

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: 2012
Last Updated: 12/2012

Y0062_RXPA11B 2012 File & Use 10082011

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 by 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 AND infliximab(Remicade)or etanercept(Enbrel) or adalimumab(Humira) was not effective after a minimum 12 week treatment course or have not been tolerated unless ALL are contraindicated AND ANC(absolute neutrophil count) is greater than 2000/mm³ AND platelet count is greater than 100,000/mm³ AND patient's AST(SGOT) and ALT (SGPT) are both 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 been ineffective, not tolerated or is contraindicated.

AFINITOR

Drugs

Afinitor

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and Waldenstrom's macroglobulinemia.

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of renal cell carcinoma where sunitinib(Sutent) has been ineffective, is contraindicated or was not tolerated OR diagnosis of pancreatic neuroendocrine tumor when prior therapy with sunitinib(Sutent) has been ineffective, is contraindicated or was not tolerated OR a diagnosis of Waldenstrom's macroglobulinemia OR diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis when surgical resection is not an option AND the condition is associated with functional impairment.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

Other Criteria

N/A

ALIMTA

Drugs

Alimta

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

A diagnosis of mesothelioma OR a diagnosis of locally advanced (Stage III or Stage IV) or metastatic non-squamous non-small cell lung cancer.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

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 that causes significant functional disability 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

Additional 12 week treatment courses may be authorized when: a minimum of 12 weeks has elapsed since the completion of the previous 12 week treatment course AND CD4+ T lymphocyte counts are within the range of normal AND there is documented clinical improvement in symptoms or function or lessening of the affected body surface area.

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 functional impairment.

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/preferred medication alternatives have been ineffective, not tolerated or contraindicated.

ANTINEOPLASTICS

Drugs

Doxil, Eloxatin, Herceptin, oxaliplatin

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 the Cold-Induced Auto-Inflammatory Syndrome 1 (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 rash that may wax and wane in intensity, sometimes exacerbated by generalized cold exposure AND there is clinical documentation of functional impairment.

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 AND fludarabine(Fludara) 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.

ATYPICAL ANTIPSYCHOTICS

Drugs

Abilify, Abilify Discmelt, Fanapt, Geodon, Invega, Latuda, Saphris, Symbyax

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 atypical antipsychotic (such as risperidone) has been ineffective, not tolerated or contraindicated.

AVASTIN

Drugs

AVASTIN

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, age related macular degeneration, branch or central retinal vein occlusion, diabetic retinopathy/macular edema.

Exclusion Criteria

N/A

Required Medical Information

Use in the eye: Used as an intravitreal(inside the eye) injection for the treatment of ocular conditions such as macular degeneration, retinal vein occlusion and diabetic retinopathy. Use in Cancers: Diagnosis of metastatic colorectal cancer(adenocarcinoma) when given in conjunction with a fluorouracil-based chemotherapy OR diagnosis of glioblastoma or ependymoma that has progressed after at least one prior therapy (such as radiation or temozolomide) OR diagnosis of unresectable, locally advanced, recurrent or metastatic non-small cell lung cancer when: patient has had no prior chemotherapy AND is administered with carboplatin and paclitaxel OR a diagnosis of metastatic renal carcinoma when: tumor has clear cell histology AND treatment with a tyrosine kinase inhibitor[pazopanib(Votrient), sorafenib(Nexavar) or sunitinib(Sutent)] has been ineffective, contraindicated or not tolerated AND is administered in conjunction with interferon alfa.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

6 months

Other Criteria

N/A

BYDUREON

Drugs

Bydureon

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Documentation that the patient's A1C value is over 7% AND treatment with metformin is contraindicated, not tolerated, or has been inadequate in reducing 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

BYETTA

Drugs

Byetta

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

There is documentation that the patient's hemoglobin A1C value is over 7% AND a 90 day treatment course with metformin did not adequately reduce the hemoglobin A1c to the 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

CAPRELSA

Drugs

Caprelsa

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

CELEBREX

Drugs

Celebrex

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

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, or meloxicam.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

N/A

CEREZYME/VPRIV

Drugs

Cerezyme, VPRIV

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of Type 1 Gaucher disease confirmed by: 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.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

6 months

Other Criteria

For continued authorization, documentation by chart notes of maintenance or improvement in disease must be provided. This may include, but is not limited to, hematologic indices, MRI of spine/femurs, quality of life and/or plain films of skeleton.

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

One generic statin 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

DEXILANT

Drugs

Dexilant

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Treatment with prescription omeprazole OR pantoprazole have been ineffective, not tolerated or is contraindicated.

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 abdominal fat due to HIV-associated lipodystrophy with the following gender-specific measures: 1. Males: a. waist circumference greater than 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

6 months initially 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 is established by a rheumatologist or dermatologist. Ankylosing spondylitis-diagnosis is established by a rheumatologist. Rheumatoid arthritis(RA) or juvenile rheumatoid arthritis(JRA, juvenile idiopathic arthritis): diagnosis established by 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 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: Chart notes support a diagnosis of chronic plaque psoriasis involving at least 10% of body surface area or that it causes a significant functional disability 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

Erbixux

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 doublet (cisplatin or carboplatin in combination with another chemotherapy medication) AND there is no known brain metastasis.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

N/A

ERIVEDGE

Drugs

Erivedge

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

A diagnosis of metastatic basal cell carcinoma OR a diagnosis of locally advanced basal cell carcinoma when the member is not a candidate for radiation AND the disease has recurred following surgery, unless the member is not a candidate for surgery.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

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

Patient has diagnosis of multiple sclerosis AND treatment with interferon beta-1a(Avonex) OR interferon beta-1a(Rebif) OR glatiramer acetate(Copaxone) has been ineffective or not tolerated.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

N/A

FENTANYL

Drugs

fentanyl citrate

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Documentation that use is for breakthrough cancer pain AND other generic/preferred formulary short acting strong narcotic analgesic alternatives (other than fentanyl such as, but not limited to, concentrated morphine oral solution, oxycodone or hydromorphone) have been ineffective, not tolerated or contraindicated AND patient is opioid tolerant, taking at least the equivalent of 60mg oral morphine sulfate daily.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

6 months

Other Criteria

N/A

FIRAZYR

Drugs

Firazyr

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Documented diagnosis of type I or type II hereditary angioedema (HAE) established by or in conjunction with an allergist, immunologist or hematologist AND clinical documentation of serum C4 and C1-INH (antigenic or functional level) that are below the limits of the laboratory's normal reference range AND clinical documentation of family history of HAE OR normal level of serum C1q antigenic protein based on the laboratory's normal reference range.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

3 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

Patient at high risk for fracture as defined by: having a 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 having 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 has not been effective after at least a 24 month treatment period based on objective documentation except if bisphosphonates are contraindicated based on current medical literature and objective documentation describing the contraindication is provided OR bisphosphonates are not tolerated due to documented clinical side effects.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

One time maximum two years of therapy authorization.

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(CML) with the presence of the Philadelphia (Ph-1) chromosome OR gastrointestinal stromal tumor(GIST) OR Philadelphia chromosome positive acute lymphoblastic leukemia(Ph+ALL) OR myelodysplastic /myeloproliferative diseases (MDS/MPD) associated with platelet derived growth factor receptor(PDGFR) gene rearrangements OR aggressive systemic mastocytosis(ASM) without the D816V c-Kit mutation or with c-Kit mutational status unknown OR hypereosinophilic syndrome(HES) and/or chronic eosinophilic leukemia(CEL) who have the FIP1L1-PDGFR alpha fusion kinase(mutational analysis or FISH demonstration of CHIC2 allele deletion) and for patients with hypereosinophilic and/or chronic eosinophilic leukemia(HES/CEL) who are FIP1L1-PDGFR alpha fusion kinase negative or unknown OR unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans(DFSP).

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 have been part of the prior treatment history unless contraindicated or not effective. Prior therapies shall include each of the following: 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, ulcerative colitis.

Exclusion Criteria

N/A

Required Medical Information

Psoriatic arthritis-when the diagnosis established by a rheumatologist or dermatologist. Ankylosing spondylitis-diagnosis established by a rheumatologist. Rheumatoid arthritis(RA) or juvenile idiopathic arthritis (JIA)-diagnosis established by 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 following criteria is met: treatment with an adequate course of systemic corticosteroids(such as, but not limited to, 40-60mg prednisone per day for 7-14 days) 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 2 months on an immune-modulatory medication(such as, but not limited to, azathioprine, mercaptopurine, cyclosporine or methotrexate) OR acute and/or maintenance of Crohn's Disease when infliximab(Remicade) has been ineffective or not tolerated. Chronic plaque psoriasis – Chart notes support a diagnosis of chronic plaque psoriasis involving at least 10% of body surface area or causes significant functional disability AND treatment with phototherapy or photochemotherapy was ineffective, not tolerated or contraindicated AND treatment with at least one oral systemic agent(such as, but not limited to, cyclosporine, methotrexate or acitretin) 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

Ulcerative colitis - acute treatment of an exacerbation of moderately to severely active ulcerative colitis where an adequate course of systemic corticosteroids was ineffective or is contraindicated AND treatment with at least one additional systemic oral agent (e.g. methotrexate, mercaptopurine) for ulcerative colitis was ineffective or not tolerated.

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

Diagnosis of severe primary IGF-1 deficiency OR growth hormone deletion OR genetic mutation of growth hormone receptor(Laron Syndrome) AND 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 (based on at least one growth hormone stimulation test) 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

Endocrinologist

Coverage Duration

1 year

Other Criteria

N/A

INLYTA

Drugs

Inlyta

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Documentation of a diagnosis of renal cell carcinoma (RCC) AND sunitinib (Sutent) has been ineffective or was not tolerated.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

12 months

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 (Cytosan), denileukin difitox (Ontak), doxorubicin liposomal (Doxil), etoposide (VePesid), gemcitabine (Gemzar), interferon alfa (Intron A), isotretinoin, methotrexate, pentostatin, pralatrexate (Folotyn), temozolomide (Temodar) and vorinostat (Zolinza) OR a diagnosis of peripheral T-cell lymphoma (PTCL) when a least two systemic therapies have been ineffective or not tolerated.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

N/A

JAKAFI

Drugs

Jakafi

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

A diagnosis of myelofibrosis, including but not limited to primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

N/A

JANUVIA/JANUMET

Drugs

Janumet, Janumet XR, Januvia

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

There is documentation that the patient's HgBA1C value is over 7% AND treatment with metformin is contraindicated, not tolerated or has been 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

JUVISYNC

Drugs

Juvisync

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

There is documentation that the patient's HgBA1C value is over 7% AND treatment with metformin is contraindicated, not tolerated or has been 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

KALYDECO

Drugs

Kalydeco

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

A diagnosis of cystic fibrosis (CF) AND confirmation that the patient has the G551D mutation in either CFTR gene.

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

The diagnosis of Rheumatoid Arthritis (RA) has been established by 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 not effective after at least a 6 to 12 week treatment course based on documentation which includes one or more of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except if documentation is submitted that methotrexate is relatively or absolutely contraindicated based on current literature OR methotrexate is not tolerated due to documented clinical side effects AND either etanercept(Enbrel) or adalimumab(Humira) is not effective after at least a 12 week treatment course unless not tolerated due to documented clinical side effects AND therapy does not exceed administration of 100mg of anakinra (Kineret) subcutaneously once daily.

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 AND neuropathic pain-when a previous history of adequate treatment courses of at least 30 days with gabapentin AND one tricyclic antidepressant(such as amitriptyline, desipramine or imipramine) 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(such as amitriptyline, desipramine or imipramine) are ineffective unless contraindicated or not tolerated.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

N/A

MODAFINIL

Drugs

modafinil

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Excessive sleepiness associated with narcolepsy(diagnosed by the criteria of DSM-IV-TR, Appendix 1) when at least one formulary/preferred treatment such as, but not limited to, methylphenidate or dextroamphetamine, has been ineffective or not tolerated OR documentation of residual excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome AND there is documentation that the patient has been compliant 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(ICSD, Appendix 2) 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

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(Razadyne), 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 has 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 renal cell carcinoma and when sunitinib(Sutent) has been ineffective, not tolerated or contraindicated OR documented diagnosis of hepatocellular carcinoma.

Age Restriction

N/A

Prescriber Restriction

Oncologist or hematologist

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, Pediatric burns

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 congenital 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 congenital 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-Diagnosis of growth hormone deficiency with panhypopituitarism-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. Short bowel syndrome (SBS)-ability to ingest solid food AND dependent on parenteral nutrition at least five days per week to provide at least 3000 calories per 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 to 1 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

Juvenile idiopathic arthritis (JIA) or rheumatoid arthritis(RA)-diagnosis established by 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 for RA AND treatment with methotrexate has been ineffective after at least a 6-12 week treatment course based on documentation which includes one or more of the components of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except if methotrexate is contraindicated or not tolerated based on clinical documentation.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

6 months initially then 1 year

Other Criteria

N/A

PART B/D DRUGS

Drugs

AccuNeb, acetylcysteine, Adriamycin PFS, albuterol sulfate, Aminosyn 10 %, Aminosyn 3.5 %, Aminosyn 5 % (sulfite-free), Aminosyn 7 %, 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 SulfiteFree, Clinimix E 2.75/D5 SulfiteFree, Clinimix E 4.25/D25 SulfiteFree, 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, doxorubicin, DuoNeb, Emend, EMLA, Engerix-B (PF), Epogen, Etopophos, etoposide, fluorouracil, 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 sugar), lidocaine (PF), lidocaine HCl, lidocaine-prilocaine, Liposyn II, Liposyn III, Miacalcin, mycophenolate mofetil, Myfortic, Nebupent, Neoral, Nephramine 5.4 %, nicardipine, Nulojix, ondansetron, ondansetron HCl, Orthoclone OKT3, Perforomist, Premasol 10 %, Premasol 6 %, Procalamine 3%, Procrit, Prograf, Prosol 20%, Pulmicort, Pulmozyme, Rapamune, Recombivax HB (PF), Rocaltrol, Sandimmune, tacrolimus, Thymoglobulin, Tobi, Toposar, topotecan, TPN Electrolytes, Travasol 10 %, Treanda, TrophAmine 10 %, Trophamine 6%, vancomycin, vinblastine, Virazole, Xopenex, Xylocaine, Zemlar, 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, Pegasys ProClick

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

ADMINISTERED WITH A HCV PROTEASE INHIBITOR: Peginterferon alfa-2a will be used in combination with a hepatitis C virus protease inhibitor (e.g. boceprevir or telaprevir) for the initial treatment or re-treatment of chronic hepatitis C when there is a diagnosis of chronic genotype 1 hepatitis C virus (HCV) infection AND prior authorization has been approved for either boceprevir (Victrelis) or telaprevir (Incivek) AND there is documentation of member's treatment history **ADMINISTERED WITHOUT A HCV PROTEASE INHIBITOR:** Peginterferon alfa-2a will be used without a hepatitis C protease inhibitor (e.g. boceprevir or telaprevir) for the initial treatment of chronic hepatitis C (any genotype) AND detectable HCV RNA levels are higher than 50 IU/ml AND Peginterferon alfa-2a will be used in combination with ribavirin, unless ribavirin is contraindicated AND patient has not received previous treatment with peginterferon alfa-2a or peginterferon alfa-2b AND there is documentation that peginterferon alfa-2a will not be used with a hepatitis C protease inhibitor (e.g. boceprevir or telaprevir) OR Peginterferon alfa-2a will be used for the treatment of chronic hepatitis B AND there is a confirmed diagnosis of compensated chronic hepatitis B AND patient has not received previous treatment with peginterferon alfa-2a or peginterferon alfa-2b.

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

DURATION OF COVERAGE WITH HCV PROTEASE INHIBITOR: Initial coverage duration with telaprevir-8 weeks initially and if HCV RNA is greater than 1000u/ml at week 4 then no additional authorization as treatment is not effective. If HCV RNA is less than 1,000IU/ml at week 4 then 4 additional week. Initial coverage duration with boceprevir-12 weeks initially then based upon HCV RNA levels at weeks 4, 8 and 20 of boceprevir. 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 RELAPSE 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.

PEGINTRON

Drugs

PegIntron, PegIntron Redipen

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

ADMINISTERED WITH A HCV PROTEASE INHIBITOR: Peginterferon alfa-2b will be used in combination with a hepatitis C virus protease inhibitor (e.g. boceprevir or telaprevir) for the initial treatment or retreatment of chronic hepatitis C AND there is a confirmed diagnosis of chronic hepatitis C genotype 1 AND prior authorization has been approved for either boceprevir (Victrelis) or telaprevir (Incivek) AND there is documentation of the patient's treatment history. **ADMINISTERED WITHOUT A HCV PROTEASE INHIBITOR:** Peginterferon alfa-2b will be used without a hepatitis C protease inhibitor (e.g. boceprevir or telaprevir) for the initial treatment of chronic hepatitis C (any genotype) AND detectable HCV RNA levels are higher than 50 IU/ml AND Peginterferon alfa-2b will be used in combination with ribavirin, unless ribavirin is contraindicated AND patient has not received previous treatment with peginterferon alfa-2a or peginterferon alfa-2b AND there is documentation that peginterferon alfa-2b will not be used with a hepatitis C protease inhibitor (e.g. boceprevir or telaprevir).

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

DURATION OF COVERAGE WITH HCV PROTEASE INHIBITOR: Initial coverage duration with telaprevir-8 weeks initially and if HCV RNA is greater than 1000u/ml at week 4 then no additional authorization as treatment is not effective. If HCV RNA is less than 1,000IU/ml at week 4 then 4 additional weeks. Initial coverage duration with boceprevir-12 weeks initially then based upon HCV RNA levels at weeks 4, 8 and 20 of boceprevir. 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 RELAPSE 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.

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, Pediatric burns.

Exclusion Criteria

N/A

Required Medical Information

Adult and Pediatric-Omnitrope or Nutropin products have not been tolerated AND documented AND Pediatrics-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 congenital 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 congenital 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-Diagnosis of growth hormone deficiency with panhypopituitarism-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. Short bowel syndrome (SBS)-ability to ingest solid food AND dependent on parenteral nutrition at least five days per week to provide at least 3000 calories per week AND chart notes indicate dietary needs and goals have been addressed.

Age Restriction

N/A

Prescriber Restriction

N/A

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 20,000/mm³ 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 (such as, but not limited to, prednisone 1-2mg/kg for 2 to 4 weeks OR pulse dexamethasone 40mg daily for 4 days) 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

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 OR pantoprazole have 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(diagnosed by the criteria of DSM-IV-TR, Appendix 1) when at least one generic or preferred brand medication, such as, but not limited to, methylphenidate or dextroamphetamine, has been ineffective or not tolerated OR documentation of residual excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome AND there is documentation that the patient has been compliant 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(ICSD, Appendix 2) 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

PULMONARY ANTIHYPERTENSIVES

Drugs

Letairis, Remodulin, Revatio, Tracleer, Ventavis

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of World Health Organization (WHO) Group 1 pulmonary arterial hypertension (PAH).

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

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

QUININE SULFATE

Drugs

quinine sulfate

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 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

Rheumatoid Arthritis (RA)-diagnosis established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of RA AND methotrexate has been ineffective after at least a 6-12 week treatment course based on documentation which includes one or more of the components of the American College of Rheumatology Assessment Components for Improvement in RA except if methotrexate is contraindicated or not tolerated based on clinical documentation AND infliximab administered with an oral DMARD (such as, but not limited to, methotrexate). Psoriatic arthritis-diagnosis is established by a rheumatologist or dermatologist.

Ankylosing spondylitis-diagnosis established by a rheumatologist. Crohn's Disease and Ulcerative Colitis-fistulizing Crohn's disease OR acute treatment of an exacerbation of Crohn's disease or ulcerative colitis where adequate course of systemic corticosteroids (such as, but not limited to, 40-60mg prednisone per day for 10-14 days) has been ineffective or contraindicated OR unable to taper off an adequate course of systemic corticosteroids without worsening or symptoms OR patient is experiencing breakthrough disease while stabilized for at least 2 months on an immunomodulatory medication (such as, but not limited to, azathioprine, mercaptopurine, cyclosporine or methotrexate). Plaque psoriasis-chart notes support a diagnosis of chronic plaque psoriasis involving at least 10% of the body surface area or causes significant functional impairment disability AND treatment with phototherapy or photochemotherapy was ineffective, not tolerated or contraindicated AND treatment with at least one oral systemic agent for psoriasis (such as, but not limited to, cyclosporine, methotrexate or acitretin) 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

Diagnosis of WHO Group 1 pulmonary arterial hypertension (PAH).

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

Diagnosis of myelodysplastic syndrome(MDS)when patient is transfusion dependent(defined as administration of 2 or more units of red blood cells (RBCs) in the previous 8 weeks) AND patient has an absolute neutrophil count of at least 500/mm³ AND patient has a platelet count of at least 50,000/mm³.
Diagnosis of multiple myeloma(MM) when lenalidomide is used in combination with corticosteroid (such as, but not limited to, dexamethasone)unless documentation is provided that a corticosteroid is contraindicated or is not tolerated AND patient has an absolute neutrophil count(ANC) 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

RITUXAN

Drugs

Rituxan

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, Refractory autoimmune hemolytic anemia (AIHA), Multicentric Castleman's disease (angiofollicular lymph node hyperplasia), Refractory Evan's syndrome, Relapsed or refractory hairy cell leukemia, Primary central nervous system (CNS) lymphoma, CD20-positive B-cell post-transplant lymphoproliferative disorder (B-PTLD), Waldenström's macroglobulinemia.

Exclusion Criteria

N/A

Required Medical Information

A diagnosis of refractory autoimmune hemolytic anemia (AIHA) when at least two prior therapies have been ineffective, are contraindicated, or not tolerated OR a diagnosis of multicentric Castleman's disease (angiofollicular lymph node hyperplasia) OR a diagnosis of lymphocyte predominant Hodgkin's lymphoma OR patients with refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) when a diagnosis of chronic ITP is made by, or in consultation with, a hematologist AND patient is at risk of spontaneous bleeding as demonstrated in chart notes by either one of the following criteria: platelet count is less than 20,000/mm³ OR platelet count is less than 30,000/mm³ accompanied by symptoms of bleeding AND treatment with at least two of the following ITP treatments was ineffective or not tolerated: adequate course of systemic corticosteroids (such as, but not limited to prednisone 1 to 2 mg/kg for 2 to 4 weeks, or pulse dexamethasone 40 mg daily for 4 days) OR immunoglobulin replacement OR splenectomy OR a diagnosis of chronic lymphocytic leukemia (CLL) OR a diagnosis of refractory Evan's syndrome when at least two prior therapies have been ineffective, contraindicated, or not tolerated OR a diagnosis of relapsed or refractory Hairy Cell Leukemia when at least two courses of a purine analog (cladribine or pentostatin) are not effective, unless contraindicated, or not tolerated OR a diagnosis of primary central nervous system (CNS) lymphoma OR a diagnosis of CD20-positive B-cell non-Hodgkin's lymphoma (NHL) OR a diagnosis of CD20-positive B-cell post-transplant lymphoproliferative disorder (B-PTLD) when tapering of immunosuppressive medications is not effective or is contraindicated OR OR diagnosis of microscopic polyarteritis nodosa in combination with glucocorticoids OR diagnosis of Wegener's granulomatosis in combination with glucocorticoids

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

OR patients with moderately to severely active rheumatoid arthritis (RA) when: the diagnosis has been established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of RA AND treatment with two biologic treatments for RA have been ineffective after at least a 12-week treatment course or have not been tolerated unless all are contraindicated AND rituximab is given in combination with methotrexate unless contraindicated or not tolerated OR a diagnosis of Waldenström's macroglobulinemia.

SERUM IMMUNOGLOBULINS GAMMA

Drugs

Carimune NF Nanofiltered, Gammagard Liquid, Gammaplex, Gamunex-C, Hizentra, Privigen, Vivaglobin

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, Acquired Factor VIII inhibitor, Acute inflammatory demyelinating polyneuropathy, Allogeneic bone marrow transplant recipients, Autoimmune hemolytic anemia, dermatomyositis, Fetal alloimmune thrombocytopenia, HIV infected children with T4 count greater than 200/mm³, Hypogammaglobulinemic neonates, Lambert-Eaton myasthenic syndrome, Multifocal motor neuropathy, Multiple myeloma, Myasthenia gravis, Intractable pediatric epilepsy, Polymyositis, Post transfusion purpura, Pure red cell aplasia, Refractory pemphigus foliaceus, Solid organ transplant, Stiff-Person syndrome, Systemic lupus erythematosus.

Exclusion Criteria

N/A

Required Medical Information

Acquired Factor VIII inhibitor-when conventional therapy (such as cyclophosphamide, corticosteroids or azathioprine) is ineffective or not tolerated. Allogeneic bone marrow transplant recipients who are 20 years of age or older for up to 4 months following transplantation. Autoimmune hemolytic anemia- warm type AIHA that does not respond to alternative therapies (such as 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 or morbidity. 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 idiopathic thrombocytopenia purpura (ITP)-when rapid increase in platelet count is necessary. Chronic ITP-platelets less than 30,000/mm³ in children or less than 20,000/mm³ in adults. ITP in pregnancy-refractory to steroids with platelet counts less than 10,000/mm³ in the 3rd trimester OR platelet less than 30,000/mm³ associated with bleeding before delivery

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 (Kawasaki Syndrome) to 1 year depending on diagnosis

Other Criteria

OR history of autoimmune thrombocytopenia with previous pregnancy OR platelets 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-other treatment options (such as 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 acute severe decompensation or chronic decompensation when other treatments (such as plasmapheresis, pyridostigmine, azathioprine, cyclosporine, or cyclophosphamide) are ineffective or not tolerated. Pediatric intractable epilepsy in candidates for surgical resection or when other interventions(such as anticonvulsant medications, ketogenic diets, or corticosteroids) are ineffective or not tolerated. Polymyositis-patients with severe active illness when other interventions (such as corticosteroid therapy, azathioprine, methotrexate, or cyclophosphamide) have been ineffective or not tolerated. Post transfusion purpura-severely affected patients. Primary humoral immunodeficiency diseases-Baseline IgG level along 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 polyclonal 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 conventional treatment (such as immunosuppressive agents or plasmapheresis). Solid organ transplant in treatment of antibody-mediated rejection and prior to transplant patient at high risk for anti-body mediated rejection and those receiving an ABO incompatible organ OR following a solid organ transplant. Stiff-Person Syndrome-when treatment with other agents (such as diazepam, baclofen, clonazepam, valproic acid, or clonidine) is ineffective or not tolerated. Systemic lupus erythematosus-severe active disease when other interventions (such as corticosteroids, cyclophosphamide or azathioprine) are ineffective or not tolerated.

SILDENAFIL

Drugs

sildenafil

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of WHO Group 1 pulmonary arterial hypertension (PAH).

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

N/A

SIMPONI

Drugs

Simponi

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of ankylosing spondylitis or psoriatic arthritis when the diagnosis has been established by a rheumatologist or dermatologist. Diagnosis of rheumatoid arthritis when the diagnosis has been established by 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 AND golimumab(Simponi) is administered with an oral DMARD.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

N/A

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(CML) OR Philadelphia chromosome positive acute lymphoblastic leukemia resistant(Ph+ ALL).

Age Restriction

N/A

Prescriber Restriction

Hematologist or oncologist

Coverage Duration

1 year

Other Criteria

N/A

STELARA

Drugs

Stelara

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of moderate to severe psoriasis where chart notes support a diagnosis of chronic plaque psoriasis involving at least 10% of the body surface area or causes significant functional disability AND treatment with phototherapy or photochemotherapy was ineffective, contraindicated or not tolerated 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 or rheumatologist

Coverage Duration

1 year

Other Criteria

N/A

SUTENT

Drugs

Sutent

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and pancreatic neuroendocrine tumors.

Exclusion Criteria

N/A

Required Medical Information

Documentation of one the following diagnoses: gastrointestinal stromal tumor(GIST) OR renal cell carcinoma(RCC) OR pancreatic neuroendocrine tumors.

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 the current RSV season and who have required medical therapy for bronchopulmonary dysplasia within 6 months of or during the RSV season or infants with bronchopulmonary dysplasia that required treatment with supplemental oxygen as neonates for at least 28 days OR infants less than or equal to 3 months of chronological age (post-natal age) at the onset of RSV season and with a history of premature birth between 32 0/7 weeks to 34 6/7 weeks gestation who have at least one of the following risk factors: childcare attendance or school aged siblings or siblings in the household who are less than 5 years of age OR infants less than or equal to 12 months of chronological age(post-natal age) with congenital abnormalities of the airway or neuromuscular disease OR infants less than or equal to 6 months chronological age(post-natal) at the onset of RSV season with a history of premature birth between 29 0/7 to 31 6/7 weeks with or without the presence of additional risk factors OR infants less than or equal to 12 months chronological age(post-natal) at the onset of RSV season and born at 28 6/7 weeks of gestation or earlier OR infants or children with hemodynamically significant congenital heart disease who are 24 months of age or younger at the onset of RSV season who: receive medication to control congestive heart failure OR have moderate to severe pulmonary hypertension OR have cyanotic heart disease.

Age Restriction

24 months or younger

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

A diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) when: 1. at least one prior chemotherapy regimen prescribed for non-small cell lung cancer was not effective (documented disease progression either during or after treatment) or 2. used as maintenance chemotherapy after four cycles of platin-based chemotherapy for NSCLC OR a diagnosis of locally advanced, unresectable or metastatic pancreatic cancer when given in combination with gemcitabine.

Age Restriction

N/A

Prescriber Restriction

Oncologist

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

Documentation of diagnosis of chronic or accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia(Ph+ CML).

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 two preferred renin-angiotensin inhibitors unless not tolerated, ineffective or contraindicated.

THIAZOLIDINEDIONES

Drugs

Actoplus MET, Actos, DUETACT, pioglitazone, pioglitazone-metformin

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, Polycystic Ovary Syndrome and Nonalcoholic Steatohepatitis.

Exclusion Criteria

N/A

Required Medical Information

Type 2 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. Nonalcoholic steatohepatitis: metformin was ineffective, contraindicated or not tolerated. Polycystic Ovary Syndrome: metformin was ineffective, contraindicated or not tolerated.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 year

Other Criteria

N/A

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, Mollusca contagiosa, Ichthyosis vulgaris, Osteoma cutis, Kaposi's sarcoma, Pityriasis rubra pilaris, Bullous congenital ichthyosiform, Keratoacanthoma, Porokeratosis, Cutaneous horn, Keratosis follicularis, Solar keratosis, Diabetic foot ulcers, Lamellar ichthyosis, Verrucae planus, Geographic tongue, Leukoplakia, Verrucae planae juvenilis

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 of HER 2 positive breast cancer.

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

Multiple Sclerosis-A definitive diagnosis of a relapsing form of multiple sclerosis(relapsing-remitting or secondary progressing multiple sclerosis) that has been established by a neurologist or multiple sclerosis physician specialist AND interferon beta product(Avonex, Rebif, Betaseron or Extavia) OR glatiramer acetate (Copaxone) was 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-A diagnosis of Crohn's disease when one of the following criteria are met: treatment with an adequate course of corticosteroids(such as, but not limited to 40-60mg prednisone per day for 7-14 days) 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 (such as, but not limited to, azathioprine, mercaptopurine, cyclosporine or methotrexate) AND infliximab(Remicade) 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(Humira) 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(CRP) 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, Waldenstrom macroglobulinemia.

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 OR a diagnosis of Waldenstrom macroglobulinemia 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

VICTOZA

Drugs

Victoza

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

There is documentation that the patient's A1C value is over 7 AND a 90-day treatment course with each metformin AND Byetta or Bydureon did not adequately reduce A1C to goal of 7% or less, were not tolerated, or are contraindicated.

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)has been ineffective, not tolerated or contraindicated.

Age Restriction

N/A

Prescriber Restriction

Oncologist

Coverage Duration

1 year

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 chart notes document that the patient is being monitored for symptoms of depression and if depression present that it 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 which supports 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 corticosteroids for exacerbation unless contraindicated AND underlying conditions or triggers for asthma or pulmonary disease are being maximally 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(a sudden loss in muscle tone and deep tendon reflexes) OR narcolepsy with excessive daytime sleepiness when modafinil(Provigil) 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

YERVOY

Drugs

Yervoy

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Diagnosis of unresectable or metastatic melanoma.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

4 infusions(one treatment course) then annually.

Other Criteria

N/A

ZAVESCA

Drugs

ZAVESCA

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and Niemann-Pick Disease Type C.

Exclusion Criteria

N/A

Required Medical Information

A diagnosis of type 1 Gaucher disease OR a diagnosis of Niemann-Pick disease.

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

1 year

Other Criteria

N/A

ZOLEDRONIC ACID

Drugs

Reclast, Zometa

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Zoledronic acid may be considered medically necessary when one of the following criteria have been met: for the treatment of osteoporosis when an oral bisphosphonate (such as alendronate, ibandronate or risedronate) has been ineffective, not tolerated or contraindicated OR for the treatment of Paget's disease OR for the treatment of cancer related indications when pamidronate has been ineffective, not tolerated or contraindicated OR for the treatment of hormone resistant prostate cancer bone metastases.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

1 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

A diagnosis of cutaneous T-cell lymphoma (CTCL) AND at least two prior system therapies [such as, but not limited to, 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, pralatrexate (Folotyn®) or temozolomide (Temodar®)] have been ineffective or not tolerated.

Age Restriction

N/A

Prescriber Restriction

N/A

Coverage Duration

6 months

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 or cabazitaxel (Jevtana) 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

Index

Abilify.....	13	Aminosyn-HBC 7%.....	51	Clinimix 4.25/D10 Sulfite Free.....	51
Abilify Discmelt.....	13	Aminosyn-HF 8 %.....	51	Clinimix 4.25/D20 Sulfite Free.....	51
AccuNeb.....	51	Aminosyn-PF 10 %.....	51	Clinimix 4.25/D25 Sulfite Free.....	51
acetylcysteine.....	51	Aminosyn-PF 7 % (Sulfite-Free).....	51	Clinimix 5%/D15 Sulfite Free.....	51
Actemra.....	1	Ampyra.....	6	Clinimix 5%/D20 Sulfite Free.....	51
Actonel.....	2	Anzemet.....	51	Clinimix 5%/D25 Sulfite Free.....	51
Actoplus MET.....	80	Aranesp (polysorbate).....	51	Clinimix E 2.75/D10 SulfiteFree.....	51
Actos.....	80	Arcalyst.....	10	Clinimix E 2.75/D5 SulfiteFree.....	51
Adriamycin PFS.....	51	Arzerra.....	11	Clinimix E 4.25/D25 SulfiteFree.....	51
Afinitor.....	3	Atelvia.....	12	Clinimix E 4.25/D5 SulfiteFree.....	51
albuterol sulfate.....	51	Atgam.....	51	Clinimix E 5%/D15 Sulfite Free.....	51
Alimta.....	4	Atralin.....	81	Clinimix E 5%/D20 Sulfite Free.....	51
Amevive.....	5	atropine.....	51	Clinimix E 5%/D25 Sulfite Free.....	51
Aminosyn 10 %.....	51	AVASTIN.....	14	Clinisol SF 15 %.....	51
Aminosyn 3.5 %.....	51	Avita.....	81	Crestor.....	21
Aminosyn 5 % (sulfite-free).....	51	Azasan.....	51	cromolyn.....	51
Aminosyn 7 %.....	51	azathioprine.....	51	CUBICIN.....	51
Aminosyn 8.5 %.....	51	azathioprine sodium.....	51	cyclophosphamide.....	51
Aminosyn 8.5 %-Electrolytes.....	51	Beconase AQ.....	47	cyclosporine.....	51
Aminosyn II 10 %.....	51	Benicar.....	7	cyclosporine modified.....	51
Aminosyn II 15%.....	51	Benicar HCT.....	7	Cymbalta.....	8
Aminosyn II 3.5 %/Dextrose 5 %.....	51	Brovana.....	51	cytarabine.....	51
Aminosyn II 3.5 %-Dextrose 25%.....	51	budesonide.....	51	cytarabine (PF).....	51
Aminosyn II 3.5% M/Dextrose 5%.....	51	Busulfex.....	51	Dacogen.....	51
Aminosyn II 3.5%-Lytes-Ca-D25W.....	51	Bydureon.....	15	Dexilant.....	22
Aminosyn II 4.25%/Dextrose 20%.....	51	Byetta.....	16	Doxil.....	9
Aminosyn II 4.25%-Dextrose 10%.....	51	Calcijex.....	51	doxorubicin.....	51
Aminosyn II 4.25%-Dextrose 25%.....	51	calcitriol.....	51	DUETACT.....	80
Aminosyn II 4.25%-Lytes-Ca-D25.....	51	Camptosar.....	51	DuoNeb.....	51
Aminosyn II 5%/Dextrose 25%.....	51	Caprelsa.....	17	Egrifta.....	23
Aminosyn II 7 %.....	51	Carimune NF Nanofiltered.....	68	Eloxatin.....	9
Aminosyn II 8.5 %.....	51	Carnitor.....	51	Emend.....	51
Aminosyn II 8.5 %-Electrolytes.....	51	Celebrex.....	18	EMLA.....	51
Aminosyn M 3.5 %.....	51	CellCept.....	51		
		CellCept Intravenous.....	51		
		Cerezyme.....	19		
		chorionic gonadotropin, human.....	20		
		cladribine.....	51		
		Clinimix 2.75%/D5 Sulfite Free.....	51		
		Clinimix 4.25%/D5 Sulfite Free.....	51		

Enbrel.....	24	Istodax.....	37	Nutropin AQ.....	49
Engerix-B (PF).....	51	Ixempra.....	51	Nutropin AQ Nuspin.....	49
Epogen.....	51	Jakafi.....	38	omeprazole-sodium	
Erbixut.....	25	Janumet.....	39	bicarbonate.....	58
Erivedge.....	26	Janumet XR.....	39	Omnamis.....	47
Etopophos.....	51	Januvia.....	39	Omnitrope.....	49
etoposide.....	51	Jevtana.....	40	ondansetron.....	51
Extavia.....	27	Juvisync.....	41	ondansetron HCl.....	51
Fanapt.....	13	Kalydeco.....	42	Orencia.....	50
fentanyl citrate.....	28	Kineret.....	43	Orthoclone OKT3.....	51
Firazyr.....	29	lansoprazole.....	58	oxaliplatin.....	9
fluorouracil.....	51	Latuda.....	13	Pegasys.....	52
Forteo.....	30	Letairis.....	60	Pegasys Convenience Pack.....	52
Freamine III 3		Leustatin.....	51	Pegasys ProClick.....	52
%-Electrolytes.....	51	levabuterol HCl.....	51	PegIntron.....	54
Freamine III 8.5 %.....	51	levocarnitine.....	51	PegIntron Redipen.....	54
Gammagard Liquid.....	68	levocarnitine (with sugar).....	51	Perforomist.....	51
Gammaplex.....	68	lidocaine (PF).....	51	pioglitazone.....	80
Gamunex-C.....	68	lidocaine HCl.....	51	pioglitazone-metformin.....	80
Gengraf.....	51	lidocaine-prilocaine.....	51	Pregnyl.....	20
Genotropin.....	56	Liposyn II.....	51	Premasol 10 %.....	51
Genotropin Miniquick.....	56	Liposyn III.....	51	Premasol 6 %.....	51
Geodon.....	13	Lyrica.....	44	Pristiq.....	8
Gleevec.....	31	Maxalt.....	84	Privigen.....	68
granisetron.....	51	Maxalt-MLT.....	84	Procalamine 3%.....	51
Granisol.....	51	Miacalcin.....	51	Procrit.....	51
Halaven.....	32	Micardis.....	7	Prograf.....	51
Hectorol.....	51	Micardis HCT.....	7	Promacta.....	57
Hepatamine 8%.....	51	modafinil.....	45	Prosol 20%.....	51
Hepatasol 8 %.....	51	mycophenolate mofetil.....	51	Provigil.....	59
Herceptin.....	9	Myfortic.....	51	Pulmicort.....	51
Hizentra.....	68	Namenda.....	46	Pulmozyme.....	51
Humatrope.....	56	Namenda Titration Pak.....	46	Qualaquin.....	61
Humira.....	33	naratriptan.....	84	quinine sulfate.....	62
Humira Crohn's Dis Start		Nasonex.....	47	Rapamune.....	51
Pck.....	33	Nebupent.....	51	Reclast.....	99
Hycamtin.....	51	Neoral.....	51	Recombivax HB (PF).....	51
Imuran.....	51	Nephramine 5.4 %.....	51	Relistor.....	63
Incivek.....	34	Nexavar.....	48	Relpax.....	84
Increlex.....	35	nicardipine.....	51	Remicade.....	64
Inlyta.....	36	Norditropin FlexPro.....	56	Remodulin.....	60
Intralipid.....	51	Norditropin Nordiflex.....	56	Retin-A.....	81
Invega.....	13	Novarel.....	20	Retin-A Micro.....	81
ipratropium bromide.....	51	Nulojix.....	51	Revatio.....	60
ipratropium-albuterol.....	51	Nutropin.....	49	Revatio.....	65
irinotecan.....	51				

REVLIMID.....	66	Viibryd.....	8
Rhinocort Aqua.....	47	vinblastine.....	51
Rituxan.....	67	Virazole.....	51
Rocaltrol.....	51	Vivaglobin.....	68
Saizen.....	56	Votrient.....	91
Saizen click.easy.....	56	VPRIV.....	19
Sandimmune.....	51	Xalkori.....	92
Saphris.....	13	Xenazine.....	93
Serostim.....	56	Xolair.....	94
sildenafil.....	70	Xopenex.....	51
Simponi.....	71	Xylocaine.....	51
Sprycel.....	72	Xyrem.....	95
Stelara.....	73	Yervoy.....	96
Sutent.....	74	ZAVESCA.....	97
Sylatron.....	75	Zelboraf.....	98
Symbyax.....	13	Zemplar.....	51
Synagis.....	76	Zolinza.....	100
tacrolimus.....	51	Zometa.....	99
Tarceva.....	77	Zomig.....	82
Tasigna.....	78	Zomig.....	83
Tekturna.....	79	Zomig ZMT.....	83
Tekturna HCT.....	79	Zorbtive.....	56
Tev-Tropin.....	56	Zortress.....	51
Thymoglobulin.....	51	Zytiga.....	101
Tobi.....	51		
Toposar.....	51		
topotecan.....	51		
TPN Electrolytes.....	51		
Tracleer.....	60		
Travasol 10 %.....	51		
Treanda.....	51		
tretinoin.....	81		
TRETIN-X.....	81		
TRETIN-X (gel).....	81		
TrophAmine 10 %.....	51		
Trophamine 6%.....	51		
Tykerb.....	85		
TYSABRI.....	86		
vancomycin.....	51		
vandetanib.....	87		
Velcade.....	88		
Ventavis.....	60		
Veramyst.....	47		
Victoza.....	89		
Victrelis.....	90		