following criteria: treatment of pulmonary arterial hypertension (WHO Group I). WHO Group I includes: Idiopathic PAH, Familial (FPAH), Associated with (APAH) connective tissue disease, Congenital systemic-to pulmonary shunts, Portal Hypertension, HIV Infection, Drugs and toxins, Pulmonary veno-occlusive disease (PVOD), Pulmonary capillary haemangiomas (PCH) or Persistent pulmonary hypertension of the newborn (PPNH). |
| Prior Authorization Group | RIBAVIRIN |
| Drug Names | RIBAVIRIN |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |

Exclusion Criteria

NON COVERAGE Ribavirin is NOT covered for members who meet the following criteria: A. Ribavirin monotherapy for the treatment of chronic hepatitis C virus (HCV) infection. B. Using Ribavirin with other than interferon alfa-2b or peginterferon alfa-2b for treatment of chronic hepatitis C virus (HCV) infection. C. Who meet the following Contraindications and Cautions: 1. Severe thrombocytopenia 2. Decompensated cirrhosis. 3. Pregnancy, or unwillingness to use effective contraception 4. Renal insufficiency 5. Severe heart disease.

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis B. If patient is diagnosed with Hepatitis C: a. Documentation showing Hepatitis C genotype b. Documentation showing baseline HCV RNA levels that are dated within the last 90 days C. If request is for treatment for Hepatitis C beyond initial 12 weeks: a. Documentation of Early Viral Response (EVR) showing at least a 2 log reduction from baseline HCV RNA levels D. If request is for Hepatitis B: a. Documentation of positive HBsAg OR liver biopsy showing chronic hepatitis b. Documentation of Hepatitis B viral load greater than 100000 copies/mL c. Documentation of elevated liver enzymes showing AST greater than 69 units/L AND ALT greater than 71 units/L

Age Restrictions

Prescriber Restrictions

Infectious Disease and Gastroenterology

Coverage Duration

Up to 1 year

Other Criteria

COVERAGE POLICY Ribavirin is covered for members who meet the following criteria: A. May approve the following dosages to through the end of the Contract year or weeks approved of Interferon: Genotype 1, 4 less than 75kg = 1,000mg per day or Genotype 1, 4 greater than 75kg = 1,200mg per day or Genotype 2, 3 800mg per day or Genotype 5, 6 between 800mg and 1,200mg per day or Chronic HCV with HIV coinfection - 800 mg/day tablets or Respiratory syncytial virus infection: (severe cases) 20 mg/mL solution aerosolized over 12-18 hr once daily for 3 to 7 days.

Prior Authorization Group

RITUXAN

Drug Names

RITUXAN

Covered Uses

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

Exclusion Criteria

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation of FDA or compendia approved diagnosis B. For RA, previous trial/failure of at least one of the following: DMARD (ex: Methotrexate, Imuran, Arava) and an inadequate response to either Enbrel or Humira are required. For continuation of RA therapy, improvement in clinical symptoms that may include improvement in tender and swollen joint count, mobility, or stiffness, or delay in progression of disease is required.

Age Restrictions

Prescriber Restrictions
Coverage Duration
Other Criteria

Rheumatologist and Oncologist

6 months

COVERAGE POLICY Rituxan is covered for members who meet the following criteria:

A. Chronic lymphoid leukemia, In combination with fludarabine and cyclophosphamide
B. Microscopic polyarteritis nodosa, In combination with glucocorticoids
C. Non-Hodgkin's lymphoma, Diffuse, large B-cell, CD20-positive, in combination for first-line treatment
D. Non-Hodgkin's lymphoma, Follicular, CD20-positive, B-cell, in combination with first-line chemotherapy and as single-agent maintenance
E. Non-Hodgkin's lymphoma, Low-grade, CD20-positive, B-cell, stable or responsive to prior CVP (cyclophosphamide, vincristine, and prednisone) chemotherapy
F. Non-Hodgkin's lymphoma, Relapsed or refractory, low-grade or follicular, CD20-positive, B-cell
G. Rheumatoid arthritis (Moderate to Severe), In combination with methotrexate, in patients who had an inadequate response to one or more tumor-necrosis-factor antagonist therapies(ex:Enbrel, Humira)
H. Wegener's granulomatosis, In combination with glucocorticoids
I. Other documented Compendia approved diagnosis will be approved.

Prior Authorization Group
Drug Names
Covered Uses

SAIZEN

SAIZEN, SAIZEN CLICK.EASY

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

Exclusion Criteria

NON COVERAGE Saizen is NOT covered for members who meet the following criteria:

A. If the patient has any of the following contraindications: hypersensitivity to somatropin or any of the product excipients, for growth promotion in pediatric patients with epiphyseal closure, active neoplastic disease being treated with chemotherapy or radiation (therapy must be complete), acute critical illness due to complications following open-heart surgery, abdominal surgery or multiple accidental trauma, or those with acute respiratory failure, patients with Prader-Willi syndrome who are severely obese or have severe respiratory impairment.

Required Medical Information

The following chart notes/lab reports are required: A. Documentation showing that the pt does NOT have any evidence of active malignancy. B. For growth hormone deficiency in adults: a. Documentation showing the pt has a neg response to 2 std growth hormone stimulation tests [Max peak less than 5ng/mL by RIA or less than 2.5 ng/mL by IRMA] OR an IGF-1 level that is two std deviations below normal for the pts age group. b. the growth hormone deficiency is due to Pituitary or hypothalamus surgery OR disease OR injury OR Radiation therapy., OR Growth-hormone deficiency during childhood. c. Documentation showing the pt has symptoms of growth hormone deficiency that includes one of the following: i. Reduced bone density of more than 1 standard deviation below the age and gender-specific mean OR Reduced ejection fracture of less than 50%. C. For AIDS wasting or AIDS cachexia: a. Documentation showing the pt has had an involuntary wt loss of more than 10% of pre-illness baseline body weight or body mass index (BMI) less than 20 kg/m² in the absence of a concurrent illness or medical condition other than HIV that may cause wt loss. b. Documentation showing that the pt has failed a 30-day drug regimen of megestrol (Megace) AND anabolic steroid D. For short bowel syndrome: a. Documentation that the pt is receiving specialized nutritional therapy and parental nutrition stable. b. Documentation that the small intestine is less than 200 cm in length and at least 2 months post resection. c. Documentation that the pt has 30% or greater functioning colon with at least 15 cm of intact jejunum or at least 90 cm of intact jejunum and/or ileum. d. Documentation showing that the pt has an intact stomach and duodenum. e. Documentation showing the pt has bilirubin less than 3 X ULN and creatinine less than 3mL/dL. f. If the pt has received previous somatropin therapy, documentation showing a positive response by showing a reduction on their dependence on total parenteral nutrition.

Age Restrictions

Prescriber Restrictions

Coverage Duration

1 Year

Other Criteria

COVERAGE POLICY Saizen is covered for members who meet the following criteria: A For the long-term treatment of pediatric patients who have growth failure due to an inadequate secretion of endogenous growth hormone. B For the long-term treatment of pediatric patients who have growth failure due to Prader-Willi syndrome. C. For long-term replacement therapy in adults with growth hormone deficiency of either childhood or adult-onset etiology. D. For the treatment of short stature associated with Turner syndrome in patients whose epiphyses are not closed. E. For the long-term treatment of idiopathic short stature, also called non-growth hormone deficient short stature, defined by height SDS less than or equal to -2.25 and associated with growth rates unlikely to permit attainment of adult height in the normal range, in pediatric patients whose epiphyses are not closed and for whom diagnostic evaluation excludes other causes associated with short stature that should be observed or treated by other means. F. For replacement of endogenous growth hormone in adults with growth hormone deficiency who meet both of the following 2 criteria: Adult onset: Patients who have growth hormone deficiency either alone, or with multiple disease, hypothalamic disease, surgery, radiation therapy, or trauma. Child onset: Patients who were growth-hormone-deficient during childhood who have growth hormone deficiency confirmed as an adult. G. For the long-term treatment of children with growth failure due to inadequate secretion of endogenous growth hormone. H. For the treatment of growth failure associated with chronic renal insufficiency up to the time of renal transplantation. I. For the long-term treatment of growth failure associated with Turner syndrome. J. For the replacement of endogenous growth hormone in patients with adult growth hormone deficiency who meet both of the following 2 criteria: Adult onset: Patients who have adult growth hormone deficiency either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma. Child onset: Patients who were growth hormone deficient during childhood, confirmed as an adult. K. For the treatment of HIV patients with wasting or cachexia to increase lean body mass and body weight, and improve physical endurance. Concomitant antiretroviral therapy is necessary.

Prior Authorization Group

SAMSCA

Drug Names

SAMSCA

Covered Uses

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

Exclusion Criteria

NON COVERAGE Samsca is NOT covered for members with the following criteria: A. Concurrently taking Ketoconazole B. Patients who are anuric.

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. serum sodium of less than 125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction

Age Restrictions

18 years or older

Prescriber Restrictions

Coverage Duration

Other Criteria

1 Year

COVERAGE POLICY Samsca is covered for members who meet the following criteria:
A. Samsca is approved for the diagnosis of Hypervolemic and euvolemic hyponatremia
B. AND if the medication meets B vs. D determination that the medication should be covered by Medicare Part D. C. AND serum sodium of less than 125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction d. CONFIRM hospitalization for initiation and reinitiation of therapy to evaluate the therapeutic response

Prior Authorization Group

Drug Names

Covered Uses

SANCUSO

SANCUSO

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

Exclusion Criteria

NON COVERAGE Sancuso is NOT covered for members with the following criteria:
A. Known hypersensitivity to granisetron or to any components of the patch.

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation showing that the patient has had a previous trial/failure to oral Ondansetron or Granisetron.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

1 Year

COVERAGE POLICY Sancuso is covered for members who meet the following criteria:
A. Patient must have previous trial/failure on oral Ondansetron OR Granisetron

Prior Authorization Group

Drug Names

Covered Uses

SOMATULINE

SOMATULINE DEPOT

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

Exclusion Criteria

NON COVERAGE Somatuline is NOT covered for members with the following criteria:
A. The diagnosis is NOT documented as acromegaly. B. The patient chart notes do not show an elevated IGF-1 level or growth hormone levels with a glucose tolerance test.
The following copies of chart notes/laboratory reports are required: A. Documentation of IGF-1 standard deviation score of less than -2.9 based on lab reference for age and sex.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

18 years or older

Endocrinologist

1 Year

COVERAGE POLICY Somatuline is covered for members who meet the following criteria: A. Diagnosis is documented as acromegaly B. Determine Part B versus Part D drug status.

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| Prior Authorization Group | SOMAVERT |
| Drug Names | SOMAVERT |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation of IGF-1 standard deviation score of less than -2.9 based on lab reference for age and sex B. Documentation showing liver tests (ALT, AST) have been performed and the upper limit of normal (ULN) is within a range of normal to 3 times ULN C. Documentation that the patient has failed Sandostatin or octreotide or Somatuline (lanveotide) D. Documentation that the patient will not receive combination therapy that can include Sandostatin, octreotide or Somatuline E. Documentation showing a reduction in their initial IGF-1 concentration if the patient has had previous Somavert therapy. |
| Age Restrictions | |
| Prescriber Restrictions | Endocrinologist |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Somavert is covered for members who meet the following criteria: A. Diagnosis is acromegaly B. The patient has tried and failed Sandostatin or octreotide or Somatuline (lanveotide) C. AND the patient will not receive combination therapy that can include Sandostatin, octreotide or Somatuline D. For retreatment, reduction in IGF-1 level from baseline E. Determine Part B versus Part D drug status. |
| Prior Authorization Group | STRATTERA |
| Drug Names | STRATTERA |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Strattera is NOT covered for members who meet the following criteria: A. MAOI concurrent use or within the last 14 days |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Confirm monitoring for suicidality, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, liver injury. |
| Age Restrictions | 6 years of age and older |
| Prescriber Restrictions | |
| Coverage Duration | 1Year |
| Other Criteria | COVERAGE POLICY STRATERA is covered for members who meet the following criteria: A. Confirm FDA approved indications. B. Confirmation patient is stable on therapy. |
| Prior Authorization Group | SUBOXONE |
| Drug Names | SUBOXONE |

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| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Confirm treatment of opioid dependence. B. Confirm narcotic dependence treatment plan. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | May approve up to 3 months or up to 1 year |
| Other Criteria | COVERAGE POLICY Suboxone is covered for members who meet the following criteria: A. Treatment of opioid dependence. |
| Prior Authorization Group | SYMLIN |
| Drug Names | SYMLIN, SYMLINPEN 120, SYMLINPEN 60 |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Symlin is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: cresol hypersensitivity, gastroparesis or hypoglycemia unawareness. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation showing that the patient does not have gastroparesis B. Documentation showing an HbA1c between 7% and 9%. Lab values must be with in the last 3 months C. Documentation showing that the patient is NOT currently receiving a Byetta drug regimen. F. For Type 1 Diabetes, documentation showing the patient has tried and failed insulin therapy G. If the patient has had previous Symlin therapy: Documentation showing that he/she has a reduction in their HbA1c since initiating Symlin therapy. Lab values must be with in the last 3 months. |
| Age Restrictions | 2 years or older |
| Prescriber Restrictions | Endocrinologist |
| Coverage Duration | 1 Year |
| Other Criteria | COVERAGE POLICY Symlin is covered for members who meet the following criteria: A. The patient must have inadequate glycemic control (HbA1c greater than 7% but less than 9%) at initiation of therapy, patient currently receiving optimal mealtime insulin therapy (Type 1 diabetes). |
| Prior Authorization Group | TESTOSTERONE INJECTABLE |
| Drug Names | TESTOSTERONE CYPIONATE, TESTOSTERONE ENANTHATE |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON-COVERAGE Testosterone is NOT covered if indicated or reference to sexual dysfunction diagnosis or to enhance athletic ability or Pregnant. |

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| <i>Required Medical Information</i> | The following copies of chart notes/laboratory reports are required: A. For Replacement Therapy current lab results measuring Testosterone levels (less than 300ng/dL) if new start. |
| <i>Age Restrictions</i> | |
| <i>Prescriber Restrictions</i> | |
| <i>Coverage Duration</i> | 1 Year |
| <i>Other Criteria</i> | COVERAGE POLICY Testosterone is covered for members who meet the following criteria: A. FDA approved indications. B. Drug is being self administered, otherwise is Part B C. If concurrent use inform prescriber of potential Drug Interaction with Anticoagulants (Warfarin), Antidiabetic drugs and insulin, ACTH and corticosteroids, Oxyphenbutazone. |
| <i>Prior Authorization Group</i> | TEV-TROPIN |
| <i>Drug Names</i> | TEV-TROPIN |
| <i>Covered Uses</i> | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| <i>Exclusion Criteria</i> | NON COVERAGE Tev-Tropin is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: hypersensitivity to somatropin or any of the product excipients, for growth promotion in pediatric patients with epiphyseal closure, active neoplastic disease being treated with chemotherapy or radiation (therapy must be complete), acute critical illness due to complications following open-heart surgery, abdominal surgery or multiple accidental trauma, or those with acute respiratory failure, patients with Prader-Willi syndrome who are severely obese or have severe respiratory impairment. |

Required Medical Information

The following chart notes/lab reports are required: A. Documentation showing that the pt does NOT have any evidence of active malignancy. B. For growth hormone deficiency in an adult: a. Documentation showing the pt has a neg response to 2 std growth hormone stimulation tests [Max peak less than 5ng/mL by RIA or less than 2.5 ng/mL by IRMA] OR an IGF-1 level that is two std deviations below normal for the pts age group. b. the growth hormone deficiency is due to Pituitary or hypothalamus surgery OR disease OR injury OR Radiation therapy., OR Growth-hormone deficiency during childhood. c. Documentation showing the pt has symptoms of growth hormone deficiency that includes one of the following: i. Reduced bone density of more than 1 standard deviation below the age and gender-specific mean OR Reduced ejection fracture of less than 50%. C. For AIDS wasting or AIDS cachexia: a. Documentation showing the pt has had an involuntary wt loss of more than 10% of pre-illness baseline body weight or body mass index (BMI) less than 20 kg/m² in the absence of a concurrent illness or medical condition other than HIV that may cause wt loss. b. Documentation showing that the pt has failed a 30-day drug regimen of megestrol (Megace). D. For short bowel syndrome: a. Documentation that the pt is receiving specialized nutritional therapy and parental nutrition stable. b. Documentation that the small intestine is less than 200 cm in length and at least 2 months post resection. c. Documentation that the pt has 30% or greater functioning colon with at least 15 cm of intact jejunum or at least 90 cm of intact jejunum and/or ileum. d. Documentation showing that the pt has an intact stomach and duodenum. e. Documentation showing the pt has bilirubin less than 3 X ULN and creatinine less than 3mL/dL. f. If the pt has received previous somatropin therapy, documentation showing a positive response by showing a reduction on their dependence on total parenteral nutrition.

Age Restrictions**Prescriber Restrictions****Coverage Duration**

Plan Year

Other Criteria

COVERAGE POLICY TEV-TROPIN is covered for members who meet the following criteria: A For the long-term treatment of pediatric patients who have growth failure due to an inadequate secretion of endogenous growth hormone. B For the long-term treatment of pediatric patients who have growth failure due to Prader-Willi syndrome. C. For long-term replacement therapy in adults with growth hormone deficiency of either childhood or adult-onset etiology. D. For the treatment of short stature associated with Turner syndrome in patients whose epiphyses are not closed. E. For the long-term treatment of idiopathic short stature, also called non-growth hormone deficient short stature, defined by height SDS less than or equal to -2.25 and associated with growth rates unlikely to permit attainment of adult height in the normal range, in pediatric patients whose epiphyses are not closed and for whom diagnostic evaluation excludes other causes associated with short stature that should be observed or treated by other means. F. For replacement of endogenous growth hormone in adults with growth hormone deficiency who meet both of the following 2 criteria: Adult onset: Patients who have growth hormone deficiency either alone, or with multiple disease, hypothalamic disease, surgery, radiation therapy, or trauma. Child onset: Patients who were growth-hormone-deficient during childhood who have growth hormone deficiency confirmed as an adult. G. For the long-term treatment of children with growth failure due to inadequate secretion of endogenous growth hormone. H. For the treatment of growth failure associated with chronic renal insufficiency up to the time of renal transplantation. I. For the long-term treatment of growth failure associated with Turner syndrome. J. For the replacement of endogenous growth hormone in patients with adult growth hormone deficiency who meet both of the following 2 criteria: Adult onset: Patients who have adult growth hormone deficiency either alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma. Child onset: Patients who were growth hormone deficient during childhood, confirmed as an adult. K. For the treatment of HIV patients with wasting or cachexia to increase lean body mass and body weight, and improve physical endurance. Concomitant antiretroviral therapy is necessary.

Prior Authorization Group

Drug Names

Covered Uses

TYZEKA

TYZEKA

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

Exclusion Criteria

NON COVERAGE Tyzeka is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: hypersensitivity to telbivudine or any component of the product.

Required Medical Information

The following copies of chart notes/laboratory reports are required: A. Documentation showing the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis. B. Documentation that the patient has a Hepatitis B viral load greater than 100,000 copies per ml. C. Documentation showing the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal. D. Documentation showing the patient has been tested for HIV. E. Documentation showing that the patient is not receiving duplicate therapy that includes Hepsera, Baraclude, Epivir, Intron A and/or Infergen. F. If the patient has received previous Tyzeka treatment, documentation showing a clinical improvement shown by a drop in viral load or reduction in the patients liver aminotransferases.

Age Restrictions

16 years or older

Prescriber Restrictions

Infectious Disease or Gastroenterologist

Coverage Duration

1 Year

Other Criteria

COVERAGE POLICY Tyzeka is covered for members who meet the following criteria: A. The patient has been diagnosed with chronic hepatitis B. B. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis. (Please verify that the patient has a HBsAg serological marker for greater than 6 months or a positive liver biopsy by reviewing the patient s drug history or chart). C. AND the patient has a Hepatitis B viral load greater than 100,000 copies per ml. D. AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal. E. AND the patient has been tested for HIV. (Tyzeka therapy can cause HIV resistance in untreated HIV infection). AND if the patient has received previous Tyzeka treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patient s liver aminotransferases. (Please verify patient s chart notes to verify drop in viral load or reduction in liver aminotransferases from their starting level). F. AND the patient is not receiving duplicate therapy that includes Hepsera, Baraclude, Epivir, Intron A and/or Infergen. (Please verify that the patient does not have duplicate therapy by reviewing the patient s drug history or chart). G. AND evidence of diagnosis, serological markers, liver biopsy, viral load, and liver aminotransferases is documented in patient's chart.

Prior Authorization Group

VANDETANIB

Drug Names

VANDETANIB

Covered Uses

All FDA approved indications not otherwise excluded from Part D

A. Vandetanib is the only agent indicated for the treatment of symptomatic or progressive MTC (Medullary Thyroid Cancer) in patients with unresectable locally advanced or metastatic disease

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| Exclusion Criteria | <p>A. Patients with Congenital Long QT Syndrome; Vandetanib should not be started in patients whose QTcF is greater than 450 ms.</p> <p>B. Vandetanib should not be given to patients who have a history of Torsades de pointes, bradyarrhythmias, or uncompensated heart failure.</p> <p>C. Documentation of Liver Function; Vandetanib is not recommended for use in patients with moderate (Child-Pugh B) and severe (Child-Pugh C) hepatic Impairment (serum bilirubin > 1.5 times the upper limit of normal d.2mg/dl & .1-1mg/dl) Look to lab scales on patients blood work for final range</p> |
| Required Medical Information | <p>"A. Appropriate diagnosis of Unresectable locally advanced or metastatic Medullary Thyroid Cancer</p> <p>B. Patient is registered in REMS Program that includes certified prescribers and pharmacies</p> <p>C. Documentation of no history of Congenital Long QT Syndrome, Torsades depointes, bradyarrhythmias, or uncompensated heart failure</p> <p>D.. Documentation of no Congenital Long QT Syndrome; history of Torsades de pointes, or bradyarrhythmias</p> <p>E. Documentation of kidney function with by Normal Creatinine Clearance; Starting dose should be reduced to 200 mg in patients with moderate (creatinine clearance e 30 to < 50ml/min) and severe (creatinine clearance < 30ml/min) renal impairment</p> <p>F. Documentation of Liver Function"</p> |
| Age Restrictions | 18 years or older |
| Prescriber Restrictions | Oncologist or endocrinologist |
| Coverage Duration | Up to 1 year |
| Other Criteria | <p>A. Normal Dosage is 300mg/day taken orally</p> <p>B. Treatment should be continued until patients are no longer benefiting from treatment or unacceptable toxicity occurs.</p> |
| Prior Authorization Group | VFEND |
| Drug Names | VFEND, VFEND IV, VORICONAZOLE |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | <p>NON COVERAGE Vfend is NOT covered for members who meet the following criteria:</p> <p>A. If the patient is taking/receiving any of the following: Astemizole, Atorvastatin, Barbiturates, Carbamazepine, Cisapride, Ergot Alkaloids, Pimozide, Quinidine, Ranolazine, Red Yeast Rice, Rifabutin, Rifampin, Rifapentine, Ritonavir, Sirolimus, St. John's Wort, Hypericum perforatum, Terfenadine or Vinca alkaloids.</p> |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation showing the patients trial/failure to itraconazole for aspergillosis. B. Documentation showing the patients trial/failure to fluconazole and itraconazole for candidiasis. C. Documentation of diagnosis for furariosis or Scedosporium sp. |

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| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | Up to 1 year |
| Other Criteria | COVERAGE POLICY Vfend is covered for members who meet the following criteria: A. The patient is diagnosed with invasive aspergillosis B. AND the patient has had previous trial and failure or contraindication to itraconazole *If aspergillosis infection is extrapulmonary no previous trial is required C. AND chart notes documenting trial and failure or contraindication to itraconazole are received D. OR the patient is diagnosed with candidiasis E. AND the patient has previous trial and failure or contraindication to BOTH fluconazole and itraconazole F. AND chart notes documenting trial and failure or contraindication to itraconazole are received G. OR the patient is diagnosed with furariosis or Scedosporium sp. H. AND Vfend is being used as salvage therapy due to failure of other therapies I. AND chart notes documenting previous treatment failures is received |
| Prior Authorization Group | VICTOZA |
| Drug Names | VICTOZA |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE: Victoza is not covered for members with the following criteria: 1. Personal or family history of medullary thyroid carcinoma (MTC) 2. Multiple Endocrine Neoplasia syndrome type 2 (MEN 2) |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Diagnosis of type 2 diabetes mellitus B. Patient has tried, failed or been intolerant to two of the following: metformin, sulfonylurea, Thiazolidinedione C. Confirm not using as first-line agent in patients who have inadequate glycemic control on diet and exercise . |
| Age Restrictions | 18 years or older |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |
| Other Criteria | |
| Prior Authorization Group | VISTIDE |
| Drug Names | VISTIDE |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Vistide is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: breast-feeding, ocular exposure, probenecid hypersensitivity, proteinuria, renal disease, renal failure, renal impairment, sulfonamide hypersensitivity or pregnancy. B. If the patient is taking/receiving any of the following: Aminoglycosides, Amphotericin B, Foscarnet, Nonsteroidal antiinflammatory drugs (NSAIDs), Pentamidine, Tacrolimus or Vancomycin. |

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| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation that the patient is not taking Aminglycosides, Amphotericin B, NSAIDs, Foscarnet, Pentamidine, Tacrolimus and Vancomycin |
| Age Restrictions | |
| Prescriber Restrictions | Infectious Disease |
| Coverage Duration | 3 months |
| Other Criteria | COVERAGE POLICY Vistide is covered for members who meet the following criteria: A. Patient is diagnosed with approved indication as stated above B. AND patient has AIDS C. AND (in prophylaxis patients) CD4+ count is Less than 100-150 cells/ mm ³ E. AND B vs. D criteria indicates that coverage should be through Medicare Part D |
| Prior Authorization Group | XENAZINE |
| Drug Names | XENAZINE |
| Covered Uses | All FDA-approved indications not otherwise excluded from Part D. Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Primary hyperkinetic dystonia. Hemiballism. |
| Exclusion Criteria | Coverage is not recommended for circumstances not listed in the Covered Uses. |
| Required Medical Information | |
| Age Restrictions | |
| Prescriber Restrictions | For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, primary hyperkinetic dystonia, or hemiballism, Xenazine must be prescribed by or after consultation with a neurologist. For TD, Xenazine must be prescribed by or after consultation with a neurologist or psychiatrist. |
| Coverage Duration | Authorization will be for 12 months, unless otherwise specified. |
| Other Criteria | |
| Prior Authorization Group | XGEVA |
| Drug Names | XGEVA |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE XGEVA is NOT covered for members who meet the following criteria: A. Experimental or investigational use for the following indications: 1. Bone loss associated with hormone-ablation therapy in breast or prostate cancer 2. Giant cell tumor of bone 3. Multiple Myeloma 4. Osteogenesis imperfect 5. Primary bone sarcomas (Ewing's Sarcoma and Osteosarcoma) 6. Rheumatoid arthritis 7. Hypocalcemia" |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Chart notes and lab reports that confirm bone metastases from solid tumors (ie breast cancer, prostate cancer) |
| Age Restrictions | 18 years or older |
| Prescriber Restrictions | |
| Coverage Duration | 1 Year |

Other Criteria

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| Prior Authorization Group | XIFAXAN |
| Drug Names | XIFAXAN |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE XIFAXAN is NOT covered for members who meet the following criteria: 1. Hypersensitivity reaction to rifamycin antimicrobial agents 2. For hepatic encephalopathy, goeses that exceed two 550mg tablets daily. |
| Required Medical Information | |
| Age Restrictions | Hepatic encephalopathy:18 yrs or older;Traveler's diarrhea:12yrs or older |
| Prescriber Restrictions | |
| Coverage Duration | Hepatic encephalopathy-6 months |
| Other Criteria | |

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| Prior Authorization Group | XOLAIR |
| Drug Names | XOLAIR |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Xolair is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: hamster protein hypersensitivity or omalizumab hypersensitivity. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation of the patients peak expiratory flow [PEF] before and after bronchodilator challenge. B. Documentation showing that the patient has tested positive to a perennial aeroallergen skin test. C. Documentation showing that the patients baseline IgE is between 30 and 700 IU/ mL. D. Documentation showing that the patient has been compliant and maintained on standard inhaled corticosteroid therapy for at least 6-months and still remains inadequately controlled. E. Documentation showing that the patient has had a 3-month trial and failure or intolerant to a long acting beta agonist agent that can Include Symbicort, Foradil, Serevent, or Advair. F. Documentation showing that the patient has experienced a reduction in symptoms and improvement in their FEV1 or PEF before initiation of re-treatment. |
| Age Restrictions | 12 years or older |
| Prescriber Restrictions | Pulmonologist, allergist, or immunologist |
| Coverage Duration | 1 Year |
| Other Criteria | |

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| Prior Authorization Group | XYREM |
| Drug Names | XYREM |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |

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| Exclusion Criteria | NON COVERAGE XYREM is NOT covered for members with the following criteria: A.Succinic semialdehyde dehydrogenase deficiency B.if the patient is taking/receiving any of the following: anxiolytics, sedatives, hypnotics, barbiturates, benzodiazepines or ethanol. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. The diagnosis is documented as excessive daytime sleepiness with symptoms that limit their ability to perform normal daily activities. B. AND the diagnosis is documented as cataplexy (a condition characterized by weak or paralyzed muscles) in patients with narcolepsy. C. AND if the patient has received prior treatment with Xyrem, the patient must experience a decrease in daytime sleepiness and/or cataplexy in a narcoleptic patient. |
| Age Restrictions | |
| Prescriber Restrictions | |
| Coverage Duration | 3 months |
| Other Criteria | |
| Prior Authorization Group | ZAVESCA |
| Drug Names | ZAVESCA |
| Covered Uses | FDA approved indications A. All FDA approved indications not otherwise excluded from Part D |
| Exclusion Criteria | NON COVERAGE Zavesca is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: pregnancy, labor, obstetric delivery or renal failure. |
| Required Medical Information | The following copies of chart notes/laboratory reports are required: A. Documentation showing that the diagnosis has been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%. B. Documentation showing that the patient has a hemoglobin concentration above 9 g/dL or a platelet count above 50 x10 ⁹ /L or active bone disease. C. Documentation showing that the patient has tried and failed enzyme replacement therapy. D. If the patient is female and of childbearing years, documentation showing that she is NOT pregnant, has NO plans for pregnancy, is on a form of contraception or has NO ability to conceive and has been educated on the potential dangers of Zavesca therapy. E. If the patient has previously received 24 months of Zavesca therapy, documentation showing that they show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration. |
| Age Restrictions | 18 years or older |
| Prescriber Restrictions | Endocrinologist |
| Coverage Duration | 1 Year |

Other Criteria

COVERAGE POLICY Zavesca is covered for members who meet the following criteria: A. Diagnosis is documented as mild-to-moderate type-1 Gaucher disease. B. AND diagnosis has been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%. C. AND the patient has a hemoglobin concentration above 9 g/dL or a platelet count above 50 x10⁹/L or active bone disease. (Zavesca has not been evaluated in patients with severe disease). D. AND the patient has tried and failed enzyme replacement therapy (e.g. Ceredase, Cerezyme) or is not a therapeutic option (e.g. allergy, hypersensitivity). (Please verify trial in the patient s drug history or chart). E. AND if the patient is female and of childbearing years, she is NOT pregnant, has NO plans for pregnancy, is on a form of contraception or has NO ability to conceive and has been educated on the potential dangers of Zavesca therapy. F. AND if the patient has previously received 24 months of Zavesca therapy, they must show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration.

Prior Authorization Group

ZYTIGA

Drug Names

ZYTIGA

Covered Uses

"All FDA approved indications not otherwise excluded from Part D

A. Treatment of metastatic castration-resistant prostate cancer who have received prior chemotherapy containing docetaxel."

Exclusion Criteria

Required Medical Information

"A. Confirmation of diagnosis of metastatic castration-resistant prostate cancer who have received prior chemotherapy containing docetaxel.

B. Confirm co-administration with prednisone"

Age Restrictions

18 years or older

Prescriber Restrictions

Oncologist, Urologist, or other qualified provider

Coverage Duration

1yr; 1 wk approvals to insure tolerability,safety,efficacy; Copay applies only to 1st fill ea mo

Other Criteria

Prior Authorization Group

ZYVOX

Drug Names

ZYVOX

Covered Uses

All FDA-approved indications not otherwise excluded from Part D plus patient already started on linezolid or intravenous vancomycin.

Exclusion Criteria

Pseudomembranous colitis. Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

VRE, cultures must be done. Methicillin-resistant Staphylococcus, cultures must be done. For patients already started on linezolid, approve oral linezolid for patients already started in hospital, or other inpatient facility, or as an outpatient on intravenous linezolid (which is now being switched to oral linezolid for continuation of therapy). For patients already started on linezolid, approve oral linezolid for patients already started in hospital or other inpatient facility on oral linezolid (to allow continuation of therapy).

Age Restrictions

Prescriber Restrictions

For non-FDA-approved indications, linezolid must be prescribed by, or after consultation with, an infectious disease physician.

Authorization will be for one fill up to one month.

Coverage Duration

Other Criteria

Approve linezolid for use in other infections that are resistant to other antibiotics, but the identified organism(s) is/are susceptible to linezolid. For safety reasons, if there is insufficient information available to make a determination regarding coverage and the prescribing physician or representative of the physician cannot be contacted, then approve.