2013 Tufts Health Plan
Senior Care Options (HMO SNP)
Prior Authorization
Medical Necessity Guidelines

Effective January 1, 2013

Updated January 18, 2013

ACTEMRA

Drugs
Actemra

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

Exclusion Criteria
None

Required Medical Information
Rheumatoid Arthritis: The member must have a documented diagnosis of rheumatoid arthritis and documented inadequate response or inability to tolerate at least one tumor necrosis factor antagonist: Cimzia, Enbrel, Humira, Remicade, or Simponi. Systemic Juvenile Idiopathic Arthritis (SJIA): The member must have has a documented diagnosis of active systemic juvenile idiopathic arthritis and has demonstrated a documented inadequate response to or an inability to tolerate both of the following types of drugs: Nonsteroidal anti-inflammatory drugs (NSAIDs) and corticosteroids.

Age Restriction
For SJIA, the member must be over 2 years of age.

Prescriber Restriction
The prescribing physician must be a rheumatologist.

Coverage Duration
Life of Plan

Other Criteria
None

AFINITOR

Drugs
Afinitor

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

Exclusion Criteria
None

Required Medical Information
Advanced Renal Cell Carcinoma: The member must have a documented diagnosis of advanced renal cell carcinoma and has a demonstrated disease progression or intolerance following an appropriate trial with sunitinib (Sutent) or sorafenib (Nexavar). Subependymal Giant Cell Astrocytoma (SEGA): The member must have a documented diagnosis of subependymal giant cell astrocytoma associated with tuberous sclerosis and the member is not a candidate for surgical resection. Progressive Neuroendocrine Tumors (PNET): The member must have a documented diagnosis of progressive neuroendocrine tumor located in the pancreas and the tumor cannot be removed by surgery or has spread to other parts of the body.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

AMPYRA

Drugs
Ampyra

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of Multiple Sclerosis and the member is receiving concurrent therapy with a disease modifying agent (e.g. Avonex, Betaseron, Copaxone, Extavia, Gilenya, Rebif, or Tysabri) if indicated, and the member is ambulatory with a baseline timed 25 foot walk between 8 and 45 seconds.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Initial authorization will be for a period of 12 weeks.

Other Criteria
Additional authorization may be provided if there is documented improvement in walking speed from pre-treatment baseline by at least 25%.

ARCALYST

Drugs
Arcalyst

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of a Cryopyrin-Associated Periodic Syndrome, Familial Cold Autoinflammatory Syndrome, or Muckle-Wells Syndrome.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

BANZEL

Drugs
Banzel

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of Lennox-Gastaut Syndrome and has had an insufficient response or intolerance to at least one of the following medications: Valproic acid derivative, topiramate, lamotrigine and/or felbamate.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

BARBITURATES

Drugs
phenobarbital

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of epilepsy/seizure disorder, cancer or chronic mental health condition.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

BENLYSTA

Drugs
Benlysta

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

Exclusion Criteria
Benlysta (belimumab) will not be approved as monotherapy, for members with severe active lupus nephritis or severe active central nervous system lupus, for members who are autoantibody negative or in combination with other biologics or intravenous cyclophosphamide.

Required Medical Information
The member must have a documented diagnosis of active, autoantibody positive (e.g. ANA, anti-ds-DNA, anti-Sm) systemic lupus erythematosus and is concurrently compliant with standard therapy for systemic lupus erythematosus (e.g., corticosteroids, antimalarials, or immunosuppressives, alone or in combination).

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a rheumatologist.

Coverage Duration
Initial authorization for Benlysta will be 6 months.

Other Criteria
For subsequent coverage requests, please submit documentation that a clinical benefit has been established and maintained compared to baseline. Re-authorization will be limited to 12-month intervals.

CAPRELSA

Drugs
Caprelsa

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease.

Age Restriction
None

Prescriber Restriction
The prescriber must be an endocrinologist or oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

CARBAGLU

Drugs
Carbaglu

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

CELEBREX

Drugs
Celebrex

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

Exclusion Criteria
None

Required Medical Information
Tufts Medicare Preferred may authorize coverage of Celebrex for members meeting one or more of the following clinical criteria: Age 65 or greater, diagnosis of Rheumatoid Arthritis and 50 years of age or older, previous or active GI bleeding or hemorrhage, history of GERD or peptic ulcer disease (PUD), demonstrated lack of effectiveness in relief of symptoms or inability to tolerate a fair trial of at least two (2) prescription non-COX-2 inhibitor NSAIDs (e.g. diclofenac, fenoprofen, ibuprofen, naproxen, etc), bleeding diathesis or other medical condition(s) that would constitute a significant predisposition to bleeding, or if the member is currently taking any of the following medications: anticoagulants (e.g. warfarin, heparin, Lovenox, Fragmin, Innohep), methotrexate, azathioprine or other metabolites, oral corticosteroids (e.g. prednisone, dexamethasone, etc.), proton pump inhibitors (PPIs) (e.g. lansoprazole, omeprazole, pantoprazole), H2 antagonists (e.g. cimetidine , famotidine, ranitidine) or misoprostol.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

CIALIS

Drugs
Cialis

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

Exclusion Criteria
Cialis is excluded from coverage for the treatment of Erectile Dysfunction.

Required Medical Information
The member must have a documented diagnosis of Benign Prostatic Hyperplasia (BPH) and has had a documented failure, adverse reaction, or contraindication to a 30-day trial of at least two (2) of the following medications: Alfuzosin, terazosin, doxazosin, or tamsulosin.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

CIMZIA

Drugs
Cimzia, Cimzia Powder for Reconst

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

Exclusion Criteria
None

Required Medical Information
Crohn's Disease: The member must have a documented diagnosis of Crohn's disease and has demonstrated an inadequate response to an appropriate trial with two (2) or more of the following agents: Corticosteroids, 5-Aminosalicylates, 6-mercaptopurine and/or azathioprine or methotrexate, or if the member demonstrates a failure or intolerance to Remicade (infliximab). Rheumatoid Arthritis: The member must have a documented diagnosis of Rheumatoid Arthritis and has had an inadequate response at optimal doses or an inability to take methotrexate.

Age Restriction
Member must be 18 years of age or older

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

CINRYZE

Drugs
Cinryze

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

Exclusion Criteria
None

Required Medical Information
The member must have all of the following: 1. A documented diagnosis of hereditary angioedema (HAE). 2. The member's history of HAE attacks is consistent with at least one or more of the following criteria: One or more abdominal or respiratory attacks per month, a history of laryngeal attacks, or requires emergency medical care 3 or more times per year. 3. The member is not concurrently taking an angiotensin converting enzyme (ACE) inhibitor or estrogen replacement therapy. 4. The member has had an insufficient response or contraindication to both of the following classes of medications: 17-alpha alkylated androgens (e.g. danazol, stanozolol, oxandrolone, methyltestosterone) and antifibrinolytic agents (e.g. aminocaproic acid, tranexamic acid).

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an immunologist.

Coverage Duration
Life of Plan

Other Criteria
None

DIFICID

Drugs
Dificid

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of Clostridium difficile infection with a treatment failure or inadequate response to metronidazole or vancomycin.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

EGRIFTA

Drugs
Egrifta

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of lipodystrophy associated with human immunodeficiency virus (HIV).

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

ENBREL

Drugs
Enbrel

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

Exclusion Criteria
None

Required Medical Information
Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis and has failed to respond to, or has been unable to tolerate treatment with one (1) of the following medications: Soriatane, methotrexate or cyclosporine. Rheumatoid Arthritis and Polyarticular Juvenile Idiopathic Arthritis: The member must have a documented diagnosis of either disease and an inadequate response after three (3) months at optimal doses or an inability to take methotrexate. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three months. Enbrel is covered for the diagnosis of ankylosing spondylitis.

Age Restriction
Member is 2 years of age or older.

Prescriber Restriction
The prescribing physician must be a dermatologist or rheumatologist.

Coverage Duration
Life of Plan

Other Criteria
None

ERIVEDGE

Drugs
Erivedge

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of advanced or metastatic basal cell carcinoma and is not a candidate for surgery or radiation.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

FABRAZYME

Drugs
Fabrazyme

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

Exclusion Criteria
None

Required Medical Information
The member must have the definitive diagnosis of Fabry disease.

Age Restriction
None

Prescriber Restriction
The prescriber must be a cardiologist or nephrologist, or specialize in metabolic disorders or genetics.

Coverage Duration
Life of Plan

Other Criteria
None

FIRAZYR

Drugs
Firazyr

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

Exclusion Criteria
Firazyr (icatibant) will not be approved for members with acquired angioedema. Firazyr will not be approved for members concurrently taking an angiotensin converting enzyme (ACE) inhibitor.

Required Medical Information
The member must have a documented diagnosis of type I or II hereditary angioedema. The diagnosis must be confirmed by laboratory testing (e.g., low C4 level, reduced C1 esterase inhibitor level or function) and the member has a history of at least one severe attack per month.

Age Restriction
The member must be 18 years of age or older.

Prescriber Restriction
The prescribing physician must be an allergist, hematologist or immunologist.

Coverage Duration
Life of Plan

Other Criteria
None

FORTEO

Drugs
Forteo

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

Exclusion Criteria
Coverage of Forteo will not be approved when used in combination with alendronate, Boniva, Fosamax or Miacalcin.

Required Medical Information
Tufts Medicare Preferred may authorize coverage of Forteo when the requesting physician has documented that the member is at high risk for fracture and has a T score less than or equal to -2.0 as evidenced via bone density scan or the requesting physician has documented that the member has had one or more osteoporotic fractures. For either condition previously listed, the member must also have had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments: alendronate, calcitonin (Miacalcin), denosumab (Prolia), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel) or zoledronic acid (Reclast).

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Coverage of Forteo is limited to 24 months.

Other Criteria
None

GAUCHER DISEASE TYPE 1 TREATMENTS

Drugs
Cerezyme, VPRIV

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

Exclusion Criteria
Not covered for Type 2 or Type 3 Gaucher Disease.

Required Medical Information
The member must have a documented diagnosis of Type 1 Gaucher disease with at least a minimal level of disease severity.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

GILENYA

Drugs
Gilenya

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of either relapsing remitting multiple sclerosis or secondary progressive multiple sclerosis.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

GROWTH HORMONE REPLACEMENT THERAPY

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

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

Exclusion Criteria
None

Required Medical Information
Pediatric GHD, Initiation, Member must be evaluated and treated by a pediatric endocrinologist, have not attained epiphyseal closure as determined by X-ray, have failed to respond to at least TWO standard GH stimulation test, have documented gender-specific delayed bone age, have the height at initiation of therapy at greater than 2 standard deviations below normal mean for age and sex.Member must have one of the following, Chronic Renal Insufficiency prior to transplantation, Turner Syndrome, Prader-Willi Syndrome, Intrauterine Growth Retardation or Noonan Syndrome. Pediatric GHD, continuation, documentation of the following is required, medical history as it relates to growth, including any test results and growth chart, Continuing care plan and at least a doubling of the annualized pre-treatment growth rate after the first 6 months of therapy then an increase growth velocity of at least 3cm per year thereafter. Continuation of Therapy after Completion of Linear Growth, member will be re-evaluated after GH treatments have been stopped for at least 3 months to determine growth hormone status AND Member must have failed to respond to at least one standard GH stimulation test. Acquired GHD, Member must have failed to respond to at least one standard GH stimulation test. AIDS Wasting Syndrome, documented diagnosis of AIDS AND a weight loss of at least 10% from baseline weight OR a BMI of less then 20 AND documentation that the member has had an adequate nutritional evaluation and has failed to respond adequately to a high calorie diet.Short Bowel Syndrome, a documented diagnosis of Short Bowel Syndrome from a gastroenterologist AND A documented dependence on IPN for nutritional support

Age Restriction
N/A

Prescriber Restriction
None

Coverage Duration
Pediatric GHD, 6 months. Acquired GHD, 1 year. Short Bowel Syndrome, Zorbtive only, 28 days

Other Criteria
None

HUMIRA

Drugs
Humira, Humira Crohn's Dis Start Pck

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

Exclusion Criteria
None

Required Medical Information
Crohn's Disease: The member must have a documented diagnosis of Crohn's disease and has demonstrated an inadequate response to an appropriate trial with two (2) or more of the following agents: Corticosteroids, 5-Aminosalicylates, 6-mercaptopurine and/or azathioprine or methotrexate, or if the member demonstrates a failure or intolerance to Remicade (infliximab). Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis and has failed to respond to, or has been unable to tolerate, treatment with one (1) of the following medications: Soriatane, methotrexate or cyclosporine. Rheumatoid Arthritis and Polyarticular Juvenile Idiopathic Arthritis: The member must have a documented diagnosis of either disease or an inadequate response after three (3) months at optimal doses or an inability to take methotrexate. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three months. Humira is covered for the diagnosis of ankylosing spondylitis.

Age Restriction
Member is 4 years of age or older

Prescriber Restriction
The prescribing physician must be a dermatologist, rheumatologist or gastroenterologist.

Coverage Duration
Life of Plan

Other Criteria
None

ILARIS

Drugs
Ilaris (PF)

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of a Cryopyrin-Associated Periodic Syndrome, Familial Cold Autoinflammatory Syndrome, or Muckle-Wells Syndrome.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

INCIVEK

Drugs
Incivek

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

Exclusion Criteria
Incivek coverage will not be approved for members who have previously failed treatment with Victrelis (boceprevir).

Required Medical Information
The member must have a documented diagnosis of Chronic Hepatitis C, genotype 1 infection. Incivek must be given in combination with a pegylated interferon and ribavirin.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

INCRELEX

Drugs
Increlex

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

Exclusion Criteria
Coverage of Increlex will not be authorized for conditions resulting in secondary forms of IGFD that include, but are not limited to: GH deficiency, malnutrition, hypothyroidism, or chronic steroid therapy.

Required Medical Information
The member must have a documented diagnosis of severe primary IGFD as defined by a height SD score less than or equal to -3.0, a basal IGF-1 SD score less than to equal to -3.0 , normal or elevated GH level OR GH gene deletion and has developed neutralizing antibodies to GH. Radiographs documenting open epiphyses are required for members who are Tanner stage III or greater.

Age Restriction
Members age 2 to 18 years

Prescriber Restriction
The prescribing physician must be an endocrinologist.

Coverage Duration
6 months initial. Subsequent authorization are annual

Other Criteria
None

INFUSED BISPHOSPHONATES

Drugs
Boniva, Reclast, Zometa

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

Exclusion Criteria
None

Required Medical Information
Boniva (ibandronate sodium) and Reclast (zoledronic acid) Injections: The member must have a documented diagnosis of osteoporosis and meet one (1) of the following criteria: 1. Documentation of an inadequate response or inability to tolerate one or more oral bisphosphonates (e.g., alendronate, Actonel, Boniva tablets). 2. Documented inability to swallow. 3. Documented inability to remain in an upright position for one hour post oral bisphosphonate administration. Tufts Medicare Preferred does not require prior authorization for coverage of Reclast Injection for the treatment of Paget's disease of the bone. Tufts Medicare Preferred does not require prior authorization for coverage of Zometa (zoledronic acid) Injection for members for the following diagnoses: Hypercalcemia of malignancy, Multiple myeloma, or documented bone metastases from solid tumors.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Initial Authorization: 24 months

Other Criteria
For coverage requests beyond 24 months, documentation must be submitted that the member is at high risk for fracture and has a T score less than or equal to -2.0 as evidenced via bone density scan or that the member has had one or more osteoporotic fractures. Boniva IV is not covered for members who are identified by CMS as having End Stage Renal Disease (ESRD) and are undergoing dialysis.

INJECTABLE DRUGS FOR ACROMEGALY

Drugs
SOMAVERT

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of acromegaly and has had a failure of, or is unable to tolerate, a treatment regimen that includes octreotide, and the member is not a candidate for surgery and/or radiation, or has had an inadequate response to surgery and/or radiation.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an endocrinologist.

Coverage Duration
Life of Plan

Other Criteria
None

INLYTA

Drugs
Inlyta

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of advanced renal cell carcinoma and has failed a trial of at least one first-line systemic therapy (e.g. Afinitor, Avastin, Nexavar, Sutent, Torisel, Votrient).

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

INTRAVENOUS IMMUNE GLOBULIN

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

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

Exclusion Criteria
Coverage not approved for progressive MS

Required Medical Information
Documented diagnosis one of the following, primary humoral immunodeficiency (Congenital agammaglobulinemia, Common variable immunodeficiency, Wiskott-Aldrich syndrome, X-linked agammaglobulinemia, or Severe combined immunodeficiency). Recurrent severe infection and documented severe deficiency or absence of IgG subclass. Clinically significant functional deficiency of humoral immunity as evidenced by documented failure to produce antibodies to specific antigens and a history of recurrent infections. Immune thrombocytopenic purpura (ITP) (Acute and Chronic refractory ITP). Chronic lymphocytic leukemia with associated hypogammaglobulinemia. Symptomatic human immunodeficiency virus (HIV) in patients less than 13 years of age, who are immunologically abnormal. Bone marrow transplantation. Solid organ transplantation. Kawasaki disease (mucocutaneous lymph node syndrome). Acute and chronic inflammatory Demyelinating polyradiculoneuropathy, Guillain-Barre syndrome, myasthenia gravis, Immune thrombocytopenic purpura in pregnancy, multifocal motor neuropathy (MMN) and dermatomyositis. Autoimmune mucocutaneous blistering diseases (Pemphigus vulgaris, Pemphigus foliaceus, Bullous pemphigoid, Mucous membrane pemphigoid (a.k.a., cicatrical pemphigoid), or Epidermolysis bullosa Acquisita). Scleromyxedema is covered for patients whose treatment with more traditional measures has failed. Humoral or vascular allograft rejection. Hemolytic uremic syndrome, Hemolytic anemia. Polymyositis and Dermatomyositis. Sensitized renal transplant recipients. Sepsis, Kidney disease, CMV infection, von Willebrand disorder, Uveitis, Toxic shock syndrome, RSV infection, HIV-associated thrombocytopenia, West Nile virus infection (including meningitis and encephalitis) and treatment of post-transfusion Purpura, chronic inflammatory demyelinating polyneuropathy, Hepatitis A, Measles (Rubeola), Rubella, Varicella in immunosuppressed patients when varicella zoster immunoglobulin is not available.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
6 months upon initial approval

Other Criteria
None

ITRACONAZOLE

Drugs
itraconazole

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

Exclusion Criteria
None

Required Medical Information
The member has must have a documented diagnosis of onychomycosis of the fingernails or toenails, or tinea capitis, and the requesting physician has documented that the member has had a treatment failure of, or is unable to tolerate, an adequate trial of terbinafine tablets or Lamisil oral granules, or the requesting physician has documented that the member has a case of one of the following fungal infections: Blastomycosis, Histoplasmosis, Cryptococcus neoformans, Aspergillosis or Tinea (pedis, corporis) resistant to aggressive topical therapy.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

JAKAFI

Drugs
Jakafi

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of intermediate or high-risk myelofibrosis.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Tufts Medicare Preferred will initially authorize Jakafi (ruxolitinib) for a period of 6 months.

Other Criteria
Subsequent authorization requires documentation of spleen size reduction or symptomatic improvement.

KALYDECO

Drugs
Kalydeco

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

Exclusion Criteria
None

Required Medical Information
Kalydeco is covered for members with a documented diagnosis of cystic fibrosis with a confirmed G551D mutation in the CFTR gene.

Age Restriction
The member must be 6 years of age or older.

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

KINERET

Drugs
Kineret

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of Rheumatoid Arthritis and has documented inadequate response at optimal doses or an inability to take methotrexate.

Age Restriction
Member is 18 years of age or older

Prescriber Restriction
The prescribing physician must be a rheumatologist.

Coverage Duration
Life of Plan

Other Criteria
None

KUVAN

Drugs
Kuvan

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

Exclusion Criteria
Tufts Health Plan will not cover Kuvan unless used in conjunction with a phenylalanine-restricted diet.

Required Medical Information
The member must have a documented diagnosis of hyperphenylalaninemia (HPA) due to tetrahydrobiopterin-(BH4-) responsive phenylketonuria (PKU).

Age Restriction
None

Prescriber Restriction
The prescribing physican must be a specialist in metabolic diseases.

Coverage Duration
Up to 8 weeks after initial approval.

Other Criteria
None

LIDODERM

Drugs
Lidoderm

Covered Uses
All medically accepted indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.

Exclusion Criteria
None

Required Medical Information
Postherpetic Neuralgia or Diabetic Neuropathy: The member must have had a failure, adverse reaction, or contraindication to gabapentin. Coverage will be authorized for members new to Tufts Medicare Preferred if their pain is currently-well controlled on Lidoderm.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

MEDICATIONS FOR CHRONIC HEPATITIS B AND C INFECTION

Drugs
Infergen, Pegasys, Pegasys Convenience Pack, Pegasys ProClick, PegIntron, PegIntron Redipen

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

Exclusion Criteria
None

Required Medical Information
Histologic and virologic evidence of chronic infection including HCV genotype and viral load and documented use of a ribavirin product in conjunction with the pegylated interferon. For Genotype 1, must have abnormal serum ALT (at least twice normal) or a liver biopsy showing portal or bridging fibrosis and at least moderate inflammation and necrosis. Authorization for genotypes 2 and 3 does not require elevated transaminase levels or abnormal liver biopsy. Coverage of Infergen therapy for up to 48 weeks if the the member demonstrates a tolerance to previous pegylated interferon therapy with Pegasys and has an inadequate response or has relapsed following its discontinuation or intolerance to Pegasys. Pegasys therapy may be authorized for Members diagnosed with HBeAg positive and HBeAg negative hepatitis B when there is histologic and virologic evidence of chronic infection. Member must be HBeAg positive for more than six months and has evidence of active virus replication (greater than 20,000 IU/ml) or the member is HBeAg-negative and has evidence of active virus replication (greater than 2,000 IU/ml) and has active liver disease with a serum ALT greater than twice the upper limit of normal or chronic hepatitis on liver biopsy.

Age Restriction
For Infergen, the member must be at least 18 years of age. For Pegasys, the member must be at least 5 years of age. For Peg-Intron, the member must be at least 3 years of age.

Prescriber Restriction
None

Coverage Duration
Geno1,16 wks,Geno2and3, 24 wks.48 wks for Infergen, co-infection w HIV or HBV.Pegasys 48 wks

Other Criteria
Tufts Health Plan will not cover pegylated interferon therapy for a member who have failed or relapsed after prior pegylated interferon therapy or for members with uncontrolled major depression due to increased risk of suicide during interferon treatment or other interferon preparations unless a member has a contraindication to Pegasys or has failed a trial of Pegasys

MEDICATIONS FOR THE TREATMENT OF PULMONARY HYPERTENSION

Drugs
Adcirca, Letairis, Remodulin, Revatio, Tracleer, Ventavis

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

Exclusion Criteria
None

Required Medical Information
The member must have a definitive diagnosis of pulmonary artery hypertension (WHO Group 1) as confirmed by right heart catheterization. World Health Organization (WHO) Classification of Pulmonary Hypertension Group I: Idiopathic PAH (primary pulmonary hypertension), Heritable PAH, drug- and toxin-induced PAH, PAH associated with other diseases and conditions (APAH), such as: Connective tissue diseases, HIV infection, portal hypertension, congenital heart disease, Schistosomiasis, or chronic hemolytic anemia.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a cardiologist or pulmonologist.

Coverage Duration
Life of Plan

Other Criteria
None

MOZOBIL

Drugs
Mozobil

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

Exclusion Criteria
N/A

Required Medical Information
The member must have a documented diagnosis of non-Hodgkin's lymphoma or multiple myeloma and Mozobil is being used in combination with one of the following colony stimulating factors: Neupogen (filgrastim) or Leukine (sargramostim), and standard stem cell mobilization procedures utilizing one of the above medications alone have been unsuccessful.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

NEXAVAR

Drugs
Nexavar

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of advanced Renal Cell Carcinoma or biopsy-proven, unresectable hepatocellular carcinoma.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a nephrologist, oncologist, or urologist.

Coverage Duration
Life of Plan

Other Criteria
None

NUEDEXTA

Drugs
Nuedexta

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

Exclusion Criteria
N/A

Required Medical Information
The member must have a documented diagnosis of pseudobulbar affect (PBA) secondary to amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), or bilateral stroke.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

ORENCIA

Drugs
Orencia

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

Exclusion Criteria
Coverage of Orencia will not be approved if administered concomitantly with another tumor necrosis factor antagonist or Kineret (anakinra).

Required Medical Information
Rheumatoid Arthritis: The member has a documented diagnosis of Rheumatoid Arthritis has a documented inadequate response or inability to tolerate at least one tumor necrosis factor antagonist, including Cimzia (certolizumab), Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab) or Simponi (golimumab). Juvenile Idiopathic Arthritis: The member has a documented inadequate response or inability to tolerate Enbrel (etanercept) or Humira (adalimumab).

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a rheumatologist.

Coverage Duration
Life of Plan

Other Criteria
None

ORFADIN

Drugs
Orfadin

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of genetic tyrosinemia Type-1 (hereditary tyrosinemia Type-1)

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

Drugs

acetylcysteine, albuterol sulfate, Aloxi, Aminosyn 8.5 %-Electrolytes, Aminosyn II 10 %, Aminosyn II 15%, Aminosyn II 7 %, Aminosyn II 8.5 %, Aminosyn II 8.5 %-Electrolytes, Aminosyn M 3.5 %, Aminosyn-HBC 7%, Aminosyn-PF 10 %, Aminosyn-PF 7 % (Sulfite-Free), Anzemet, Aranesp (in polysorbate), Azasan, azathioprine, azathioprine sodium, Brovana, budesonide, calcitonin (salmon), calcitriol, CellCept, Cesamet, Clinimix 2.75%/D5 Sulfite Free, Clinimix 4.25%/D5 Sulfite Free, Clinimix 4.25/D10 Sulfite Free, Clinimix 4.25/D20 Sulfite Free, Clinimix 4.25/D25 Sulfite Free, Clinimix 5%/D15 Sulfite Free, Clinimix 5%/D20 Sulfite Free, Clinimix 5%/D25 Sulfite Free, Clinimix E 2.75/D10 SulfitFree, Clinimix E 2.75/D5 SulfiteFree, Clinimix E 4.25/D25 SulfitFree, Clinimix E 4.25/D5 SulfiteFree, Clinimix E 5%/D15 Sulfite Free, Clinimix E 5%/D20 Sulfite Free, Clinimix E 5%/D25 Sulfite Free, Clinisol SF 15 %, cromolyn, CUBICIN, cyclophosphamide, cyclosporine, cyclosporine modified, dronabinol, Emend, Engerix-B (PF), Epogen, Freamine III 3 %-Electrolytes, Freamine III 8.5 %, Gengraf, granisetron, granisetron (PF), Granisol, Hectorol, heparin (porcine), heparin (porcine) in D5W, heparin (porcine) in NaCl (PF), heparin(porcine) in 0.45% NaCl, Hepatamine 8%, Hepatasol 8 %, Intralipid, ipratropium bromide, ipratropium-albuterol, levalbuterol HCl, levocarnitine, levocarnitine (with sugar), methotrexate sodium, mycophenolate mofetil, Myfortic, Nebupent, Nephramine 5.4 %, Nulojix, ondansetron, ondansetron HCl, ondansetron HCl (PF), Pentam, Perforomist, Premasol 10 %, Premasol 6 %, Procalamine 3%, Procrit, Prograf, Prosol 20%, Pulmicort, Pulmozyme, Rapamune, Recombivax HB (PF), Sancuso, Simulect, tacrolimus, Tobi, TPN Electrolytes, Travasol 10 %, Trexall, TrophAmine 10 %, Trophamine 6%, vancomycin, Xopenex, Zemplar, Zortress

Covered Uses

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Other Criteria

POTIGA

Drugs
Potiga

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of partial-onset seizures and has had an insufficient response or intolerance to at least one other medication indicated for adjunct partial seizures (e.g. Felbatol (felbamate), Gabitril (tiagabine), Lamictal (lamotrigine), Lyrica (pregabalin), Keppra / Keppra XR (levetiracetam), Neurontin (gabapentin), Topamax (topiramate), Trileptal (oxcarbazepine) and/or Zonegran (zonisamide)).

Age Restriction
The member must must be 18 years of age or older.

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

PRADAXA

Drugs
Pradaxa

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of atrial fibrillation.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

PROLIA AND XGEVA

Drugs
Prolia, Xgeva

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

Exclusion Criteria
None

Required Medical Information
Tufts Medicare Preferred may authorize coverage of Prolia (denosumab) for the treatment of postmenopausal women with osteoporosis when the following criteria are met: The member is at high risk of fracture defined as a history of osteoporotic fracture or multiple risk factors for fracture and a T score less than or equal to -2.0 as evidenced via bone density scan or the member has had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments: alendronate, calcitonin (Miacalcin), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel), or zoledronic acid (Reclast). For men with non-metastatic prostate cancer, the member must have a documented diagnosis of non-metastatic prostate cancer and is at high risk of fracture defined as a history of osteoporotic fracture or multiple risk factors for fracture and a T score less than or equal to -2.0 as evidenced via bone density scan and the member is receiving androgen deprivation therapy. For women with breast cancer, the member must have a definitive diagnosis of breast cancer is at high risk of fracture defined as a history of osteoporotic fracture or multiple risk factors for fracture and a T score less than or equal to -2.0 as evidenced via bone density scan and is receiving adjuvant aromatase inhibitor therapy. Tufts Medicare Preferred may authorize coverage of Xgeva (denosumab) for prevention of skeletal-related events in patients with bone metastases from solid tumors only.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

PROMACTA

Drugs
Promacta

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) and has had an insufficient response or intolerance to corticosteroids and/or immunoglobulins, or the member has not responded to splenectomy.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

REMICADE

Drugs
Remicade

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

Exclusion Criteria
None

Required Medical Information
Crohn’s Disease or Ulcerative Colitis / Pediatric Ulcerative Colitis: The member has a documented diagnosis of Crohn's disease or Ulcerative Colitis and has demonstrated an inadequate response to an appropriate trial with one (1) or more of the following agents: Corticosteroids, 5-Aminosalicylates, 6-mercaptopurine and/or azathioprine or methotrexate. Plaque Psoriasis: The member must have a documented diagnosis of severe chronic plaque psoriasis and has failed to respond to, or has been unable to tolerate, treatment with one (1) of the following medications: Soriatane, methotrexate or cyclosporine. Rheumatoid Arthritis: The member must have a documented diagnosis of rheumatoid arthritis and a documented inadequate response or inability to tolerate methotrexate. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and a documented inadequate response or inability to tolerate methotrexate. Remicade is covered for the diagnosis of ankylosing spondylitis.

Age Restriction
The member must be 18 years of age or older. For pediatric Crohn's Disease and Ulcerative Colitis, the member must 6 years of age or older.

Prescriber Restriction
The prescribing physician must be a dermatologist, gastroenterologist, or rheumatologist.

Coverage Duration
Life of Plan

Other Criteria
None

RESTASIS

Drugs
Restasis

Covered Uses
All medically accepted indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.

Exclusion Criteria
None

Required Medical Information
The member must have a definitive diagnosis of Keratoconjuctivitis Sicca (KCS), Sjogrens Syndrome, or is being treated for Ocular Graft vs. Host Disease or Corneal Transplant Rejection.

Age Restriction
The member must be 16 years of age or older.

Prescriber Restriction
The prescribing physician must be an ophthalmologist or optometrist.

Coverage Duration
Life of Plan

Other Criteria
None

RETINOIDS FOR THE TOPICAL TREATMENT OF ACNE VULGARIS AND PSORIASIS

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

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

Exclusion Criteria
Tufts Medicare Preferred will not authorize coverage of topical acne products for cosmetic purposes,

Required Medical Information
Tufts Medicare Preferred may authorize coverage of the topical acne products for members 26 years of age or older, when either one of the following criteria is met: The member has a physician documented diagnosis of acne, comedones (white heads), or actinic keratosis. For Tazorac, the member must have a physician documented diagnosis of plaque psoriasis or documented diagnosis of skin cancer provided effective treatment with Tazorac is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

REVLIMID

Drugs
REVLIMID

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

Exclusion Criteria
None

Required Medical Information
Myelodysplastic Syndrome: The member must have a documented diagnosis of transfusion-dependent anemia due to myelodysplastic syndrome associated with the 5q-deletion cytogenetic abnormality.
Multiple Myeloma: The member must have a documented diagnosis of Multiple Myeloma and Revlimid is being used in combination with dexamethasone and the member has received and failed to respond to at least one prior therapy.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a hematologist or oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

RITUXAN

Drugs
Rituxan

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

Exclusion Criteria
None

Required Medical Information
Tufts Medicare Preferred may authorize coverage of Rituxan in combination with methotrexate for members with a diagnosis of active rheumatoid arthritis and have a documented inadequate response to an appropriate trial with at least one tumor necrosis factor (TNF) antagonist therapy, including Cimzia (certolizumab pegol), Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab) or Simponi (golimumab). Tufts Medicare Preferred may authorize coverage of Rituxan for members with a documented diagnosis of Wegener's granulomatosis or microscopic polyangiitis, and the member is concurrently taking glucocorticoids (e.g., prednisone). Rituxan does not require prior authorization for members with a diagnosis of Non-Hodgkins Lymphoma or Chronic Lymphocytic Leukemia.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist or rheumatologist.

Coverage Duration
Authorization for Wegener's granulomatosis or microscopic polyangiitis will be limited to 6 months.

Other Criteria
Additional authorization for Wegener's granulomatosis or microscopic polyangiitis may be given if documentation of an objective measurable effect is provided indicating clinical improvement of condition. Subsequent authorizations may be given in 6-month intervals.

SIMPONI

Drugs
Simponi

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

Exclusion Criteria
None

Required Medical Information
Rheumatoid Arthritis: The member must have a documented diagnosis of Rheumatoid Arthritis and has had an inadequate response or inability to tolerate methotrexate at optimal doses. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to tolerate methotrexate or sulfasalazine at maximal doses. Simponi is covered for members with a documented diagnosis of ankylosing spondylitis.

Age Restriction
The member must be 18 years of age or older.

Prescriber Restriction
The prescribing physician must be a dermatologist or rheumatologist.

Coverage Duration
Life of Plan

Other Criteria
None

SPRYCEL

Drugs
Sprycel

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

Exclusion Criteria
None

Required Medical Information
Chronic Myeloid (or Myelogenous) Leukemia (CML): The member must have a documented diagnosis of accelerated, or myeloid or lymphoid blast phase Ph+ CML and documented resistance or intolerance to prior therapy, including Gleevec (imatinib mesylate). Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL): The member must have a documented diagnosis of Ph+ALL and documented resistance or intolerance to prior therapy, including Gleevec (imatinib mesylate). Philadelphia chromosome-positive chronic myeloid leukemia in chronic phase (Ph+ CP-CML): The member must have a documented diagnosis of Ph+ CP-CML.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

STELARA

Drugs
Stelara

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

Exclusion Criteria
None

Required Medical Information
Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis and has failed to respond to, or has been unable to tolerate, treatment with one (1) of the following medications: Soriatane (acitretin), methotrexate or cyclosporine.

Age Restriction
The member must be 18 years of age or older.

Prescriber Restriction
The prescribing physician must be a dermatologist.

Coverage Duration
Life of Plan

Other Criteria
None

SUBOXONE

Drugs
Suboxone

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

Exclusion Criteria
Suboxone will not be covered to treat pain.

Required Medical Information
The member must have a documented diagnosis of opioid dependence.

Age Restriction
None

Prescriber Restriction
The requesting physician must be certified to prescribe buprenorphine for opioid dependence and has been granted a special DEA waiver and prefix code (X DEA number), in accordance with DATA 2000.

Coverage Duration
Life of Plan

Other Criteria
None

SUTENT

Drugs
Sutent

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

Exclusion Criteria
None

Required Medical Information
Advanced Renal Cell Carcinoma: The member must have a documented diagnosis of advanced renal cell carcinoma. Gastrointestinal Stromal Tumor (GIST): The member must have a documented diagnosis of gastrointestinal stromal tumor and has a demonstrated disease progression or intolerance following an appropriate trial with Gleevec (imatinib mesylate). Progressive Neuroendocrine Tumors: The member must have a documented diagnosis of progressive neuroendocrine tumor located in the pancreas and the tumor cannot be removed by surgery or has spread to other parts of the body.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

SYLATRON

Drugs
Sylatron

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of melanoma with microscopic or gross nodal involvement and the melanoma has been completely excised with adequate surgical margins and complete lymphadenectomy must have occurred within 84 days.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a dermatologist or an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

SYNAGIS

Drugs
Synagis

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

Exclusion Criteria
None

Required Medical Information
For Chronic Lung Disease, infants and children less than 24 months of age with a diagnosis of chronic lung disease (CLD, formerly Bronchopulmonary Dysplasia) requiring medical management within the 6 months prior to the anticipated RSV season. Examples of medical management include, but are not limited to, oxygen therapy, diuretics or inhaled corticosteroids. For prematurity, infants born at 32 weeks gestation or less who do not have a diagnosis of chronic lung disease or do not meet the above criteria, but are either born at 29 - 32 weeks of gestation and are age 6 months or less at onset of the RSV season or born at 28 weeks of gestation or less and are age 12 months or less at onset of the RSV season. For immunodeficiency, children under 24 months of age at the onset of RSV season with an immunodeficiency caused by, but not limited to, HIV or cancer chemotherapy that may make them more susceptible to severe lower respiratory tract disease. For congenital heart disease, infants and children under age 24 months at the start of the RSV season with hemodynamically significant congenital heart disease, which includes congestive heart failure, moderate to severe pulmonary artery hypertension or cyanotic heart disease. For infants born at 32 to 35 weeks gestation and age less than 6 months at the beginning of the RSV season with two (2) or more of the following underlying conditions, which are severe neuromuscular disease, school-aged siblings, congenital abnormalities of the airways, daycare and/or exposure environmental air pollutants, including tobacco smoke.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Injections are administered monthly for a maximum of 5 doses during the RSV season.

Other Criteria
The first dose must be administered after October 15 and the last dose before March 15.

TASIGNA

Drugs
Tasigna

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

Exclusion Criteria
None

Required Medical Information
Newly Diagnosed Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML-CP): The member must have a documented diagnosis of Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase. Resistant or Intolerant Ph+ CML-CP and CML-AP: The member must have a documented diagnosis of Philadelphia chromosome positive chronic myelogenous leukemia in chronic phase or in accelerated phase and documented resistance or intolerance to prior therapy, including Gleevec (imatinib mesylate).

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

TYKERB

Drugs
Tykerb

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

Exclusion Criteria
None

Required Medical Information
For HER2 overexpressing advanced or metastatic breast cancer, the member must have all of the following: 1. A documented diagnosis of HER2 overexpressing advanced or metastatic breast cancer. 2. The member has failed prior therapy with an appropriate trial of an anthracycline and a taxane chemotherapeutic agent. 3. The member has failed prior therapy with an appropriate trial of Herceptin (trastuzumab). 4. The member is concurrently treated with Xeloda (capecitabine). Hormone receptor positive metastatic breast cancer in post-menopausal women: The member must have a documented diagnosis of hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor and is concurrently being treated with an aromatase inhibitor (e.g. anastrozole, exemestane, or lotrozole).

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

TYSABRI

Drugs
TYSABRI

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

Exclusion Criteria
Tufts Health Plan will not approve Tysabri when used in conjunction with other medications for the treatment of progressive multiple sclerosis (Betaseron, Avonex, Rebif or Copaxone) or when used in conjunction with other medications (corticosteroids, 5-aminosalicylates, 6-mercaptopurine and/or azathioprine, methotrexate or Humira)

Required Medical Information
Multiple Sclerosis: The member must have a documented diagnosis of relapsing multiple sclerosis and has a documented inadequate response or inability to tolerate an appropriate trial with at least one of the following agents: Avonex, Betaseron, Copaxone, Extavia, Gilenya, or Rebif. For Crohn's Disease, the member must have all of the following: 1. A documented diagnosis of Crohn's Disease. 2. Demonstrated an inadequate response to an appropriate trial with two (2) or more of the following agents: Corticosteroids (e.g., prednisone, prednisolone, methylprednisolone), 5-Aminosalicylates (e.g., sulfasalazine, Azulfidine, Asacol, Pentasa, Rowasa, Dipentum, Colazal), 6-mercaptopurine (6-MP, Purinethol) and/or azathioprine, and/or methotrexate. 3. The Member has demonstrated an inadequate response to an appropriate trial with at least one of the following TNF-inhibitors: Cimzia, Humira or Remicade.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a gastroenterologist or neurologist.

Coverage Duration
Coverage will be intially authorized for 6 months. Re-authorization will be in 6-month increments.

Other Criteria
None

VICTRELIS

Drugs
Victrelis

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

Exclusion Criteria
Victrelis coverage will not be approved for members who have previously failed treatment with Incivek (telaprevir).

Required Medical Information
The member must have a documented diagnosis of Chronic Hepatitis C, genotype 1 infection. Vitrelis must be given in combination with a pegylated interferon and ribavirin.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

VIMPAT

Drugs
Vimpat

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of partial-onset seizures and has had an insufficient response or intolerance to at least one other medication indicated for adjunct partial seizures, such as: felbamate, Gabitril (tiagabine), Lamictal XR, lamotrigine, Lyrica (pregabalin), levetiracetam, gabapentin, topiramate, oxcarbazepine and/or zonisamide.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

VOTRIENT

Drugs
Votrient

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of advanced Renal Cell Carcinoma.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

XALKORI

Drugs
Xalkori

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by a Food and Drug Administration (FDA)-approved test.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

XARELTO

Drugs
Xarelto

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

Exclusion Criteria
None

Required Medical Information
Tufts Medicare Preferred may authorize coverage of Xarelto (rivaroxaban) 15 mg or 20 mg for members with a documented diagnosis of non-valvular atrial fibrillation.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
Xarelto 10 mg is covered without Prior Authorization for deep vein thrombosis (DVT) prophylaxis with a quantity limitation of 35 tablets per fill.

XENAZINE

Drugs
Xenazine

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of at least moderate chorea associated with Huntington's Disease and has demonstrated an inadequate response to OR is unable to tolerate an adequate trial with at least one of the following medications or classes of medication: Benzodiazepines, amantadine and/or Antipsychotics.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

XIFAXAN 550 MG

Drugs
Xifaxan

Covered Uses
All medically accepted indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D.

Exclusion Criteria
Coverage will not be authorized for treatment of diarrhea caused by pathogens other than E. coli, diarrhea complicated by fever or bloody stools, Irritable Bowel Syndrome, or prevention of traveler's diarrhea.

Required Medical Information
Hepatic Encephalopathy: The member must have a documented diagnosis of hepatic encephalopathy and has had an inadequate response or has a contraindication to lactulose (Constulose, Duphalac, Enulose, Generlac). Inflammatory Bowel Disease: The member must have a documented diagnosis of Inflammatory Bowel Disease (IBD) and has failed to respond to or has a contraindication to standard antibiotic treatment (e.g., ciprofloxacin, metronidazole).

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
Xifaxan 200 mg tablets do not require authorization.

XOLAIR

Drugs
Xolair

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

Exclusion Criteria
None

Required Medical Information
Tufts Medicare Preferred may authorize coverage of Xolair when all of the following criteria are met: 1. The member has had a failure of a treatment regimen that included inhaled corticosteroids, oral corticosteroids, leukotriene modifiers and inhaled long-acting bronchodilators, or is unable to tolerate these medications. 2. The member shows a definitive sensitivity on allergy testing to one or more perennial allergens. 3. The member has a pre-treatment serum IgE level equal to or greater then 30 IU/mL and less than or equal to 700 IU/mL.

Age Restriction
The member must 12 years of age or older.

Prescriber Restriction
The prescribing physician must be an asthma specialist (allergist, immunologist, or pulmonologist).

Coverage Duration
Life of Plan

Other Criteria
None

ZAVESCA

Drugs
ZAVESCA

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of Type 1 Gaucher Disease and cannot be treated with enzyme replacement therapy (e.g. Cerezyme).

Age Restriction
The member must be 18 years of age or older.

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

ZELBORAF

Drugs
Zelboraf

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of unresectable or metastatic melanoma that is BRAF V600E mutation-positive as detected by an FDA-approved test.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

ZOLINZA

Drugs
Zolinza

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of advanced cutaneous T-cell lymphoma (Stage IIB and higher) and progressive, persistent or recurrent disease and documented current or prior treatment or treatment failure with at least one (1) systemic chemotherapeutic agents for cutaneous T-cell lymphoma.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

ZYTIGA

Drugs
Zytiga

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of metastatic castration-resistant prostate cancer (CRPC) and has received prior chemotherapy containing docetaxel. Zytiga must be used in combination with prednisone.

Age Restriction
None

Prescriber Restriction
The prescriber must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

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