Medicare Part D

Prior Authorization Requirements

The medications in this document have requirements that must be met for coverage on our Medicare plans to be considered.

A Health plan with a Medicare contract
A Medicare-approved Part D sponsor

Contract Year: 2011
Last Updated: 12/2011

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ACTEMRA

Drugs
Actemra

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

Exclusion Criteria
N/A

Required Medical Information
Rheumatoid arthritis(RA)-diagnosis established a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate alone is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation AND infliximab(Remicade®)or etanercept(Enbrel®) or adalimumab(Humira®) was not effective after a minimum 12 week treatment course unless not tolerated due to documented clinical side effects AND ANC(absolute neutrophil count) is greater than 2000mm3 and platelet count is greater than 100,000mm3 and patient AST(SGOT) or ALT (SGPT) is less than 1.5 times the upper limit of normal.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
6 months initially then annually

Other Criteria
N/A

ACTONEL

Drugs
Actonel

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Generic oral bisphosphonate (such as alendronate) has not been tolerated or is contraindicated.

AFINITOR

Drugs
Afinitor

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of renal cell carcinoma where sunitinib(Sutent®) has not been effective.

Age Restriction
N/A

Prescriber Restriction
Oncologist

Coverage Duration
12 months

Other Criteria
N/A

AMEVIVE

Drugs
Amevive

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

Exclusion Criteria
N/A

Required Medical Information
Documented diagnosis of chronic plaque psoriasis involving a minimum of 10% of body surface area (or documentation of significant functional impairment) AND treatment with phototherapy or photochemotherapy was ineffective, not tolerated or contraindicated AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated.

Age Restriction
N/A

Prescriber Restriction
Dermatologist

Coverage Duration
12 weeks

Other Criteria
N/A

AMPYRA

Drugs
Ampyra

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

Exclusion Criteria
N/A

Required Medical Information
Documentation that the following criteria have been met: adult with a diagnosis of multiple sclerosis AND dalfampridine is being used for improvement of speed of ambulation AND the patient has the ability to ambulate at least 25 feet AND there is documentation of significant limitations of instrumental activities of daily living (for example, meal preparation, household chores) attributable to slow ambulation (intermittent occupational tasks that are not required as a daily part of job functioning are not considered instrumental activities of daily living).

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
Initial-3 months then annually

Other Criteria
Continued authorization or re-authorization (after the initial 3-month period) shall be reviewed at least annually. Clinical documentation indicating that the functional impairment resolved as a result of increased speed of ambulation, resulting in the member being able to complete instrumental activities of daily living, must be provided.

ANGIOTENSIN II RECEPTOR ANTAGONISTS

Drugs
Benicar, Benicar HCT, Micardis, Micardis HCT

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Treatment with one generic renin-angiotensin inhibitor ineffective, not tolerated or contraindicated.

ANTIDEPRESSANTS

Drugs
Cymbalta, Pristiq, Viibryd

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Treatment with two generic or preferred brand alternatives have been ineffective, not tolerated or contraindicated.

ANTINEOPLASTICS

Drugs
Alimta, AVASTIN, Herceptin, Rituxan

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of diagnosis.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

ARCALYST

Drugs
Arcalyst

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

Exclusion Criteria
N/A

Required Medical Information
There is laboratory evidence of a genetic mutation in CIAS1, also known as NLRP-3 AND there is clinical documentation that the patient is experiencing the classic symptoms of CAPS in either: Familial Cold Auto-Inflammatory Syndrome (FCAS) including recurrent intermittent episodes of fever and rash that primarily followed natural, artificial or both types of generalized cold exposure OR Muckle-Wells Syndrome (MWS), a syndrome of chronic fever and fever that may wax and wane in intensity AND there is clinical documentation of significant functional impairment leading resulting in significant impairment or limitation of activities of daily living(ADLs).

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
Initial-1 month then annually with documentation of disease stability or improvement.

Other Criteria
N/A

ARZERRA

Drugs
Arzerra

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of chronic lymphocytic leukemia where fludarabine and alemtuzumab(Campath®) have been ineffective, not tolerated or contraindicated.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

ATELVIA

Drugs
Atelvia

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Generic oral bisphosphonate (such as alendronate) has not been tolerated or is contraindicated.

BYETTA

Drugs
Byetta

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

Exclusion Criteria
N/A

Required Medical Information
Documented hemoglobin A1C greater than 7% AND a 90 day treatment course with metformin did not adequately reduce the hemoglobin A1c to a goal of 7% or less or was not tolerated or is contraindicated.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

CELEBREX

Drugs
Celebrex

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Used in the treatment of chronic pain and/or inflammation when treatment with at least two generically available prescription nonsteroidal anti-inflammatory drugs (NSAIDs) were ineffective or not tolerated where one of the previously used NSAIDs must be diclofenac, etodolac, nabumetone, salsalate or meloxicam OR used to reduce the number of adenomatous colorectal polyps in familial adenomatous polyposis (FAP) as an adjunct to usual care

CEREZYME

Drugs
Cerezyme

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

Exclusion Criteria
N/A

Required Medical Information
Biochemical assay of glucocerebrosidase activity in WBCs or skin fibroblasts is less than or equal to 30% of normal activity OR genotype mutation of two alleles of the glucocerebrosidase gene AND symptomatic manifestations of the disease are present

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
6 months

Other Criteria
N/A

CHORIONIC GONADOTROPIN

Drugs
chorionic gonadotropin, human, Novarel, Pregnyl

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of diagnosis

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

CRESTOR

Drugs
Crestor

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

Exclusion Criteria
N/A

Required Medical Information
Greater than 40% reduction in LDL is needed OR simvastatin or pravastatin or lovastatin has not achieved the LDL-C target after at least two months of treatment or is not tolerated

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

EGRIFTA

Drugs
Egrifta

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

Exclusion Criteria
N/A

Required Medical Information
Tesamorelin(Egrifta) may be considered medically necessary when: patient is infected with human immunodeficiency virus (HIV) AND there is excess accumulation of fat due to HIV-associated lipodystrophy with the following gender-specific measures: 1. Males: a. waist circumference greater then 37.4 inches (95cm) and b. waist-to-hip ratio greater than 0.94 2. Females: a. waist circumference greater than 37 inches (94cm) and b. waist-to-hip ratio greater than 0.88 AND there is documentation in chart notes that excess accumulation of abdominal fat has impaired function such as significantly limiting instrumental activities of daily living(for example, meal preparation, household chores). Intermittent occupational tasks that are not required as a daily part of job functioning are not considered instrumental activities of daily living AND lateral (side view) photographs including the abdomen are required with the submitted clinical description.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
Initial authorization 6 months then annually

Other Criteria
N/A

ENBREL

Drugs
Enbrel

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

Exclusion Criteria
N/A

Required Medical Information
Psoriatic arthritis-diagnosis established by or in consultation with a rheumatologist or dermatologist. Ankylosing spondylitis-diagnosis established by or in consultation with a rheumatologist. Rheumatoid arthritis(RA) or polyarticular juvenile idiopathic arthritis: diagnosis established by or in consultation with a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation. Chronic plaque psoriasis: Documented diagnosis of chronic plaque psoriasis involving a minimum of 10% of body surface area (or documentation of significant functional impairment) AND treatment with phototherapy or photochemotherapy was ineffective, not tolerated or contraindicated AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated

Age Restriction
N/A

Prescriber Restriction
Chronic Plaque Psoriasis-dermatologist or rheumatologist

Coverage Duration
1 year

Other Criteria
N/A

ERBITUX

Drugs
Erbitux

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

Exclusion Criteria
N/A

Required Medical Information
A diagnosis of advanced (unresectable) or metastatic colorectal cancer (CRC) when no KRAS mutation is present (for use with KRAS wild type tumors only) OR a diagnosis of advanced (unresectable), metastatic, or recurrent squamous cell carcinoma of the head and neck (SCCHN) OR diagnosis of advanced (stage IIIb or IV) non-small cell lung cancer when documentation is provided that the tumor expresses epidermal growth factor receptor (EGFR) AND cetuximab is given in conjunction with a platin (e.g. cisplatin or carboplatin) and vinorelbine AND The patient has not had prior chemotherapy AND there is no known brain metastasis

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

EXTAVIA

Drugs
Extavia

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Treatment with interferon beta-1a(Avonex®) OR interferon beta-1a(Rebif®) OR glatiramer acetate(Copaxone®) is ineffective or not tolerated

FENTANYL

Drugs
fentanyl citrate

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of breakthrough cancer pain AND other generic or preferred brand formulary short acting strong narcotic analgesic alternatives (other than fentanyl) have been ineffective, not tolerated or contraindicated AND patient is opioid tolerant, taking at least the equivalent of 60mg oral morphine sulfate

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
6 months

Other Criteria
N/A

FORTEO

Drugs
Forteo

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

Exclusion Criteria
N/A

Required Medical Information
Bone mineral density that is 2.5 or more standard deviations below that of a young, normal adult(T score at or below -2.5) OR have osteopenia with T-score between -1 and -2.5 and a history of previous fractures or glucocorticoid use for at least 3 months at a dose of 5mg per day of prednisone or equivalent AND at least one bisphosphonate is not effective after minimum 24 month treatment period based on objective documentation unless there is documented bisphosphonate contraindication based on current medical literature or bisphosphonates are not tolerated due to documented clinical side effects

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
One time two year authorization then annually

Other Criteria
N/A

GLEEVEC

Drugs
Gleevec

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of chronic myelogenous leukemia with the presence of the Philadelphia (Ph-1) chromosome, gastrointestinal stromal tumor, relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia, myelodysplastic /myeloproliferative diseases associated with platelet derived growth factor receptor gene arrangements, aggressive systemic mastocytosis without the D816V c-Kit mutation or with c-Kit mutational status unknown, hypereosinophilic syndrome and/or chronic eosinophilic leukemia who have the FIP1L1-PDGFR alpha fusion kinase and for patients with hypereosinophilic and/or chronic eosinophilic leukemia who are FIP1L1-PDGFR alpha fusion kinase negative or unknown, unresectable recurrent and/or metastatic dermatofibrosarcoma protuberans

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

HALAVEN

Drugs
Halaven

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of recurrent or metastatic breast cancer AND at least two prior systemic therapies for metastatic breast cancer have been ineffective or not tolerated. Prior therapies shall include each of the following: 1. A taxane-based chemotherapy regimen [docetaxel (Taxotere) or paclitaxel (Taxol or Abraxane)] AND an anthracycline-based chemotherapy regimen [doxorubicin (Adriamycin, Doxil) or epirubicin (Ellence)].

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

HUMIRA

Drugs
Humira, Humira Crohn's Dis Start Pck

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

Exclusion Criteria
N/A

Required Medical Information
Psoriatic arthritis-diagnosis established by or in consultation with a rheumatologist or dermatologist. Ankylosing spondylitis-diagnosis established by or in consultation with a rheumatologist. Rheumatoid arthritis(RA) or polyarticular juvenile idiopathic arthritis (JIA)-diagnosis established by or in consultation with a rheumatologist or for RA meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND 6-12 week course of methotrexate was ineffective based on documentation which includes one or more of the American College of Rheumatology Assessment Components for improvement in Rheumatoid Arthritis unless methotrexate is contraindicated or not tolerated based on clinical documentation. Crohn's Disease-Fistulizing Crohn's Disease OR acute treatment of an exacerbation when at least one of the three the following criteria is met: treatment with an adequate course of systemic corticosteroids has been ineffective or is contraindicated, patient has been unable to taper off an adequate course of systemic corticosteroids without experiencing worsening of disease, patient is experiencing breakthrough disease while stabilized for at least 2 months on an immunomodulatory medication OR acute and/or maintenance of Crohn's Disease when infliximab has been ineffective or not tolerated. Chronic plaque psoriasis - Documented diagnosis of chronic plaque psoriasis involving a minimum of 10% of body surface area (or documentation of significant functional impairment) AND treatment with phototherapy or photochemotherapy was ineffective, not tolerated or contraindicated AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated AND prescribing physician is a dermatologist or rheumatologist.

Age Restriction
N/A

Prescriber Restriction
Chronic Plaque Psoriasis-dermatologist or rheumatologist

Coverage Duration
Rheumatologic conditions, chronic plaque psoriasis-annually, Crohn's Disease-3 months then annually

Other Criteria
N/A

INCIVEK

Drugs
Incivek

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

Exclusion Criteria
N/A

Required Medical Information
A diagnosis of chronic genotype 1 hepatitis C virus (HCV) infection AND peginterferon and ribavirin will be used in combination with telaprevir AND liver biopsy results are obtained unless liver biopsy is contraindicated or there is documentation of compensated cirrhosis based on imaging studies AND there is documentation that indicates patient has not previously been treated with a protease inhibitor for chronic hepatitis C.

Age Restriction
Minimum 18 years of age

Prescriber Restriction
N/A

Coverage Duration
Initial=8 wks

Other Criteria
Continued Authorization: If HCV RNA is greater than 1,000 IU/mL at week 4 then no additional authorization as treatment is not effective. If HCV RNA less than 1,000 IU/mL at week 4 then 4 additional weeks.

INCRELEX

Drugs
Increlex

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

Exclusion Criteria
N/A

Required Medical Information
Current high measurement at less than 3rd percentile for age and sex AND IGF-1 level greater than or equal to 3 standard deviations below normal AND normal or elevated growth hormone levels based upon at least one growth hormone stimulation test AND open growth plates

Age Restriction
N/A

Prescriber Restriction
Pediatric endocrinologist

Coverage Duration
1 year

Other Criteria
N/A

ISTODAX

Drugs
Istodax

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of cutaneous T-cell lymphoma (CTCL) AND at least two prior systemic therapies for CTCL have been ineffective or not tolerated. Systemic therapies include all-trans retinoic acid (Vesanoid®), bexarotene (Targretin®), bortezomib (Velcade®), chlorambucil (Leukeran®), cyclophosphamide (Cytoxan®), denileukin diftitox (Ontak®), doxorubicin, liposomal (Doxil®), etoposide (VePesid®), gemcitabine (Gemzar®), interferon alfa (Intron A®), isotretinoin, methotrexate, pentostatin, temozolomide (Temodar®) and vorinostat (Zolinza®).

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

JANUVIA/JANUMET

Drugs
Janumet, Januvia

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

Exclusion Criteria
N/A

Required Medical Information
Documented hemoglobin A1C greater than 7% AND treatment with metformin is contraindicated, not tolerated or ineffective in reducing hemoglobin A1C to goal of 7% or less after 90 days of therapy

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

JEVTANA

Drugs
Jevtana

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of metastatic hormone-resistant prostate cancer(mHRPC) AND prior treatment with docetaxel (Taxotere) has been ineffective or not tolerated.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

KINERET

Drugs
Kineret

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

Exclusion Criteria
N/A

Required Medical Information
Rheumatoid arthritis(RA)-diagnosis established by or in consultation with a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate alone is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation AND etanercept or adalimumab was not effective after a minimum 12 week treatment course unless not tolerated due to documented clinical side effects AND therapy does not exceed administration of anakinra 100mg subcutaneously once daily

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

LIPITOR

Drugs
Lipitor

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

Exclusion Criteria
N/A

Required Medical Information
Rosuvastatin (Crestor®) is ineffective at achieving the LDL-C target after at least two months of treatment or is not tolerated AND either the need for greater than 40% LDL-C reduction is documented OR simvastatin or pravastatin or lovastatin has not achieved the LDL-C target after at least two months of treatment or is not tolerated

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

LYRICA

Drugs
Lyrica

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of diagnosis

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Neuropathic pain- when a previous history of adequate treatment courses of at least 30 days with gabapentin AND one tricyclic antidepressant are ineffective unless contraindicated or not tolerated. Fibromyalgia-when a previous history of adequate treatment course of at 30 least days with gabapentin AND either cyclobenzaprine or a tricyclic antidepressant are ineffective unless contraindicated or not tolerated.

NAMENDA

Drugs
Namenda, Namenda Titration Pak

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Treatment with galantamine, oral or transdermal rivastigmine (Exelon®) or donepezil(Aricept®) ineffective, not tolerated or contraindicated.

NASAL CORTICOSTEROIDS

Drugs
Beconase AQ, Nasonex, Omnaris, Rhinocort Aqua, Veramyst

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Treatment with two generic nasal corticosteroids have been ineffective or not tolerated.

NEXAVAR

Drugs
Nexavar

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

Exclusion Criteria
N/A

Required Medical Information
Documented diagnosis of advanced renal cell carcinoma and sunitinib(Sutent®) ineffective, not tolerated or contraindicated OR diagnosis of unresectable hepatocellular carcinoma.

Age Restriction
N/A

Prescriber Restriction
Oncologist

Coverage Duration
1 year

Other Criteria
N/A

NUTROPIN/OMNITROPE

Drugs
Nutropin, Nutropin AQ, Nutropin AQ Nuspin, Omnitrope

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

Exclusion Criteria
N/A

Required Medical Information
Pediatric-Documented GHD defined as two GH stimulation tests below 10ng/ml OR at least one GH stimulation test less than 15ng/ml and IGF-1 and IGF-BP3 levels below normal for bone age and sex OR one GH stimulation test below 10ng/ml for those with defined CNS pathology, history of irradiation, or genetic condition associated with GHD OR growth stimulation hormone tests, IGF-1 or IGF-BP3 levels are not needed for GHD if multiple pituitary hormone deficiencies exist OR for congential GHD. Open growth plates-an initial bone age, demonstration of open growth plates. Short Stature/Growth failure-Height is less than the minimum percentile specified for age/sex OR when the height is below the minimum percentile specified for age/sex and untreated growth velocity with a minimum of 1 year of growth data is below the 25th percentile OR if GHD defined as GH stimulation tests, IGF-1 or IGF-BP3 levels not needed for cogential GHD, growth failure/short stature is not needed. Chronic Renal Insufficiency-requires weekly dialysis OR chronic renal insufficiency defined as glomerular filtration rate (GFR) less than 75ml/min/1.73m2. Pediatric burns-burns over at least 40% of total body surface area. Adults-One pituitary hormone deficiency other than growth hormone requiring hormone replacement AND at least one known cause for pituitary disease or condition affecting pituitary function is documented AND one provocative stimulation test less than 5ng/ml OR three pituitary hormone deficiencies other than growth hormone requiring hormone replacement AND an IGF-1 below 80ng/ml. SBS-ability to ingest solid food AND dependent on parenteral nutrition at least five days per week to provide at least 3000kcal/week AND chart notes indicate dietary needs and goals have been addressed

Age Restriction
N/A

Prescriber Restriction
Pediatrics-pediatric endocrinologist, pediatric nephrologist, trauma/burn surgeon

Coverage Duration
Short bowel syndrome-up to 4 weeks. All other indications-up to1 year

Other Criteria
N/A

ORENCIA

Drugs
Orencia

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

Exclusion Criteria
N/A

Required Medical Information
Polyarticular juvenile idiopathic arthritis (JIA) or rheumatoid arthritis(RA)-diagnosis established by or in consultation with a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis for RA AND treatment with methotrexate has been ineffective after 6-12 weeks based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis or not tolerated or contraindicated based on clinical documentation

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
6 months initially then 1 year

Other Criteria
N/A

Drugs

AccuNeb, acetylcysteine, Adriamycin PFS, albuterol sulfate, Aminosyn 10 %, Aminosyn 3.5 %, Aminosyn 5 % (sulfite-free), Aminosyn 7 %, Aminosyn 7 % with Electrolytes, Aminosyn 8.5 %, Aminosyn 8.5 %-Electrolytes, Aminosyn II 10 %, Aminosyn II 15%, Aminosyn II 3.5 %/Dextrose 5 %, Aminosyn II 3.5 %-Dextrose 25%, Aminosyn II 3.5% M/Dextrose 5%, Aminosyn II 3.5%-Lytes-Ca-D25W, Aminosyn II 4.25%/Dextrose 20%, Aminosyn II 4.25%-Dextrose 10%, Aminosyn II 4.25%-Dextrose 25%, Aminosyn II 4.25%-Lytes-Ca-D25, Aminosyn II 5%/Dextrose 25%, Aminosyn II 7 %, Aminosyn II 8.5 %, Aminosyn II 8.5 %-Electrolytes, Aminosyn M 3.5 %, Aminosyn-HBC 7%, Aminosyn-HF 8 %, Aminosyn-PF 10 %, Aminosyn-PF 7 % (Sulfite-Free), Anzemet, Aranesp (polysorbate), Atgam, atropine, Azasan, azathioprine, azathioprine sodium, Brovana, budesonide, Busulfex, Calcijex, calcitriol, Camptosar, Carnitor, CellCept, CellCept Intravenous, cladribine, Clinimix 2.75%/D5 Sulfite Free, Clinimix 4.25%/D5 Sulfite Free, Clinimix 4.25/D10 Sulfite Free, Clinimix 4.25/D20 Sulfite Free, Clinimix 4.25/D25 Sulfite Free, Clinimix 5%/D15 Sulfite Free, Clinimix 5%/D20 Sulfite Free, Clinimix 5%/D25 Sulfite Free, Clinimix E 2.75/D10 SulfitFree, Clinimix E 2.75/D5 SulfiteFree, Clinimix E 4.25/D25 SulfitFree, Clinimix E 4.25/D5 SulfiteFree, Clinimix E 5%/D15 Sulfite Free, Clinimix E 5%/D20 Sulfite Free, Clinimix E 5%/D25 Sulfite Free, Clinisol SF 15%, cromolyn, CUBICIN, cyclophosphamide, cyclosporine, cyclosporine modified, cytarabine, cytarabine (PF), Dacogen, Doxil, doxorubicin, DuoNeb, Eloxatin, Emend, EMLA, Engerix-B (PF), Epogen, Etopophos, etoposide, fluorouracil, Freamine HBC 6.9 %, Freamine III 3 %-Electrolytes, Freamine III 8.5 %, Gengraf, granisetron, Granisol, Hectorol, Hepatamine 8%, Hepatasol 8 %, Hycamtin, Imuran, Intralipid, ipratropium bromide, ipratropium-albuterol, irinotecan, Ixempra, Leustatin, levalbuterol HCl, levocarnitine, levocarnitine (with sucrose), lidocaine (PF), lidocaine HCl, lidocaine-prilocaine, Liposyn II, Liposyn III, Miacalcin, mycophenolate mofetil, Myfortic, Nebupent, Neoral, Nephramine 5.4 %, nicardipine, Novamine 15 % (Hospira), Nulojix, ondansetron, ondansetron HCl, Orthoclone OKT3, oxaliplatin, Perforomist, Premasol 10 %, Premasol 6 %, Procalamine 3%, Procrit, Prograf, Prosol 20%, Pulmicort, Pulmozyme, Rapamune, Recombivax HB (PF), Renamin 6.5 %, Rocaltrol, Sandimmune, tacrolimus, Thymoglobulin, Tobi, Toposar, topotecan, TPN Electrolytes, Travasol 10 %, Treanda, TrophAmine 10 %, Trophamine 6%, vancomycin, Ventavis, vinblastine, Virazole, Xopenex, Xylocaine, Zemplar, Zortress

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 Restriction

Prescriber Restriction

Coverage Duration

Other Criteria

PEGASYS

Drugs
Pegasys, Pegasys Convenience Pack

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

Exclusion Criteria
N/A

Required Medical Information
Chronic hepatitis C in combination with ribavirin-hepatitis C viral RNA levels are greater than 50IU/ml AND has not received previous treatment with peginterferon. Chronic hepatitis C-ribavirin contraindicated AND detectable hepatitis C RNA levels are greater than 50IU/ml AND has not received previous treatment with peginterferon. Chronic hepatitis B-confirmed diagnosis of compensated hepatitis B AND has not received previous treatment with peginterferon

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
Genotype 2,3-24 weeks, not 2,3 -12wks then 36wks, ribavirin contraindicated/HIV+-48wks, hep B-48wks

Other Criteria
N/A

PEGINTRON

Drugs
PegIntron, PegIntron Redipen

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

Exclusion Criteria
N/A

Required Medical Information
Chronic hepatitis C in combination with ribavirin-hepatitis C viral RNA levels are greater than 50IU/ml AND has not received previous treatment with peginterferon. Chronic hepatitis C-ribavirin contraindicated AND detectable hepatitis C viral RNA levels are greater than 50IU/ml AND has not received previous treatment with peginterferon.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
Genotype 2,3-24 weeks,genotype not 2,3-12 weeks then 36 wks,ribavirin contraindicated/HIV+-48 wks

Other Criteria
N/A

PITUITARY

Drugs
Genotropin, Genotropin Miniquick, Humatrope, Norditropin FlexPro, Norditropin Nordiflex, Saizen, Saizen click.easy, Serostim, Tev-Tropin, Zorbtive

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

Exclusion Criteria
N/A

Required Medical Information
Adult and Pediatric-Omnitrope and Nutropin products have not been tolerated AND documented Pediatric-GHD defined as two GH stimulation tests below 10ng/ml OR at least one GH stimulation test less than 15ng/ml and IGF-1 and IGF-BP3 levels below normal for bone age and sex OR one GH stimulation test below 10ng/ml for those with defined CNS pathology, history of irradiation, or genetic condition associated with GHD OR growth stimulation hormone tests, IGF-1 or IGF-3 levels are not needed for GHD if multiple pituitary hormone deficiencies exist OR for congential GHD. Open growth plates-an initial bone age, demonstration of open growth plates. Short Stature/Growth failure-Height is less than the minimum percentile specified for age/sex OR when the height is below the minimum percentile specified for age/sex and untreated growth velocity with a minimum of 1 year of growth data is below the 25th percentile OR if GHD defined as GH stimulation tests, IGF-1 or IGF-BP3 levels not needed for cogential GHD, growth failure/short stature is not needed. Chronic Renal Insufficiency-requires weekly dialysis OR chronic renal insufficiency defined as glomerular filtration rate (GFR) less than 75ml/min/1.73m2. Pediatric burns-burns over at least 40% of total body surface area. Adults-One pituitary hormone deficiency other than growth hormone requiring hormone replacement AND at least one known cause for pituitary disease or condition affecting pituitary function is documented AND one provocative stimulation test less than 5ng/ml OR three pituitary hormone deficiencies other than growth hormone requiring hormone replacement AND an IGF-1 below 80ng/ml.SBS-ability to ingest solid food AND dependent on parenteral nutrition at least five days per week to provide at least 3000kcal/week AND chart notes indicate dietary needs and goals have been addressed

Age Restriction
N/A

Prescriber Restriction
Children-pediatric endocrinologist, pediatric nephrologist or trauma/burn surgeon

Coverage Duration
Short bowel syndrome-up to 4 weeks. All other indications- up to 1 year.

Other Criteria
N/A

PROMACTA

Drugs
Promacta

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of chronic ITP made by or in consultation with a hematologist AND patient is at risk of spontaneous bleeding as demonstrated in chart notes by either platelet count less than 20,000mm3 or platelet count less than 30,000/mm3 accompanied by symptoms of bleeding AND treatment with at least one of the following ITP treatments was ineffective or not tolerated: adequate course of systemic corticosteroids or immunoglobulin replacement therapy or splenectomy.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
Initial-3 months then every 6 months

Other Criteria
N/A

PROTON PUMP INHIBITORS

Drugs
Dexilant, lansoprazole, omeprazole-sodium bicarbonate

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Treatment with prescription omeprazole has been ineffective, not tolerated or is contraindicated.

PROVIGIL

Drugs
Provigil

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

Exclusion Criteria
N/A

Required Medical Information
Excessive sleepiness associated with narcolepsy when at least one generic or preferred brand medication has been ineffective or not tolerated OR documentation of residual excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome and documented compliance with CPAP or BiPAP for at least 2 months OR excessive sleepiness associated with shift-work disorder when diagnosis is made using the criteria from International Classification of Sleep Disorders AND sleep disturbance causes measurable functional impairment in social, occupational or other important areas of functioning that has persisted for at least three months AND sleep disturbance is not due to otherwise reversible conditions AND non-pharmacologic therapies have been inadequate in improving functional impairments.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
Narcolepsy and shift work disorder-1 year. Obstructive sleep apnea/hypoapnea-6 months then annually

Other Criteria
N/A

QUALAQUIN

Drugs
Qualaquin

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

Exclusion Criteria
N/A

Required Medical Information
Documented diagnosis of uncomplicated malaria due to Plasmodium falciparum

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
7 days

Other Criteria
N/A

RELISTOR

Drugs
Relistor

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of opioid-induced constipation where an adequate trial of a prescribed bowel regimen has been ineffective AND patient has an advanced medical illness with a a life expectancy of less than 6 months and is enrolled in a hospice program or meets hospice criteria AND patient is receiving chronic opioid therapy

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
Up to 4 months

Other Criteria
N/A

REMICADE

Drugs
Remicade

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

Exclusion Criteria
N/A

Required Medical Information
RA-diagnosed by or in consultation with a rheumatologist AND 6-12 week course of methotrexate ineffective alone AND infliximab administered with methorexate(MTX). Psoriatic arthritis-diagnosed by or in consultation with a rheumatologist or dermatologist. Ankylosing spondylitis-diagnosed by or in consultation with a rheumatologist. Crohn's Disease and ulcerative colitis-fistulizing Crohn's disease OR acute treatment of an exacerbation of Crohn's disease or ulcerative colititis where adequate course of systemic corticosteroids ineffective or contraindicated OR unable to taper off an adequate course of systemic corticosteroids without worsening or symptoms OR breakthrough disease while stabilized for at least 2 months on an immunomodulatory medication. Plaque psoriasis-Documented diagnosis of chronic plaque psoriasis involving a minimum of 10% of body surface area (or documentation of significant functional impairment) AND treatment with phototherapy or photochemotherapy was ineffective, not tolerated or contraindicated AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated

Age Restriction
N/A

Prescriber Restriction
Plaque psoriasis-dermatologist or rheumatologist

Coverage Duration
Initial authorization-6 months then continued authorization 1 year

Other Criteria
N/A

REVATIO

Drugs
Revatio

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of diagnosis

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

REVLIMID

Drugs
REVLIMID

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

Exclusion Criteria
N/A

Required Medical Information
Myelodysplastic syndrome-patient is transfusion dependent AND has an absolute neutrophil count of at least 500/mm3 AND has a platelet count of at least 50,000/mm3. Multiple Myeloma-lenalidomide is used in combination with dexamethasone AND patient has an absolute neutrophil count of at least 1,000/mm3 AND patient has a platelet count of at least 30,000/mm3

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
MDS-Initially 3 months then yearly. MM-1 year

Other Criteria
N/A

SERUM IMMUNOGLOBULINS GAMMA

Drugs
Carimune NF Nanofiltered, Gammagard Liquid, Gammaplex, Gamunex, Hizentra, Privigen, Vivaglobin

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

Exclusion Criteria
N/A

Required Medical Information
Acquired Factor VIII inhibitor-cyclophosphamide, corticosteroids or azathioprine is ineffective or not tolerated. Autoimmune hemolytic anemia-patient is diagnosed with warm type AIHA that does not respond to corticosteroids, immunosuppressive agents, plasmapheresis, or splenectomy. Dermatomyositis-documented EMG abnormalities and/or increased CPK levels with associated severe disability when corticosteroid therapy is ineffective or not tolerated. Fetal alloimmune thrombocytopenia-documented diagnosis. HIV infected children(less than 13 years of age) when T4 cell count is greater than 200/mm3. Hypogammaglobulinemia(acquired) associated with either chronic B-cell lymphocytic leukemia or post allogeneic bone marrow transplant and documented with laboratory findings. Hypogammaglobulinemic neonates-low birth weight(less than 1500g) or in a setting with high baseline infection rate. Inflammatory demyelinating polyneuropathy(acute) including Guillain-Barre' syndrome with deteriorating pulmonary function tests OR rapid deterioration with symptoms for less than 2 weeks OR rapidly deteriorating ability to ambulate OR inability to walk independently for 10 meters. Inflammatory demyelinating polyneuropathy(chronic, CIDP) with significant functional disability AND documentation of slowing of nerve conduction velocity on EMG/NCS AND documentation of elevated spinal fluid protein on lumbar puncture or a nerve biopsy confirming diagnosis. Acute ITP-when rapid increase in platelet count is necessary such as acute bleeding episode or prior to surgery. Chronic ITP-platelet count is less than 30,000 cells/mm3 in children or less than 20,000 cells/mm3 in adults.

Age Restriction
Allogeneic bone marrow transplant recipients- 20 years of age or older. HIV infected children-less than 13 years of age

Prescriber Restriction
N/A

Coverage Duration
2 weeks to 1 year depending on diagnosis

Other Criteria

ITP in pregnancy-refractory to steroids with platelet counts less than 10,000cells/mm3 in the third trimester OR platelet counts less than 30,000/mm3 associated with bleeding before vaginal delivery of C-section OR history of autoimmune thrombocytopenia during a previous pregnancy OR platelet counts less than 50,000/mm3 during current pregnancy OR past history of splenectomy. Kawasaki syndrome-during first 10 days of diagnosis. Lambert-Eaton myasthenic syndrome-when pyridostigmine bromide, azathioprine or prednisone are ineffective or not tolerated. Multifocal motor neuropathy-in patient with anti-GM1 antibodies and conduction block. Multiple myeloma-patients with stable disease and high risk of recurrent infections despite prophylactic antibiotic therapy, patients with poor IgG response to the pneumococcal vaccine or have low normal IgG levels during acute sepsis episodes. Myasthenia gravis-treatment of severe decompensation or chronic decompensation when plasmapheresis, pyridostigmine, azathioprine, cyclosporine, or cyclophosphamide is ineffective or not tolerated. Pediatric intractable epilepsy in candidates for surgical resection-when anticonvulsant medications, ketogenic diets, or corticosteroids is ineffective or not tolerated. Polymyositis-patients with severe active illness when corticosteroid therapy , azathioprine, methotrexate, or cyclophosphamide has been ineffective or not tolerated. Post transfusion purpura-severly affected patients. Primary humoral immunodeficiency diseases with documented laboratory findings including X-linked agammaglobulinemia diagnosis accompanied by marked deficits or absence of all five immunoglobulin classes, decreased circulating B lymphocytes and normal numbers of functioning T lymphocytes OR hypogammaglobulinemia OR common variable immunodeficiency documented with low to normal IgG levels and inability to produce an antibody response to protein or carbohydrate antigens OR immunoglobulin subclass deficiency accompanied by very low serum IgG, IgA and IgE with normal or elevated IgM OR combined immunodeficiency syndromes including Wiskott-Aldrich accompanied by marked deficits in IgG, IgA, IgM, low lymphocyte counts and absent or below normal levels of both B and T lymphocytes. Pure red cell aplasia with documented parvovirus B19 infection and severe anemia. Refractory pemphigus foliaceus resistant to immunosuppressive agents or plasmapheresis. Solid organ transplant in treatment of antibody-mediated rejection-prior to transplant patient at high risk for anti-body mediated rejection OR following a solid organ transplant. Stiff-Person Syndrome-when treatment with diazepam, baclofen, clonazepam, valproic acid, or clonidine is ineffective or not tolerated. Systemic lupus erythematosus-severe active disease when corticosteroids, cyclophosphamide or azathioprine are ineffective or not tolerated.

SPRYCEL

Drugs
Sprycel

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of chronic myelogenous leukemia, Philadelphia chromosome positive acute lymphoblastic leukemia resistant or intolerant to treatment with imatinib(Gleevec®).

Age Restriction
N/A

Prescriber Restriction
Hematologist or oncologist

Coverage Duration
1 year

Other Criteria
N/A

SUBOXONE

Drugs
Suboxone

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

Exclusion Criteria
N/A

Required Medical Information
Documentation that diagnosis of opioid dependence has been established AND the prescribing provider has a valid DATA waiver.

Age Restriction
N/A

Prescriber Restriction
Provider has valid DATA waiver

Coverage Duration
1 year

Other Criteria
N/A

SUTENT

Drugs
Sutent

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of gastrointestinal stromal tumor or renal cell carcinoma

Age Restriction
N/A

Prescriber Restriction
Hematologist or oncologist

Coverage Duration
1 year

Other Criteria
N/A

SYLATRON

Drugs
Sylatron

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

Exclusion Criteria
N/A

Required Medical Information
Documentation Sylatron is being used for the adjuvant treatment (after surgery) of malignant melanoma.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

SYNAGIS

Drugs
Synagis

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

Exclusion Criteria
N/A

Required Medical Information
Infants with bronchopulmonary dysplasia who are less than 2 years of age at the start of RSV season and who have required medical therapy for bronchopulmonary dysplasia within 6 months or during the RSV season and infants that required treatment with supplemental oxygen as neonates for at least 28 days OR infants less than or equal to 6 months of chronological age at the onset of RSV season and history of premature birth between 32 1/7 weeks to 35 0/7 weeks gestation who have two or more of the following risk factors: childcare attendance, school aged siblings, exposure to environmental air pollutants, congential abnormalities of the airways, severe neuromuscular disease OR infants less than or equal to 6 months chronological age at the onset of RSV season with a history of premature birth between 29 0/7 to 32 0/7 weeks with or without the presence of additional risk factors OR infants less than or equal to 12 months chronological age at the onset of RSV season and born at 28 6/7 weeks of gestation or earlier OR infants or children at the onset of RSV season are younger than 24 months of age with hemodynamically significant congenital heart disease or an infant younger than 12 months of age with congenital heart disease who: receive medication to control congestive heart failure or have moderate to severe pulmonary hypertension or have cyanotic heart disease

Age Restriction
Younger than 24 months

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
N/A

TARCEVA

Drugs
Tarceva

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

Exclusion Criteria
N/A

Required Medical Information
Locally advanced or metastatic non-small cell lung cancer where at least one prior chemotherapy regimen prescribed for non-small cell lung cancer was not effective OR palliative treatment for non-small cell lung cancer in terminally ill patient at end of life OR diagnosis of locally advanced, unresectable or metastatic pancreatic cancer when given in combination with gemcitabine.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

TASIGNA

Drugs
Tasigna

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

Exclusion Criteria
N/A

Required Medical Information
Chronic or accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia resistant or intolerant to treatment with imatinib

Age Restriction
N/A

Prescriber Restriction
Hematologist or oncologist

Coverage Duration
1 year

Other Criteria
N/A

TEKTURNA

Drugs
Tekturna, Tekturna HCT

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Treatment with generic angiotensin receptor blocker and preferred brand angiotensin receptor blocker unless not tolerated, ineffective or contraindicated.

THIAZOLIDINEDIONES

Drugs
Actoplus MET, Actos, DUETACT

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

Exclusion Criteria
N/A

Required Medical Information
Type II diabetes mellitus: documentation that the patient's hemoglobin A1C is over 7% AND treatment with metformin is contraindicated, not tolerated or has been inadequate in reducing hemoglobin A1C to goal of 7% or less after 90 days of therapy.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Nonalcoholic steatohepatitis-metformin was ineffective, contraindicated or not tolerated. Polycystic Ovary Syndrome-metformin was ineffective, contraindicated or not tolerated

TRETINOIN TOPICAL PRODUCTS

Drugs
Atralin, Avita, Retin-A, Retin-A Micro, tretinoin, TRETIN-X, TRETIN-X (gel)

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of diagnosis

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

TRIPTANS NASAL

Drugs
Zomig

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
Generic sumatriptan nasal spray has been ineffective, not tolerated or contraindicated.

TRIPTANS NON PREFERRED

Drugs
Zomig, Zomig ZMT

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
One generic triptan and one preferred brand triptan [rizatriptan (Maxalt®, MaxaltMLT®) or eletriptan (Relpax®)]have been ineffective, not tolerated or contraindicated.

TRIPTANS PREFERRED

Drugs
Maxalt, Maxalt-MLT, naratriptan, Relpax

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

Exclusion Criteria
N/A

Required Medical Information
N/A

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
One generic triptan has been ineffective, not tolerated or contraindicated.

TYKERB

Drugs
Tykerb

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of diagnosis

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

TYSABRI

Drugs
TYSABRI

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

Exclusion Criteria
N/A

Required Medical Information
MS-Definitive diagnosis of relapsing form of multiple sclerosis that has been established by or in consultation with a neurologist or multiple sclerosis physician specialist AND interferon beta product or glatiramer acetate documented in clinical notes to be ineffective, contraindicated or not tolerated with ineffectiveness defined as meeting two of the following criteria: patient continues to have clinical relapses(at least two clinical relapses within the past 12 months) or patient continues to have CNS lesion progression as measured by MRI or patient continues to have worsening disability . Crohn's Disease-Diagnosis when one of the following critieria are met: treatment with an adequate course of corticosteroids has been ineffective or is contraindicated OR patient has been unable to taper off an adequate course of systemic corticosteroids without experiencing worsening of disease OR patient is experiencing breakthrough disease while stabilized for at least two months on an immunomodulatory medication AND infliximab is not effective after at least an initial induction period (5mg/kg on weeks 0,2,6) except if not tolerated due to documented clinical side effects AND adalimumab is not effective after at least an initial 3-dose induction period except if not tolerated due to documented clinical side effects AND patients have an elevated (greater than 6mg/dl) baseline C-reactive protein level

Age Restriction
N/A

Prescriber Restriction
Multiple Sclerosis-Prescribed by or in consultation with a neurologist or multiple sclerosis physician specialist

Coverage Duration
MS-1 year, Crohn's-initially 12 weeks then every 6 months

Other Criteria
N/A

VANDETANIB

Drugs
vandetanib

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of diagnosis.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

VELCADE

Drugs
VELCADE

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

Exclusion Criteria
N/A

Required Medical Information
A diagnosis of multiple myeloma OR a diagnosis of mantle cell lymphoma in patients who have received at least one prior therapy.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

VICTRELIS

Drugs
Victrelis

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

Exclusion Criteria
N/A

Required Medical Information
A diagnosis of chronic genotype 1 hepatitis C virus (HCV) infection AND peginterferon and ribavirin will be administered for four weeks immediately preceding initiation of boceprevir AND boceprevir will be given concomitantly with peginterferon and ribavirin for the appropriate treatment course based upon member treatment history and HCV RNA level AND liver biopsy results are obtained unless liver biopsy is contraindicated or there is documentation of compensated cirrhosis based on imaging studies AND treatment with telaprevir (Incivek) is contraindicated or not recommended AND there is documentation of any one of the four that indicates the patient is: 1) treatment-naïve who has never received therapy for the treatment for hepatitis C or 2) a relapser who had an undetectable HCV RNA level at the end of prior therapy with peginterferon and ribavirin but had a subsequent detectable HCV RNA level during the follow-up period or 3) a partial responder who had a HCV RNA reduction of greater than or equal to 2 log10 after 12 weeks of prior therapy with peginterferon and ribavirin, but still had a detectable HCV RNA level during the treatment period or 4) a null responder who had a less than 2 log10 reduction in HCV RNA after 12 weeks of prior therapy with peginterferon and ribavirin.

Age Restriction
Minimum 18 years of age

Prescriber Restriction
N/A

Coverage Duration
8 weeks initially then based upon HCV RNA levels at weeks 4, 8, and 20 of boceprevir

Other Criteria

Continued authorization: TREATMENT-NAÏVE-If HCV RNA is greater than 100 IU/mL at week 8 of boceprevir then no additional authorization as treatment is not effective. If HCV RNA is less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks. If HCV RNA is greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment is not effective. If HCV RNA is less than 10 IU/mL at week 20 of boceprevir and HCV RNA was less than 10IU/ml(undetectable) at week 4 of boceprevir then no additional authorization as treatment is complete or if HCV RNA at week 4 of boceprevir was greater than 10IU/ml(detectable) then 8 additional weeks. PRIOR RELAPSERS OR PRIOR PARTIAL RESPONDERS-If HCV RNA greater than 100 IU/mL at week 8 of boceprevir then no additional authorization as treatment is not effective. If HCV RNA less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks. If HCV RNA is greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment is not effective. If HCV RNA is less than 10 IU/mL at week 20 of boceprevir 8 additional weeks . COMPENSATED CIRRHOSIS OR PRIOR NULL-RESPONDERS-If HCV RNA greater than 100 IU/mL at week 8 of boceprevir no additional authorization as treatment is not effective. If HCV RNA less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks then if HCV RNA greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment not effective or if HCV RNA is less than 10 IU/mL at week 20 of boceprevir then 20 additional weeks.

VOTRIENT

Drugs
Votrient

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of renal cell carcinoma and sunitinib(Sutent®) ineffective, not tolerated or contraindicated.

Age Restriction
N/A

Prescriber Restriction
Oncologist

Coverage Duration
1 year

Other Criteria
N/A

VPRIV

Drugs
VPRIV

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

Exclusion Criteria
N/A

Required Medical Information
Velaglucerase alfa may be considered medically necessary in pediatric and adult patients with Gaucher disease when diagnosis of Type 1 Gaucher disease confirmed by one of the following: biochemical assay of glucocerebrosidase activity in WBCs or skin fibroblasts is less than or equal to 30% of normal activity. (note: laboratory normals may vary) OR genotyping revealing two pathogenic mutations of the glucocerebrosidase gene AND symptomatic manifestations of the disease are present, such as anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly OR patient has previously received treatment with imglucerase (Cerezyme).

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
6 months

Other Criteria
N/A

XALKORI

Drugs
Xalkori

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

Exclusion Criteria
N/A

Required Medical Information
A diagnosis of locally advanced or metastatic non small cell lung cancer(NSCLC) AND there is documentation that the tumor expresses anaplastic lymphoma kinase (ALK), meaning that it is an ALK positive tumor.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

XENAZINE

Drugs
Xenazine

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

Exclusion Criteria
N/A

Required Medical Information
Diagnosis of Huntington's disease with presence of chorea symptoms as confirmed by a neurologist AND documentation of screening for depression and if depression present that treatment is being addressed.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
Initially 3 months then every 6 months

Other Criteria
N/A

XOLAIR

Drugs
Xolair

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

Exclusion Criteria
N/A

Required Medical Information
Patient is followed by an asthma specialist (allergist, immunologist or pulmonologist) AND positive skin prick test or in-vitro specific IgE test to one or more allergens supporting the patient's clinical history AND total serum IgE level is greater than or equal to 30IU/ml and less than or equal to 700IU/ml AND clinical documentation of poor asthma control or recurrent exacerbation requiring additional medical treatment with recurrent exacerbation defined as 2 or more acute exacerbations in a 12 month period AND clinical documentation that the patient is compliant with high dose inhaled corticosteroids and long-acting beta-2 agonists and use of oral corticosteriods for exacerbation unless contraindicated AND underlying conditions or triggers for asthma or pulmonary disease are being maxmially managed

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
6 months

Other Criteria
N/A

XYREM

Drugs
Xyrem

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

Exclusion Criteria
N/A

Required Medical Information
Narcolepsy with cataplexy OR narcolepsy with excessive daytime sleepiness when modafinil in doses up to 400mg daily has been ineffective, not tolerated or contraindicated AND at least one other generic stimulant drug or preferred brand stimulant drug (Adderall-XR or Metadate-CD) has been ineffective, not tolerated or contraindicated.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

ZAVESCA

Drugs
ZAVESCA

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

Exclusion Criteria
N/A

Required Medical Information
Documentation of diagnosis

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

ZELBORAF

Drugs
Zelboraf

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

Exclusion Criteria
N/A

Required Medical Information
A diagnosis of unresectable or metastatic melanoma AND there is documentation of a BRAFV600 genetic mutation as detected by a Food and Drug Administration(FDA)approved test.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
One year

Other Criteria
N/A

ZOLINZA

Drugs
Zolinza

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

Exclusion Criteria
N/A

Required Medical Information
Progressive, persistent or recurrent disease on or following two systemic therapies including, but not limited to, bexarotene (Targretin®), denileukin diftitox (Ontak®), doxorubicin (Doxil®), and gemcitabine (Gemzar®).

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

ZYTIGA

Drugs
Zytiga

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

Exclusion Criteria
N/A

Required Medical Information
A diagnosis of metastatic castration-resistant prostate cancer AND
prior treatment with docetaxel has been ineffective, contraindicated or not tolerated AND Zytiga will be used in combination with prednisone.

Age Restriction
N/A

Prescriber Restriction
N/A

Coverage Duration
1 year

Other Criteria
N/A

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