2014 Tufts Health Plan
Senior Care Options (HMO SNP)
Prior Authorization
Medical Necessity Guidelines

Effective January 1, 2014

Updated October 01, 2014

ACTEMRA

Drugs
ACTEMRA INTRAVENOUS SOLUTION 200 MG/10 ML (20 MG/ML), ACTEMRA SUBCUTANEOUS

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

Exclusion Criteria
None

Required Medical Information
Member must have a documented diagnosis of Rheumatoid Arthritis or a documented diagnosis of Systemic Juvenile Idiopathic Arthritis.

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

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

AFINITOR

Drugs
AFINITOR, AFINITOR DISPERZ

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

Exclusion Criteria
None

Required Medical Information
Advanced Renal Cell Carcinoma: Documented diagnosis of advanced renal cell carcinoma and the member has a demonstrated disease progression or intolerance following an appropriate trial with sunitinib (Sutent) or sorafenib (Nexavar). Advanced Hormone Receptor-Positive, HER2-Negative Breast Cancer (Advanced HR+ BC): Documented diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer, the member is postmenopausal, concurrently taking exemestane (Aromasin) and has a documented failure of letrozole (Femara) or anastrozole (Arimidex). Progressive Neuroendocrine Tumors: Documented diagnosis of progressive neuroendocrine tumors of pancreatic origin in adult patients with unresectable, locally advanced, or metastatic disease. Renal Angiomyolipoma with Tuberous Sclerosis Complex: Documented presence of tuberous sclerosis and renal angiomyolipoma(s) greater than or equal to 3 cm in longest diameter.Subependymal Giant Cell Astrocytoma (SEGA): Documented diagnosis of subependymal giant cell astrocytoma associated with tuberous sclerosis and the member is not a candidate for surgical resection.

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%.

APTIOM

Drugs
APTIOM

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. felbamate (Felbatol), gabapentin (Fanatrex, Gralise, Neurontin), lamotrigine (Lamictal, Lamictal XR, Lamictal ODT), Lyrica, levetiracetam (Keppra, Keppra XR), oxcarbazepine (Oxtellar XR, Trileptal), tiagabine (Gabitril), topiramate (Topamax, Trokendi XR), Potiga, Vimpat, and/or zonisamide (Zonegran)).

Age Restriction
The member 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

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

AUBAGIO

Drugs
AUBAGIO

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

Exclusion Criteria
None

Required Medical Information
The member must have documented diagnosis of a relapsing form of multiple sclerosis (relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapse) or the member has a documented failure, contraindication, or intolerance to fingolimod (Gilenya).

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

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

BELEODAQ

Drugs
BELEODAQ

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 relapsed or refractory peripheral T-cell lymphoma (PTCL).

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

BENLYSTA

Drugs
BENLYSTA INTRAVENOUS RECON SOLN 120 MG

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
None

Coverage Duration
Life of Plan

Other Criteria
None

BOSULIF

Drugs
BOSULIF ORAL TABLET 100 MG, 500 MG

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, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) with a documented resistance or intolerance to prior therapy, including Gleevec (imatinib mesylate).

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

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

CAPRELSA

Drugs
CAPRELSA ORAL TABLET 100 MG, 300 MG

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, Eliquis, Pradaxa, Xarelto), 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 ORAL TABLET 2.5 MG, 5 MG

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, Avodart, doxazosin, finasteride, tamsulosin, or terazosin.

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. Psoriatic Arthritis: The member has a documented diagnosis of psoriatic arthritis. Ankylosing Spondylitis: The member has a documented diagnosis of active ankylosing spondylitis.

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 a documented diagnosis of Hereditary Angioedema.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

COMETRIQ

Drugs
COMETRIQ

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 progressive, metastatic medullary thyroid cancer.

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

Prescriber Restriction
The prescribing physician must be an oncologist.

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

ENBREL

Drugs
ENBREL SUBCUTANEOUS KIT, ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51), 50 MG/ML (0.98 ML)

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 INTRAVENOUS RECON SOLN 35 MG

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
None

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

FYCOMPA

Drugs
FYCOMPA

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

Exclusion Criteria
None

Required Medical Information
Fycompa may be approved as adjunctive therapy for the treatment of partial-onset seizures with or without secondarily generalized seizures in members with a documented diagnosis of epilepsy and the member has tried and failed two or more alternatives, including, but not limited to: Banzel, carbamazepine, Celontin, clonazepam, diazepam, Dilantin, divalproex, ethosuximide, felbamate, gabapentin, Gabitril, Lamictal ODT, lamotrigine, levetiracetam, Lyrica, Onfi, oxcarbazepine, Oxtellar XR, Peganone, phenobarbital, phenytoin, Potiga, primidone, Sabril, Savella, Stavzor, Tegretol XR, tiagabine, topiramate, Trokendi XR, valproic acid, Vimpat and/or zonisamide

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

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

GATTEX

Drugs
GATTEX ONE-VIAL

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 Short Bowel Syndrome(SBS) and a history of dependence on parenteral nutrition (PN)

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

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

GAUCHER DISEASE TYPE 1 TREATMENTS

Drugs
CEREZYME INTRAVENOUS RECON SOLN 200 UNIT, ELELYSO, 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 or the member has a documented failure, contraindication, or intolerance to teriflunomide (Aubagio).

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

GILOTRIF

Drugs
GILOTRIF

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 non-small cell lung cancer and a documented epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations 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

GROWTH HORMONE REPLACEMENT THERAPY

Drugs
EGRIFTA SUBCUTANEOUS RECON SOLN 2 MG, GENOTROPIN, GENOTROPIN MINIQUICK, HUMATROPE, NORDITROPIN FLEXPRO, NORDITROPIN NORDIFLEX, NUTROPIN AQ NUSPIN SUBCUTANEOUS CARTRIDGE 5 MG/2 ML (2.5 MG/ML), NUTROPIN AQ SUBCUTANEOUS CARTRIDGE, NUTROPIN SUBCUTANEOUS RECON SOLN 10 MG, OMNITROPE, SAIZEN CLICK.EASY, SAIZEN SUBCUTANEOUS RECON SOLN 5 MG, SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG, 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
None

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
For Crohn's disease, the Member has a documented diagnosis of Crohns disease and has demonstrated an inadequate response to an appropriate trial with two 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). For Ulcerative Colitis, the Member has a documented diagnosis of Ulcerative Colitis and has demonstrated an inadequate response to an appropriate trial with two 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). For psoriasis, the member must have a definitive diagnosis of moderate-to-severe chronic plaque psoriasis and the member has failed to respond to, or have been unable to tolerate, Psoralens with UVA light and ONE of the following, Soriatane, Methotrexate or Cyclosporine. For rheumatoid arthritis and juvenile idiopathic arthritis, the Member must have an inadequate response after three months at optimal doses or an inability to take methotrexate. For psoriatic arthritis, the Member must have an inadequate response or inability to take methotrexate OR sulfasalazine at maximal doses for three months. For ankylosing spondylitis, the Member must have a 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

ICLUSIG

Drugs
ICLUSIG

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

Exclusion Criteria
None

Required Medical Information
Acute lymphoblastic leukemia: The member must have a documented diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) that is resistant or intolerant to prior tyrosine kinase inhibitor therapy. Chronic myeloid leukemia: The member must have a documented diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) that is resistant or intolerant to prior tyrosine kinase inhibitor therapy.

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

Prescriber Restriction
The prescribing physician must be an oncologist.

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, or the member has a documented diagnosis of Systemic Juvenile Idiopathic Arthritis (SJIA).

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

IMBRUVICA

Drugs
IMBRUVICA

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 Mantle Cell Lymphoma (MCL) or Chronic Lymphocytic Leukemia (CLL)and has received at least one prior therapy.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

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 INTRAVENOUS, *ibandronate intravenous solution* , RECLAST, *zoledronic acid intravenous solution* , *zoledronic acid-mannitol-water intravenous solution* , ZOMETA

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

Exclusion Criteria
None

Required Medical Information
Boniva (ibandronate sodium) and 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, ibandronate 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 zoledronic acid injection for members with any of the following diagnoses: Hypercalcemia of malignancy, Paget's disease of the bone, 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 SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 MG

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
BIVIGAM, CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM, GAMASTAN S/D, GAMMAGARD LIQUID, GAMMAPLEX, GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %), PRIVIGEN, THYMOGLOBULIN

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
This criteria applies to brand name Onmel

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.

JUXTAPID

Drugs
JUXTAPID

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

Exclusion Criteria
None

Required Medical Information
The member must have a laboratory-confirmed documented diagnosis of homozygous familial hypercholesterolemia (HoFH) based on one of the following tests: a) LDLR DNA Sequence Analysis or LDLR Deletion/Duplication Analysis for large gene rearrangement testing - only if the Sequence Analysis is negative or APOB and PCSK9 testing if both of the above tests are negative but a strong clinical picture exists and the member is concurrently taking lipid-lowering medications or has a documented contraindication to lipid-lower medications.

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

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

KADCYLA

Drugs
KADCYLA INTRAVENOUS RECON SOLN 100 MG

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 human epidermal growth factor receptor 2 (HER2)-positive, metastatic breast cancer and has previously received trastuzumab (Herceptin) and a taxane, separately or in combination. Patients should have either received prior therapy for metastatic disease or developed disease recurrence during or within 6 months of completing adjuvant therapy.

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

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

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 one of the following confirmed mutations G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R 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. For Neonatal-Onset Multisystem Inflammatory Disease (NOMID): The member has a documented diagnosis of Neonatal-Onset Multisystem Inflammatory Disease (NOMID).

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 ORAL TABLET,SOLUBLE

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

KYNAMRO

Drugs
KYNAMRO

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

Exclusion Criteria
None

Required Medical Information
The member must have a laboratory-confirmed documented diagnosis of homozygous familial hypercholesterolemia (HoFH) based on one of the following tests: a) LDLR DNA Sequence Analysis or LDLR Deletion/Duplication Analysis for large gene rearrangement testing - only if the Sequence Analysis is negative or APOB and PCSK9 testing if both of the above tests are negative but a strong clinical picture exists and the member is concurrently taking lipid-lowering medications or has a documented contraindication to lipid-lower medications.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

LIDODERM

Drugs
lidocaine topical adhesive patch,medicated , LIDODERM

Covered Uses
All FDA-approved 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
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 135 MCG/0.5 ML, PEGASYS SUBCUTANEOUS SOLUTION, PEGASYS SUBCUTANEOUS SYRINGE, PEGINTRON REDIPEN, PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5 ML

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. 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 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 co-infection w HIV or HBV.Pegasys 48 wks

Other Criteria
Tufts Health Plan will not cover pegylated interferon therapy 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, ADEMPAS, *epoprostenol (glycine)* , FLOLAN, LETAIRIS, OPSUMIT, ORENITRAM, REMODULIN, *revatio intravenous* , SILDENAFIL, TRACLEER, TYVASO, VELETRI, 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

MEKINIST

Drugs
MEKINIST

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

Exclusion Criteria
If Mekinist (trametinib) is being used as a single agent it will not be approved for members who have received prior BRAF-inhibitor therapy.

Required Medical Information
The member must have a documented diagnosis of unresectable or metastatic melanoma with a BRAF V600E or BRAF V600K mutation as confirmed by an FDA-approved test for the detection of BRAF V600 mutations in tumor specimens.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

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
None

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).

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. Differentiated Thyroid Carcinoma: The member must have a documented diagnosis of locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment.

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
None

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

OLYSIO

Drugs
OLYSIO

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

Exclusion Criteria
None

Required Medical Information
Chronic hepatitis C: The member must have a documented diagnosis of genotype 1 chronic hepatitis C virus(HCV) AND members with HCV genotype 1a infection must be screened for and test negative for the presence of virus with the NS3 Q80K polymorphism AND Olysio must be used in combination with peginterferon alfa and ribavirin in patients with HCV genotype 1 with compensated liver disease (including cirrhosis). Olysio (simeprevir) will be approved for members meeting the first two criteria when used in combination with Sovaldi (sofosbuvir) only if the member is treatment naive, has compensated liver disease, and is not eligible to receive interferon or the member is a prior non-responder to interferon and ribavirin therapy.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

ORENCIA

Drugs
ORENCIA, ORENCIA (WITH MALTOSE)

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
None

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

PERJETA

Drugs
PERJETA

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 breast cancer and Perjeta is being used in combination with trastuzumab (Herceptin) and docetaxel for the treatment of human epidermal growth factor receptor 2 (HER2)-positive metastatic breast cancer and the member has not received prior anti-HER2 therapy or chemotherapy for metastatic disease. Neoadjuvant Treatment of Breast Cancer: The member has a documented history of HER2-positive, locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive).

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

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

POMALYST

Drugs
POMALYST

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 myeloma and has received at least 2 prior therapies including lenalidomide (Revlimid) and bortezomib (Velcade), and has demonstrated disease progression or intolerance to therapy on Pomalyst, or within 60 days of completion of the last therapy.

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

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

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

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 Health Plan may authorize coverage of Prolia (denosumab) for the treatment of osteoporosis in men and postmenopausal women 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 (Fosamax), calcitonin (Miacalcin), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel), zoledronic acid (Reclast)] or the member is a female at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer and is using Prolia (desosumab) as a treatment to increase bone mass. Tufts Health Plan may authorize coverage of Prolia for men at high risk of fracture who are receiving androgen deprivation therapy for nonmetastatic prostate cancer. Tufts Health Plan may authorize coverage of Xgeva (denosumab) for prevention of skeletal-related events in patients with bone metastases from solid tumors only or the member is being treated for unresectable giant cell tumor of bone (GCTB) or surgical resection of GCTB is likely to result in severe morbidity.

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
Tufts Health Plan may authorize coverage of Promacta for members with a documented diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) and have had an insufficient response or intolerance to corticosteroids and/or immunoglobulins, OR the member has not responded to splenectomy. Coverage may also be authorized for the treatment of thrombocytopenia in patients with chronic hepatitis C.

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
None

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 TOPICAL GEL 0.3 %, DIFFERIN TOPICAL LOTION, FABIOR, RETIN-A, RETIN-A MICRO, RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.08 %, TAZORAC, TRETIN-X (GEL), TRETIN-X TOPICAL COMBO PACK, *tretinoin topical*

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
None

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.

SIGNIFOR

Drugs
SIGNIFOR

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

Exclusion Criteria
None

Required Medical Information
The Member has a documented diagnosis of Cushing's diseaseANDPituitary surgery is not an option or has not been curative for the Member

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

Prescriber Restriction
The prescribing physician is an endocrinologist

Coverage Duration
Life of Plan

Other Criteria
None

SIMPONI

Drugs
SIMPONI ARIA, SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML

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 (Simponi only): 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. Ulcerative Colitis (Simponi only): The member must have a documented diagnosis of moderately to severely active ulcerative colitis and has demonstrated an inadequate response to an appropriate trial with two 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) or Humira (adalimumab) OR failure or intolerance to infliximab (Remicaid) or adalimumab (Humira). 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, gastroenterologist or rheumatologist.

Coverage Duration
Life of Plan

Other Criteria
None

SOVALDI

Drugs
SOVALDI

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

Exclusion Criteria
None

Required Medical Information
Chronic hepatitis C: The member must have a documented diagnosis of genotype 1, 2, 3, or 4 chronic hepatitis C virus (HCV) AND Sovaldi must be used in combination with ribavirin or with peginterferon alfa and ribavirin, including patients with hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation) and those with HCV/HIV-1 coinfection. Sovaldi (sofosbuvir) will be approved for members meeting the first criterion when used in combination with Olysio (simeprevir), only if the member is treatment naive, has compensated liver disease, and is not eligible to receive interferon or the member is a prior non-responder to interferon and ribavirin therapy.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

SPRYCEL

Drugs
SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

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 SUBCUTANEOUS SYRINGE

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 moderate-to-severe chronic plaque psoriasis. Psoriatic Arthritis: The member has a documented diagnosis of psoriatic arthritis.

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

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

STIVARGA

Drugs
STIVARGA

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 colorectal cancer and has been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an antivascular endothelial growth factor (VEGF) therapy, and, if KRAS wild type, an antiepidermal growth factor receptor (EGFR) therapy. For advanced gastrointestinal stromal tumors (GIST), the member must have a documented diagnosis of GIST and documented prior failure, contraindication or intolerance to therapy with both imatinib mesylate (Gleevec) and sunitinib malate (Sutent).

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

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

SUBOXONE

Drugs
buprenorphine-naloxone , SUBOXONE SUBLINGUAL FILM, ZUBSOLV

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

SYLVANT

Drugs
SYLVANT INTRAVENOUS RECON SOLN 100 MG

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 multicentric Castleman disease and is HIV negative and human herpesvirus-8 (HHV-8) negative.

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

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

Coverage Duration
Life of Plan

Other Criteria
None

TAFINLAR

Drugs
TAFINLAR

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 with a BRAF V600E mutation as confirmed by an FDA-approved test for the detection of BRAF V600 mutations in melanoma.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

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

TECFIDERA

Drugs
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG

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 a relapsing form of multiple sclerosis OR the Member has a documented failure, contraindication, or intolerance to at least ONE of the following multiple sclerosis immunomodulator agents: teflunomide (Aubagio) or fingolimod (Gilenya)

Age Restriction
None

Prescriber Restriction
The prescribing physician is a neurologist

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 ORAL SOLUTION, VIMPAT ORAL TABLET

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 or Advanced Soft Tissue Sarcoma.

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

XELJANZ

Drugs
XELJANZ

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 a documented inadequate response at optimal doses or an inability to take methotrexate or other nonbiologic disease-modifying antirheumatic drugs (DMARDs).

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

Prescriber Restriction
The prescribing physician must be a rheumatologist.

Coverage Duration
Life of Plan

Other Criteria
None

XENAZINE

Drugs
XENAZINE ORAL TABLET 12.5 MG, 25 MG

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 ORAL TABLET 550 MG

Covered Uses
All FDA-approved 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 thaAllergic Asthma: Coverage of Xolair may be authorized 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 than 30 IU/mL and less than or equal to 700 IU/mL.Chronic Idiopathic Urticaria (CIU): Coverage of Xolair may be authorized when all of the following criteria are met: 1. The member has a definitive diagnosis of chronic idiopathic urticarial for at least 6 moths and the following pretreatment disease severity scores: Weekly urticarial activity score (UAS7) of greater than 16 and a weekly itch severity score of geater than 8. 2. The physician has documented that the member remains symptomatic despite H1 antihistamine treatment.t 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
None

Coverage Duration
Life of Plan

Other Criteria
None

XTANDI

Drugs
XTANDI

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 and has previously received docetaxel.

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

Prescriber Restriction
The prescribing physician must be an oncologist.

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

ZYKADIA

Drugs
ZYKADIA

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 anaplastic lymphoma kinase (ALK)-positive metastatic nonsmall cell lung cancer (NSCLC) and has had disease progression on or is intolerant to crizotinib (Xalkori).

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

Prescriber Restriction
The prescribing physician must be an oncologist.

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 Zytiga is being used in combination with prednisone.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None