2015 Tufts Health Plan Senior Care Options (HMO SNP) Prior Authorization Medical Necessity Guidelines

Effective January 1, 2015

Updated June 2015

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 a documented inadequate response or inability to tolerate at least one tumor necrosis factor antagonist: Cimzia (certolizumab), Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab), Simponi/Simponi Aria (golimumab). Polyarticular Juvenile Idiopathic Arthritis (PJIA) and Systemic Juvenile Idiopathic Arthritis (SJIA): The member must have a documented diagnosis of either disease and has a documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate OR BOTH corticosteroids (e.g., methylprednisolone, prednisolone, prednisone) AND NSAIDs (e.g. diclofenac, fenoprofen, ibuprofen, naproxen, etc.)

Age Restriction
For PJIA and 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. Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Rebif, Tecfidera, 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 two (2) or more medications indicated for adjunct partial seizures (e.g. felbamate (Felbatol), Fycompa, 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) or dimethyl fumurate (Tecfidera).

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

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
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

BUPRENORPHINE

Drugs
buprenorphine HCl sublingual

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

Exclusion Criteria
Buprenorphine 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

BUPRENORPHINE/NALOXONE

Drugs
Bunavail, buprenorphine-naloxone, Suboxone sublingual film, Zubsolv

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

Exclusion Criteria
Buprenorphine/naloxone preparations will not be covered to treat pain.

Required Medical Information
The member must have a physician-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

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, celecoxib

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

Exclusion Criteria
None

Required Medical Information
Coverage may be authorized for members meeting one or more of the following clinical criteria: 1) 65 years of age or older. 2) Diagnosis of Rheumatoid Arthritis and 50 years of age or older. 3) Previous or active GI bleeding or hemorrhage. 4) History of GERD or peptic ulcer disease (PUD). 5) 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). 6) Inability to tolerate other agents in the NSAID class as evidenced by significant symptoms of GI intolerance (e.g., dyspepsia, gastritis, abdominal or stomach pain, heartburn). 7) Bleeding diathesis or other medical condition(s) that would constitute a significant predisposition to bleeding (e.g. coagulopathy, hemophilia, low platelet count, surgical procedure booked within 5 days of starting the COX-2 drug, etc.). 8) The member is currently taking any of the following medications: a) anticoagulants (e.g. Coumadin, Eliquis, enoxaparin, fondaparinux, Fragmin, heparin, Innohep, Lovenox, Pradaxa, Xarelto, warfarin) b) Methotrexate, azathioprine or other metabolites c) Oral corticosteroids (e.g. prednisone, dexamethasone, etc.) d) Proton pump inhibitors (PPIs) (e.g. lansoprazole, omeprazole, pantoprazole) e) H2 antagonists (e.g. cimetidine , famotidine, ranitidine) or misoprostol.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

CERDELGA

Drugs
Cerdelga

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 documentation the member is a cytochrome P450 2D6 extensive metabolizer (EMs), intermediate metabolizer (IMs), or poor metabolizer (PMs) as detected by an FDA-cleared test.

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

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 a documented diagnosis of Crohn's disease and an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. Asacol, azulfidine, Colazal, Dipentum, Pentasa, Rowasa, sulfasalazine). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate OR the member has demonstrated failure or intolerance to infliximab (Remicade). 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 (3) months. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of rheumatoid arthritis and has documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate. Ankylosing Spondylitis: The member has a documented diagnosis of active ankylosing spondylitis.

Age Restriction
The 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
The prescribing physician must be an immunologist.

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

CRESTOR

Drugs
Crestor

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

Exclusion Criteria
None

Required Medical Information
Crestor 5 mg or 10 mg: The member requires moderate LDL lowering (30% to 50% reduction) and the member has tried two (2) or more of the following drugs and could not tolerate treatment due to adverse effects or there was inadequate response despite compliance with maximum tolerable doses: Either simvastatin 20 mg or higher OR pravastatin 40 mg or higher, AND atorvastatin 10 mg or higher. For Crestor 20 mg and 40 mg: The member requires high LDL lowering (over 50% reduction) and the member has tried atorvastatin 40 mg or 80 mg and was unable to tolerate treatment due to adverse effects or there was inadequate response despite compliance with maximum tolerable doses.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
2 years

Other Criteria
None

DEXILANT

Drugs
Dexilant

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

Exclusion Criteria
None

Required Medical Information
The prescribing physician must submit documentation that the member has tried and failed, or has a contraindication to omeprazole OR pantoprazole, AND lansoprazole OR rabeprazole.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
2 years

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 recon soln, 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: cyclosporine, methotrexate, or Soriatane (acitretin). Rheumatoid Arthritis (RA) and Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a documented diagnosis of either disease and has a documented 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 (3) months. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of rheumatoid arthritis and has documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate. Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis.

Age Restriction
the member must be 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 metastatic basal cell carcinoma or locally advanced basal cell carcinoma that has recurred following surgery, or who are not candidates for surgery or radiation.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

ESBRIET

Drugs
Esbriet

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 idiopathic pulmonary fibrosis (IPF) and the member is not currently taking Ofev (nintedanib).

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a pulmonologist.

Coverage Duration
Life of Plan

Other Criteria
None

FABRAZYME

Drugs
Benlysta, 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
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 in the past 6 months.

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 any of the other osteoporosis agents listed in the "Required Medical Information" section.

Required Medical Information
Coverage of Forteo may be authorized 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 (Fosamax), 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

FULYZAQ

Drugs
Fulyzaq

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 noninfectious diarrhea associated with HIV or AIDS.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

FYCOMPA

Drugs
Fycompa

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 two (2) or more medications indicated for adjunct partial seizures (e.g. Aptiom, 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 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
Elelyso, VPRIV

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

Exclusion Criteria
Coverage will not be approved 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 dimethyl fumurate (Tecfidera) or 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, Genotropin, Genotropin MiniQuick, Humatrope, Norditropin FlexPro subcutaneous pen injector 10 mg/1.5 mL (6.7 mg/mL), 15 mg/1.5 mL (10 mg/mL), 5 mg/1.5 mL (3.3 mg/mL), Norditropin Nordiflex, Nutropin AQ Nuspin, Nutropin AQ subcutaneous cartridge, 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
None

Prescriber Restriction
None

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

Other Criteria
None

HARVONI

Drugs
Harvoni

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 Hepatitis C (CHC) genotype 1.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.

Coverage Duration
12 weeks: Treatment-naïve with or without cirrhosis, or treatment-experienced without cirrhosis.

Other Criteria
24 weeks: Treatment-experienced with cirrhosis

HETLIOZ

Drugs
Hetlioz

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

Exclusion Criteria
Coverage will not be authorized for the diagnosis of insomnia.

Required Medical Information
The member must be completely blind AND has a physician-documented diagnosis of non-24-hour sleep-wake disorder (non-24).

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a sleep specialist.

Coverage Duration
Initial authorization of Hetlioz (tasimelteon) is for four (4) months.

Other Criteria
Authorization for eight (8) additional months will require documentation of efficacy from the prescriber. Authorization for Life of Plan will require confirmation of continued efficacy beyond twelve (12) months.

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 and Ulcerative Colitis (UC): The member must a documented diagnosis of either disease and an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. Asacol, azulfidine, Colazal, Dipentum, Pentasa, Rowasa, sulfasalazine). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate OR the member has demonstrated failure or intolerance to infliximab (Remicade). 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 phototherapy and one (1) of the following medications: cyclosporine, methotrexate, or Soriatane (acitretin). Rheumatoid Arthritis (RA) and Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a documented diagnosis of either disease and has a documented 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 (3) months. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of rheumatoid arthritis and has documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate. Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis.

Age Restriction
The member must be 4 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

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) for whom no other tyrosine kinase inhibitor therapy is indicated or who are T315I positive. Chronic Myeloid Leukemia: The member must have a documented diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) for whom no other tyrosine kinase inhibitor therapy is indicated or who are T315I 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

ILARIS

Drugs
Ilaris (PF)

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

Exclusion Criteria
None

Required Medical Information
Cryopyrin-Associated Periodic Syndromes: The member has a documented diagnosis of a Cryopyrin-Associated Periodic Syndrome (CAPS) including Familial Cold Autoinflammatory Syndrome (FCAS), or Muckle-Wells Syndrome (MWS). Systemic Juvenile Idiopathic Arthritis (SJIA): The member must have a documented diagnosis of systemic juvenile idiopathic arthritis and has a documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate OR BOTH corticosteroids (e.g., methylprednisolone, prednisolone, prednisone) AND NSAIDs (e.g. diclofenac, fenoprofen, ibuprofen, naproxen, etc.).

Age Restriction
CAPS: The member must be 4 years of age or older. SJIA: The member must be 2 years of age or older.

Prescriber Restriction
SJIA: The prescribing physician must be a rheumatologist.

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 Chronic Lymphocytic Leukemia (CLL) or Mantle Cell Lymphoma (MCL) and has received at least one prior therapy, or the member has CLL with 17p deletion.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

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 or 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
The member must be aged 2 to 18 years.

Prescriber Restriction
The prescribing physician must be an endocrinologist.

Coverage Duration
Initial authorization is for 6 months. Subsequent authorization are annual.

Other Criteria
None

INFUSED BISPHOSPHONATES

Drugs
ibandronate intravenous solution, Reclast, zoledronic acid intravenous solution, zoledronic acid-mannitol-water intravenous solution

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

Exclusion Criteria
None

Required Medical Information
Ibandronate sodium (Boniva) and zoledronic acid (Reclast) injections: The member must have a documented diagnosis of osteoporosis and meet one (1) of the following criteria: a) Documentation of an inadequate response or inability to tolerate one or more oral bisphosphonates (e.g., alendronate, Actonel, ibandronate tablets) b) Documented inability to swallow c) Documented inability to remain in an upright position for one hour post oral bisphosphonate administration. Prior authorization is not required for coverage of Reclast for Paget's disease or for zoledronic acid (Zometa) injection for members with a diagnoses of 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 (1) 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 intravenous recon soln 12 gram, 6 gram, GamaSTAN S/D, Gammagard Liquid, Gamunex-C, Privigen

Covered Uses
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, Onmel

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. The member must have a documented diagnosis of polycythemia vera with an inadequate response to or intolerance to hydroxyurea.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Initial authorization is for 6 months.

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

JUXTAPID

Drugs
Juxtapid oral capsule 10 mg, 20 mg, 5 mg

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

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
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

KALYDECO

Drugs
Kalydeco oral tablet

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

Exclusion Criteria
Kalydeco is not effective in patients with cystic fibrosis who are homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene and has not been studied in other populations of patients with cystic fibrosis.

Required Medical Information
Kalydeco is covered for members with a documented diagnosis of cystic fibrosis who have one of the following mutations in the CFTR gene: G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, or S549R. If the patient's genotype is unknown, a US Food and Drug Administration-cleared cystic fibrosis mutation test should be used to detect the presence of the G551D mutation.

Age Restriction
Tablets: 6 years or older. Granules: 2-6 years of age.

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
Rheumatoid Arthritis (RA): The member must have a documented diagnosis of rheumatoid arthritis and has documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate.
Neonatal-Onset Multisystem Inflammatory Disease (NOMID): The member has a documented diagnosis of NOMID.

Age Restriction
For RA, 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

KUVAN

Drugs
Kuvan oral tablet,soluble

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

Exclusion Criteria
Kuvan will not be covered 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
Initial approval is for 8 weeks. Subsequent approval is for Life of Plan.

Other Criteria
Coverage may be authorized for continuing therapy if the member has demonstrated at least a 30% reduction in phenylalanine levels compared to baseline.

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
The member must be 18 years of age or older.

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

LIDOCAINE TRANSDERMAL PATCHES

Drugs
lidocaine topical adhesive patch,medicated

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

Exclusion Criteria
None

Required Medical Information
For Postherpetic Neuralgia or Diabetic Neuropathy, the member must have had a failure, adverse reaction, or contraindication to gabapentin.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
Coverage will be authorized for new members if their pain is currently well-controlled on lidocaine transdermal patches (Lidoderm).

LYNPARZA

Drugs
Lynparza

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 deleterious or suspected deleterious germline BRCA mutated (as detected by an FDA-approved test) advanced ovarian cancer and provide documentation of failure of at least three prior lines of chemotherapy.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

MEDICATIONS FOR THE TREATMENT OF PULMONARY HYPERTENSION

Drugs
Adcirca, Adempas, epoprostenol (glycine), Flolan, Letairis, Opsumit, Orenitram, Remodulin, Revatio intravenous, Revatio oral suspension for reconstitution, 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 arterial hypertension (WHO group I: see below) as confirmed by right heart catheterization. World Health Organization (WHO) Classification of Pulmonary Hypertension - Group 1: a) Idiopathic PAH (primary pulmonary hypertension). b) Heritable PAH. c) Drug- and toxin-induced PAH. d) PAH associated with other diseases and conditions (APAH), such as: i) Connective tissue diseases ii) HIV infection iii) Portal hypertension iv) Congenital heart disease v) Schistosomiasis vi) Chronic hemolytic anemia. e) Persistent pulmonary hypertension of the newborn AND the pulmonary hypertension has progressed despite surgical treatment and/or maximal medical treatment of the underlying condition AND the medication used for treatment is consistent with its FDA approved functional class (see Other Criteria).

Age Restriction
None

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

Coverage Duration
Life of Plan

Other Criteria
Adcirca-NYHA Class II and III: Adempas-WHO Class II and III (Pulmonary Arterial Hypertension): epoprostenol (Flolan/Veletri)-NYHA Class III and IV: Letairis-WHO Class II and III: Opsumit-WHO Class II and III: Orenitram-WHO Class II and III: Remodulin-NYHA Class II, III, and IV: sildenafil-NYHA Class II and III: Tracleer-NYHA Class II, III, and IV: Tyvaso-NYHA Class III: Ventavis-NYHA Class III and IV

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 one of the following: 1. Documented diagnosis of advanced Renal Cell Carcinoma (RCC). 2. Biopsy-proven, unresectable hepatocellular carcinoma (HCC). 3. Documented diagnosis of locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment.

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

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

Coverage Duration
Life of Plan

Other Criteria
None

NEXIUM

Drugs
Nexium

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

Exclusion Criteria
None

Required Medical Information
The prescribing physician must submit documentation that the member has tried and failed, or has a contraindication to omeprazole OR pantoprazole, AND lansoprazole OR rabeprazole.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
2 years

Other Criteria
None

NORTHERA

Drugs
Northera

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 neurogenic orthostatic hypotension (NOH) and has had a treatment failure or contraindication to midodrine and fludrocortisone.

Age Restriction
None

Prescriber Restriction
None

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

OFEV

Drugs
Ofev

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 idiopathic pulmonary fibrosis (IPF) and the member is not currently taking Esbriet (pirfenidone).

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a pulmonologist.

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
Diagnosis of chronic hepatitis C infection has been confirmed by presence of HCV RNA in serum prior to starting therapy. For treatment (tx) with pegylated interferon (PegIFN)and RBV: 1) must have HCV genotype 1 (Genotype 1a or genotype 1b) or genotype 4 infection, 2) For genotype 1a infection, absence of NS3 Q80K polymorphism must be confirmed by a laboratory testing prior to starting therapy, 3) Allow a total of 12 weeksfor patients with Genotype 1 infection or Genotype 4 infection who are treatment-naïve or prior relapsers to PegIFN and RBV. For tx with Sovaldi with or without RBV: 1) must have Genotype 1 infection, 2) total 24 weeks for recurrent HCV infection post liver transplantation, 3) total 12 weeks for patients who had nonresponse to prior PegIFN and RBV therapy, 4) total 12 weeks for treatment naïve patients and relapsers to prior PegIFN and RBV therapy with documented intolerance or ineligibility to receive IFN.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.

Coverage Duration
12 to 24 weeks depending on genotype, treatment regimen and transplantation status.

Other Criteria
Ineligibility to receive IFN is defined as having one or more of the following: autoimmune hepatitis and other autoimmune disorders, hypersensitivity to PEG or any of its components, decompensated liver disease (eg, Child-Pugh score 7 or above [class B and C]), history of depression, or clinical features consistent with depression, history of pre-existing cardiac disease, a baseline neutrophil count less than 1,500/uL, a baseline platelet count less than 90,000/uL, or baseline hemoglobin less than 10 g/dL.

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 must have a documented diagnosis of rheumatoid arthritis and a documented inadequate response or inability to tolerate at least one tumor necrosis factor antagonist: Cimzia (certolizumab), Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab), Simponi/Simponi Aria (golimumab). Juvenile Idiopathic Arthritis (JIA): The member must have a documented diagnosis of juvenile idiopathic arthritis and 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

OTEZLA

Drugs
Otezla

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

Exclusion Criteria
None

Required Medical Information
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.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: cyclosporine, methotrexate, or Soriatane (acitretin). 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 for three (3) months.

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

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

Coverage Duration
Life of Plan

Other Criteria
None

PEGYLATED INTERFERONS

Drugs
Pegasys ProClick, Pegasys subcutaneous solution, Pegasys subcutaneous syringe, 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. 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
Pegasys: Member must be 5 years of age or older. Peg-Intron: Member must be 3 years of age or older.

Prescriber Restriction
The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.

Coverage Duration
Geno 1=16 wks. intial, 12-32 wks addtional. Geno 2 & 3=24 wks. Co-infection w HIV= 48 wks.

Other Criteria
Pegylated interferon therapy will not be covered for a member who has 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.

PERJETA

Drugs
Perjeta

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

Exclusion Criteria
None

Required Medical Information
Metastatic Breast Cancer: The member must have a documented history of human epidermal growth factor receptor 2 (HER2)-positive metastatic breast cancer and 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 on or within 60 days of completion of the last therapy.

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

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 two (2) or more medications indicated for adjunct partial seizures (e.g. Aptiom, felbamate (Felbatol), Fycompa, 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), 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

PROLIA AND XGEVA

Drugs
Prolia, Xgeva

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

Exclusion Criteria
None

Required Medical Information
Coverage of Prolia (denosumab) for the treatment of osteoporosis in men and postmenopausal women may be authorized 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. Coverage of Prolia may be authorized for men at high risk of fracture who are receiving androgen deprivation therapy for nonmetastatic prostate cancer. Coverage for Xgeva (denosumab) may be authorized 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, or for the treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy.

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 have had an insufficient response or intolerance to corticosteroids, immunoglobulins, or splenectomy. Coverage may also be authorized for the treatment of thrombocytopenia in patients with chronic hepatitis C infection. Coverage may be authorized for the treatment of severe aplastic anemia in patients who have had an insufficient response to immunosuppressive therapy.

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, Pediatric Ulcerative Colitis, or Ulcerative Colitis (UC): The member must a documented diagnosis of one of the aforementioned diseases and an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. Asacol, azulfidine, Colazal, Dipentum, Pentasa, Rowasa, sulfasalazine). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) 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: cyclosporine, methotrexate, or Soriatane (acitretin). 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 (3) months. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of rheumatoid arthritis and has documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate. Ankylosing Spondylitis: The member must have a documented diagnosis of active 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 FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria
None

Required Medical Information
The member must have a definitive diagnosis of Chronic Dry Eye Syndrome, Keratoconjuctivitis Sicca (KCS), Keratitis Sicca, Xerophthalmia, or 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 topical cream, adapalene topical gel, Atralin, Avita, Differin topical lotion, Fabior, Retin-A, Retin-A Micro Pump topical gel with pump 0.1 %, Retin-A Micro topical gel 0.04 %, Tazorac, TRETIN-X Cream Kit topical combo pack 0.05 %, tretinoin microspheres topical gel with pump, tretinoin topical

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

Exclusion Criteria
Coverage of topical acne products will not authorized for cosmetic purposes.

Required Medical Information
The member must have a physician-documented diagnosis of acne vulgaris, 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
This criteria only applies to members age 26 or older. Authorization is not required for members 25 years of age or younger.

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. Mantle Cell Lymphoma: The member has a documented diagnosis of mantle cell lymphoma and the member's disease has relapsed or progressed after two prior therapies, one of which included Velcade (bortezomib).

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
Coverage for Rituxan may be authorized when used 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/Simponi Aria (golimumab). Coverage may authorized 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 disease and pituitary surgery is not an option or has not been curative.

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

Prescriber Restriction
The prescribing physician must be 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
Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. 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 (3) months. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of rheumatoid arthritis and has documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate. Ulcerative Colitis (UC): The member must a documented diagnosis of moderate to severely active ulcerative colitis and an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. Asacol, azulfidine, Colazal, Dipentum, Pentasa, Rowasa, sulfasalazine). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate OR the member has demonstrated failure or intolerance to infliximab (Remicade).

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

SIRTURO

Drugs
Sirturo

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 pulmonary multi-drug resistant tuberculosis (MDR-TB) and Sirturo (bedaquiline) is being used in combination with at least three other drugs to which the patient's MDR-TB isolate has been shown to be susceptible in vitro. If in vitro testing results are unavailable, treatment may be initiated with Sirturo in combination with at least four other drugs to which the patient's MDR-TB isolate is likely to be susceptible.

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

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

SOMAVERT

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

SOVALDI

Drugs
Sovaldi

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

Exclusion Criteria
None

Required Medical Information
Chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to starting therapy. For treatment (tx) with peginterferon (PegIFN) and RBV: 1) total 24 weeks (wks) for recurrent HCV infection post liver transplantation with Genotype (G) 1, 2) total 12 wks for G1 to 6 patients who had nonresponse to prior HCV therapy to PegIFN and RBV (with or without a protease inhibitor), 3) total 12 wks for G 1, 3, 4, 5, or 6 patients who are tx-naïve and relapsers to prior HCV therapy. For tx with Olysio with or without RBV: 1) has G1 infection, 2) total 24 wks for recurrent HCV infection post liver transplantation, 3) total 12 wks for patients with nonresponse to prior PegIFN and RBV therapy, 4) total 12 wks for tx-naïve patients and relapsers to prior PegIFN and RBV with documented intolerance or ineligibility to receive IFN. For tx with RBV: 1) total 48 wks for patients with decompensated liver disease (e.g., Child-Pugh Class B or C), 2) total 48 wks or until liver transplantation, whichever occurs first for patients with hepatocellular carcinoma awaiting for liver transplantation meeting MILAN criteria, 3) total 24 wks for recurrent HCV infection post liver transplantation with G 1, 2, or 3 infection, 4) total 24 wks for G1 or 4 with documented intolerance or ineligibility to receive IFN, 5) total 24 wks for G3, 6) for G2, total 16 wks if patient is nonresponder to prior HCV therapy with PegIFN and RBV (with or without a protease inhibitor) AND has cirrhosis. Otherwise total 12 wks.

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

Prescriber Restriction
The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.

Coverage Duration
12 to 48 weeks.

Other Criteria
Ineligibility to receive IFN is defined as having one or more of the following: autoimmune hepatitis and other autoimmune disorders, hypersensitivity to PEG or any of its components, decompensated liver disease (eg, Child-Pugh score 7 or above [class B and C]), history of depression, or clinical features consistent with depression, history of pre-existing cardiac disease, a baseline neutrophil count less than 1,500/uL, baseline platelet count less than 90,000/uL, or baseline hemoglobin less than 10 g/dL. MILAN criteria is defined as the presence of a tumor 5cm or less in diameter in patients with single hepatocellular carcinomas, and no more than 3 tumor nodules, each 3cm or less in diameter in patients with multiple tumors and no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor.

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
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 phototherapy and one (1) of the following medications: cyclosporine, methotrexate, or Soriatane (acitretin). 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 (3) months.

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

SUBLINGUAL ALLERGY IMMUNOTHERAPY

Drugs
Grastek, Ragwitek

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

Exclusion Criteria
None

Required Medical Information
Grastek: The member must have documentation of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing within the last 2 years for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens. Ragwitek: The member must have documentation of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or in vitro testing within the last 2 years for pollen-specific IgE antibodies for short ragweed pollen. For both Grastek and Ragwitek, the must also have failed, had an inadequate response, or is unable to tolerate treatment with two (2) or more agents in the following drug categories: leukotriene modifiers, oral antihistamines, intranasal antihistamines and/or intranasal corticosteroids.

Age Restriction
Grastek age 5-65 years old, Ragwitek 18-65 years old. Neither agent is FDA-approved for members over 65 years of age.

Prescriber Restriction
The prescribing physician must be or has consulted with an allergist or immunologist.

Coverage Duration
One year

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

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 or BRAF V600K 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

TRANSMUCOSAL IMMEDIATE-RELEASE FENTANYL (TIRF)

Drugs
Abstral, Actiq, fentanyl citrate, Fentora, Lazanda, Subsys

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

Exclusion Criteria
The Transmucosal Immediate-Release Fentanyl (TIRF) products will not be covered for any non-cancer pain indication.

Required Medical Information
The Transmucosal Immediate-Release Fentanyl (TIRF) products may be covered for the management of breakthrough pain in adult cancer patients who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain.

Age Restriction
None.

Prescriber Restriction
The prescribing physician must be an oncologist or a pain management specialist.

Coverage Duration
Life of Plan

Other Criteria
Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of morphine oral 60 mg daily or more, fentanyl transdermal 25 mcg/hour or more, oxycodone oral 30 mg daily or more, hydromorphone oral 8 mg daily or more, or an equianalgesic dose of another opioid daily for a week or longer. Patients must remain on around-the-clock opioids when taking fentanyl sublingual.

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
Tysabri will not be approved 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: Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Rebif, or Tecfidera. Crohn's Disease: The member must a documented diagnosis of Crohn's disease and both of the following: 1. An inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. Asacol, azulfidine, Colazal, Dipentum, Pentasa, Rowasa, sulfasalazine). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate. 2. 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
Intial authorization=6 months. Re-authorization may be given 12-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
Chronic hepatitis C: Treatment of genotype 1 chronic hepatitis C virus (HCV) in combination with peginterferon alfa and ribavirin in adult patients with compensated liver disease, including cirrhosis, who are treatment-naive or who have previously been treated with interferon-based treatment, including prior null responders, partial responders, and relapsers.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.

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 (1) other medication indicated for adjunct partial seizures (e.g. Aptiom, felbamate (Felbatol), Fycompa, 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, and/or zonisamide (Zonegran)).

Age Restriction
The member must be 17 years of age or older.

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

VIRAZOLE

Drugs
Virazole

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 severe lower respiratory tract infection due to respiratory syncytial virus (RSV).

Age Restriction
None

Prescriber Restriction
None

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, and, for soft tissue sarcoma, the member must have received prior chemotherapy, including anthracycline treatment, or was unsuited for such therapy.

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 moderate to severely active 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 (IBD): The member must have a documented diagnosis of IBD and has failed to respond to or has a contraindication to standard antibiotic treatment (e.g., ciprofloxacin, metronidazole).

Age Restriction
For Hepatic Encephalopathy, the member must be 18 years of age or older.

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
Coverage 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 then 30 IU/mL and less than or equal to 700 IU/mL. Chronic Idiopathic Urticaria (CIU): Coverage of Xolair may be authorized if the member has a definitive diagnosis of CIU for at least 6 moths and the physician has documented that the member remains symptomatic despite H1 antihistamine treatment.

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

Prescriber Restriction
The precribing physician must be an allergist, immunologist or pulmonologist.

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.

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

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

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
InformationThe member must have a documented diagnosis of mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy (e.g. Cerezyme) is not a therapeutic option (e.g. because of allergy, hypersensitivity, or poor venous access).

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
Zelboraf is not indicated for treatment of patients with wild-type BRAF melanoma.

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

ZYDELIG

Drugs
Zydelig

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

Exclusion Criteria
None

Required Medical Information
Chronic Lymphocytic Leukemia (CLL): The member must have a documented diagnosis of relapsed CLL and Zydelig will be given in combination with rituximab (Rituxan).Follicular B-cell non-Hodgkin lymphoma: The member must have a documented diagnosis of relapsed follicular B-cell non-Hodgkin lymphoma and the member must have documentation of at least 2 prior systemic therapies.Small Lymphocytic Lymphoma (SLL): The member must have a documented diagnosis of relapsed SLL and the member must have documentation of at least 2 prior systemic therapies.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

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
The prescribing physician must be an oncologist or urologist.

Coverage Duration
Life of Plan

Other Criteria
None