Medicare Part D

Prior Authorization Requirements

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

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

Contract Year: 2013
Last Updated: 11/2013

Y0062_RXPA 2013

ACTEMRA

Drugs
Actemra

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

Exclusion Criteria

Required Medical Information
Rheumatoid arthritis(RA)-diagnosis established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation AND infliximab(Remicade)was not effective after a minimum 12 week treatment course or has not been tolerated unless contraindicated AND ANC(absolute neutrophil count)is greater than 2000/mm3 AND platelet count is greater than 100,000/mm3 AND patient has an AST(SGOT) and ALT (SGPT) below 1.5 times the upper limit of normal. Systemic juvenile idiopathic arthritis-a diagnosis of SJIA/Still's disease with disease activity greater than 6 months confirmed by a rheumatologist AND treatment with at least one oral systemic agent for SJIA/Still's disease was ineffective or not tolerated AND patient has an absolute neutrophil acount (ANC) above 2,000mm3 AND patient has a platelet count above 100,000/mm3 AND patient has an ALT and AST below 1.5 times the upper limit of normal.

Age Restriction

Prescriber Restriction

Coverage Duration
6 months initially then annually

Other Criteria

AFINITOR

Drugs
Afinitor, Afinitor Disperz

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

ALIMTA

Drugs
Alimta

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

AMPYRA

Drugs
Ampyra

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

Exclusion Criteria

Required Medical Information
Documentation that the following criteria have been met: adult with a diagnosis of multiple sclerosis AND dalfampridine is being used for improvement of speed of ambulation AND the patient has the ability to ambulate at least 25 feet AND there is documentation of functional impairment.

Age Restriction

Prescriber Restriction

Coverage Duration
Initial-3 months then annually

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

ANGIOTENSIN II RECEPTOR ANTAGONISTS

Drugs
Benicar, Benicar HCT, Micardis, Micardis HCT

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
Treatment with one generic angiotensin II receptor blocker ineffective, not tolerated or contraindicated.

ANTIDEPRESSANTS

Drugs
Cymbalta, Pristiq, Viibryd

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

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

ANTINEOPLASTICS

Drugs
Herceptin

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

ARCALYST

Drugs
Arcalyst

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

Exclusion Criteria

Required Medical Information
There is laboratory evidence of a genetic mutation in the Cold-Induced Auto-Inflammatory Syndrome 1 (CIAS1, also known as NLRP-3) AND there is clinical documentation that the patient is experiencing the classic symptoms of CAPS in either: Familial Cold Auto-Inflammatory Syndrome (FCAS) including recurrent intermittent episodes of fever and rash that primarily followed natural, artificial or both types of generalized cold exposure OR Muckle-Wells Syndrome (MWS), a syndrome of chronic fever and rash that may wax and wane in intensity, sometimes exacerbated by generalized cold exposure.

Age Restriction

Prescriber Restriction

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

Other Criteria

ARZERRA

Drugs
Arzerra

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

ATYPICAL ANTIPSYCHOTICS

Drugs
Abilify, Abilify Discmelt, Abilify Maintena, Fanapt, FazaClo, Invega, Latuda, Saphris

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

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

AVASTIN

Drugs
AVASTIN

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

BISPHOSPHONATES

Drugs
Actonel, Atelvia

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
Treatment with one generic bisphosphonate ineffective, not tolerated or contraindicated.

BOSULIF

Drugs
Bosulif

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

Exclusion Criteria

Required Medical Information
Documentation of chronic myelogenous leukemia (CML) AND documentation that the patient's CML is Philadelphia chromosone-positive AND one prior tyrosine kinase inhibitor therapy for CML has not been effective or is contraindicated.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

BYDUREON

Drugs
Bydureon

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

BYETTA

Drugs
Byetta

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

Exclusion Criteria

Required Medical Information
Documentation that the patient's hemoglobin A1C value is over 7% AND a 90 day treatment course with metformin did not adequately reduce the hemoglobin A1c to the goal of 7% or less or was not tolerated or is contraindicated.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

CAPRELSA

Drugs
Caprelsa

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

CELEBREX

Drugs
Celebrex

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

Exclusion Criteria

Required Medical Information
Used in the treatment of chronic pain and/or inflammation when treatment with at least two generically available prescription nonsteroidal anti-inflammatory drugs (NSAIDs) were ineffective or not tolerated where one of the previously used NSAIDs must be diclofenac, etodolac, nabumetone, or meloxicam.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

CEREZYME/VPRIV

Drugs
Cerezyme, VPRIV

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

Exclusion Criteria

Required Medical Information
Diagnosis of Type 1 Gaucher disease confirmed by: biochemical assay of glucocerebrosidase activity in WBCs or skin fibroblasts is less than or equal to 30% of normal activity (note: laboratory normals may vary) OR genotyping revealing two pathogenic mutations of the glucocerebrosidase gene AND symptomatic manifestations of the disease are present such as anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly.

Age Restriction

Prescriber Restriction

Coverage Duration
6 months

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

CHORIONIC GONADOTROPIN

Drugs
chorionic gonadotropin, human, Pregnyl

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

COMETRIQ

Drugs
Cometriq

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

Exclusion Criteria

Required Medical Information
Carbozantinib (Cometriq) may be considered medically necessary in patients with a diagnosis of metastatic medullary thyroid cancer.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

Drugs
Janumet, Janumet XR, Januvia, Juvisync

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

Exclusion Criteria

Required Medical Information
Documentation that the patient's HgBA1C value is over 7% AND treatment with metformin is contraindicated, not tolerated or has been ineffective in reducing hemoglobin A1C to goal of 7% or less after 90 days of therapy.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

DOXIL

Drugs
Doxil

Covered Uses
All FDA-approved indications not otherwise excluded from Part D, cutaneous T-cell lymphoma (CTCL), non-AIDs related Kaposi's sarcoma

Exclusion Criteria

Required Medical Information
A diagnosis of ovarian cancer, recurrent or progressive, after treatment with a platinum-based chemotherapy OR a diagnosis of progressive Kaposi's sarcoma (KS) requiring systemic therapy OR a diagnosis of multiple myeloma (MM) after at least one prior therapy has been ineffective or not tolerated OR a diagnosis of cutaneous T-cell lymphoma after treatment with gemcitabine unless ineffective, contraindicated or not tolerated.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

DOXORUBICIN LIPOSOMAL

Drugs
doxorubicin HCl peg-liposomal

Covered Uses
All FDA-approved indications not otherwise excluded from Part D, cutaneous T-cell lymphoma (CTCL), non-AIDs related Kaposi's sarcoma.

Exclusion Criteria

Required Medical Information
A diagnosis of ovarian cancer, recurrent or progressive, after treatment with a platinum-based chemotherapy OR a diagnosis of progressive Kaposi's sarcoma (KS) requiring systemic therapy OR a diagnosis of multiple myeloma (MM) after at least one prior therapy has been ineffective or not tolerated OR a diagnosis of cutaneous T-cell lymphoma after treatment with gemcitabine unless ineffective, contraindicated or not tolerated.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

EGRIFTA

Drugs
Egrifta

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
6 months initially then annually

Other Criteria

ELIQUIS

Drugs
Eliquis

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

Exclusion Criteria

Required Medical Information
Documentation that rivaroxaban (Xarelto) and dabigatran (Pradaxa) have each been ineffective, not tolerated or contraindicated.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
QLL 60/30

ENBREL

Drugs
Enbrel

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Chronic Plaque Psoriasis-dermatologist or rheumatologist

Coverage Duration
1 year

Other Criteria

ERBITUX

Drugs
Erbitux

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

Exclusion Criteria

Required Medical Information
A diagnosis of advanced (unresectable) or metastatic colorectal cancer (CRC) when no KRAS mutation is present (for use with KRAS wild type tumors only) OR a diagnosis of advanced (unresectable), metastatic, or recurrent squamous cell carcinoma of the head and neck (SCCHN) OR diagnosis of advanced (stage IIIb or IV) non-small cell lung cancer when documentation is provided that the tumor expresses epidermal growth factor receptor (EGFR) AND cetuximab is given in conjunction with a platin doublet (cisplatin or carboplatin in combination with another chemotherapy medication) AND there is no known brain metastasis.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

ERIVEDGE

Drugs
Erivedge

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

EXTAVIA

Drugs
Extavia

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

FENTANYL

Drugs
fentanyl citrate

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

FIRAZYR

Drugs
Firazyr

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

FOLOTYN

Drugs
Folotyn

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

Exclusion Criteria

Required Medical Information
Diagnosis of peripheral T-cell lymphoma (PTCL) and at least one prior therapy for PTCL has been ineffective or not tolerated.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

FORTEO

Drugs
Forteo

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

Exclusion Criteria

Required Medical Information
Patient at high risk for fracture as defined by: having a bone mineral density that is 2.5 or more standard deviations below that of a young, normal adult(T score at or below -2.5) OR having osteopenia with T-score between -1 and -2.5 and a history of previous fractures or glucocorticoid use for at least 3 months at a dose of 5mg per day of prednisone or equivalent AND at least one bisphosphonate has not been effective based on objective documentation except if bisphosphonates are contraindicated based on current medical literature and objective documentation describing the contraindication is provided OR bisphosphonates are not tolerated due to documented clinical side effects.

Age Restriction

Prescriber Restriction

Coverage Duration
One time maximum two years of therapy authorization.

Other Criteria

GILOTRIF

Drugs
Gilotrif

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

Exclusion Criteria

Required Medical Information
A diagnosis of metastatic non-small cell lung cancer (NSCLC) AND documentation of an EGFR exon 19 deletion or exon 21 (L858R) substitution mutation is provided AND patient has had no prior cytotoxic or targeted chemotherapy for NSCLC.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
30 tablets per month

GLEEVEC

Drugs
Gleevec

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

HALAVEN

Drugs
Halaven

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

HUMIRA

Drugs
Humira, Humira Crohn's Dis Start Pck

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

Exclusion Criteria

Required Medical Information
Psoriatic arthritis-when the diagnosis established by a rheumatologist or dermatologist. Ankylosing spondylitis-diagnosis established by a rheumatologist. Rheumatoid arthritis(RA) or juvenile idiopathic arthritis (JIA)-diagnosis established by a rheumatologist or for RA meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND 6-12 week course of methotrexate was ineffective based on documentation which includes one or more of the American College of Rheumatology Assessment Components for improvement in Rheumatoid Arthritis unless methotrexate is contraindicated or not tolerated based on clinical documentation. Crohn's Disease-Fistulizing Crohn's Disease OR acute treatment of an exacerbation when at least one of the three following criteria is met: treatment with an adequate course of systemic corticosteroids(such as, but not limited to, 40-60mg prednisone per day for 7-14 days) has been ineffective or is contraindicated OR patient has been unable to taper off an adequate course of systemic corticosteroids without experiencing worsening of disease OR patient is experiencing breakthrough disease while stabilized for at least 2 months on an immune-modulatory medication(such as, but not limited to, azathioprine, mercaptopurine, cyclosporine or methotrexate) OR acute and/or maintenance of Crohn's Disease when infliximab(Remicade) has been ineffective or not tolerated. Chronic plaque psoriasis ? Chart notes support a diagnosis of chronic plaque psoriasis involving at least 10% of body surface area or causes significant functional disability AND treatment with at least one oral systemic agent(such as, but not limited to, cyclosporine, methotrexate or acitretin) for psoriasis was ineffective or not tolerated, unless all are contraindicated.

Age Restriction

Prescriber Restriction
Chronic Plaque Psoriasis-dermatologist or rheumatologist. Ulcerative colitis-gastroenterologist.

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

Other Criteria
Ulcerative colitis - acute treatment of an exacerbation of moderately to severely active ulcerative colitis where an adequate course of systemic corticosteroids was ineffective or is contraindicated AND treatment with an oral aminosalicylate (such as balasalazide, mesalamine or sulfasalazine) for ulcerative colitis was ineffective or not tolerated.

ICLUSIG

Drugs
Iclusig

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

Exclusion Criteria

Required Medical Information
Panotinib (Iclusig) may be considered medically necessary when criteria A and B below are met: A.?Documentation of chronic myelogenous leukemia (CML) OR Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) AND B. Prior therapy with other tyrosine kinase inhibitors is not effective or is not tolerated, unless all other TKIs are contraindicated.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

INCIVEK

Drugs
Incivek

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

Exclusion Criteria

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

Age Restriction
Minimum 18 years of age

Prescriber Restriction

Coverage Duration
Initial=8 wks

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

INCRELEX

Drugs
Increlex

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

Exclusion Criteria

Required Medical Information
Diagnosis of severe primary IGF-1 deficiency OR growth hormone deletion OR genetic mutation of growth hormone receptor(Laron Syndrome) AND current high measurement at less than 3rd percentile for age and sex AND IGF-1 level greater than or equal to 3 standard deviations below normal (based on at least one growth hormone stimulation test) AND normal or elevated growth hormone levels based upon at least one growth hormone stimulation test AND open growth plates.

Age Restriction

Prescriber Restriction
Endocrinologist

Coverage Duration
1 year

Other Criteria

INLYTA

Drugs
Inlyta

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

Exclusion Criteria

Required Medical Information
Documentation of a diagnosis of renal cell carcinoma (RCC) AND sunitinib (Sutent) or sorafenib(Nexavar) or pazopanib(Votrient) has been ineffective or was not tolerated.

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

ISTODAX

Drugs
Istodax

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

JAKAFI

Drugs
Jakafi

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

JEVTANA

Drugs
Jevtana

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

KADCYLA

Drugs
Kadcyla

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

Exclusion Criteria

Required Medical Information
Diagnosis of HER2-positive metastatic breast cancer AND disease progression after treatment with trastuzumab and a taxane (separately or in combination).

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

KALYDECO

Drugs
Kalydeco

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

KINERET

Drugs
Kineret

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

Exclusion Criteria

Required Medical Information
The diagnosis of Rheumatoid Arthritis (RA) has been established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate alone is not effective after at least a 6 to 12 week treatment course based on documentation which includes one or more of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except if documentation is submitted that methotrexate is relatively or absolutely contraindicated based on current literature OR methotexate is not tolerated due to documented clinical side effects AND either etanercept(Enbrel) or adalimumab(Humira)or golimumab(Simponi) is not effective after at least a 12 week treatment course unless not tolerated due to documented clinical side effects AND therapy does not exceed administration of 100mg of anakinra (Kineret) subcutaneously once daily.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

LYRICA

Drugs
Lyrica

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

MEKINIST

Drugs
Mekinist

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

Exclusion Criteria

Required Medical Information
A definitive diagnosis of unresectable or metastatic melanoma AND there is documentation of a BRAF V600E or V600K mutation as detected by a Food and Drug Administration (FDA) approved test.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
QLL: 30 per month

MODAFINIL

Drugs
modafinil

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

Exclusion Criteria

Required Medical Information
Excessive sleepiness associated with narcolepsy(diagnosed by the criteria of DSM-IV-TR, Appendix 1) when at least one generic or preferred brand medication, such as, but not limited to, methylphenidate or dextroamphetamine, has been ineffective or not tolerated OR documentation of residual excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome AND there is documentation that the patient has been compliant with CPAP or BiPAP for at least 2 months OR excessive sleepiness associated with shift-work disorder when diagnosis is made using the criteria from International Classification of Sleep Disorders(ICSD, Appendix 2) AND sleep disturbance causes measurable functional impairment in social, occupational or other important areas of functioning that has persisted for at least three months AND sleep disturbance is not due to otherwise reversible conditions AND non-pharmacologic therapies have been inadequate in improving functional impairments.

Age Restriction

Prescriber Restriction

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

Other Criteria

NAMENDA

Drugs
Namenda, Namenda Titration Pak

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

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

NASAL CORTICOSTEROIDS

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

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

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

NEXAVAR

Drugs
Nexavar

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Oncologist or hematologist

Coverage Duration
1 year

Other Criteria

NUTROPIN/OMNITROPE

Drugs
Nutropin, Nutropin AQ, Nutropin AQ Nuspin, Omnitrope

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

Exclusion Criteria

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

Age Restriction

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

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

Other Criteria

ORENCIA

Drugs
Orencia

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

Exclusion Criteria

Required Medical Information
Juvenile idiopathic arthritis (JIA) or rheumatoid arthritis(RA)-diagnosis established by a rheumatologist or for RA meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis for RA AND treatment with methotrexate has been ineffective after at least a 6-12 week treatment course based on documentation which includes one or more of the components of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except if methotrexate is contraindicated or not tolerated based on clinical documentation AND infliximab (Remicade) is not effective after at least a 12 week treatment course of therapy except if not tolerated due to documented clinical side effects.

Age Restriction

Prescriber Restriction

Coverage Duration
6 months initially then 1 year

Other Criteria

Drugs

acetylcysteine, albuterol sulfate, Aminosyn 8.5 %-Electrolytes, Aminosyn II 10 %, Aminosyn II 15%, Aminosyn II 7 %, Aminosyn II 8.5 %, Aminosyn II 8.5 %-Electrolytes, Aminosyn M 3.5 %, Aminosyn-HBC 7%, Aminosyn-PF 10 %, Aminosyn-PF 7 % (Sulfite-Free), Anzemet, Aranesp (in polysorbate), Atgam, atropine, Azasan, azathioprine, azathioprine sodium, Brovana, budesonide, Busulfex, calcitriol, CellCept, CellCept Intravenous, cladribine, Clinimix 5%/D15W Sulfite Free, Clinimix 5%/D25W Sulfite Free, Clinimix 2.75%/D5W Sulfit Free, Clinimix 4.25%/D10W Sulf Free, Clinimix 4.25%/D20W Sulf Free, Clinimix 4.25%/D25W Sulf Free, Clinimix 4.25%/D5W Sulfit Free, Clinimix 5%/D20W Sulfite Free, Clinimix E 2.75%/D10W Sul Free, Clinimix E 2.75%/D5W Sulf Free, Clinimix E 4.25%/D25W Sul Free, Clinimix E 4.25%/D5W Sulf Free, Clinimix E 5%/D15W Sulfit Free, Clinimix E 5%/D20W Sulfit Free, Clinimix E 5%/D25W Sulfit Free, Clinisol SF 15 %, cromolyn, CUBICIN, cyclophosphamide, cyclosporine, cyclosporine modified, cytarabine, cytarabine (PF), Dacogen, decitabine, doxorubicin, Emend, Engerix-B (PF), Engerix-B Pediatric (PF), Epogen, Etopophos, etoposide, fluorouracil, Freamine III 3 %-Electrolytes, Freamine III 8.5 %, Gengraf, granisetron, Granisol, Hecoria, Hectorol, Hepatamine 8%, Hepatasol 8 %, Intralipid, ipratropium bromide, ipratropium-albuterol, irinotecan, Ixempra, levalbuterol HCl, levocarnitine, levocarnitine (with sugar), lidocaine (PF), lidocaine-prilocaine, Liposyn III, Miacalcin, mycophenolate mofetil, Myfortic, Nebupent, Neoral, Nephramine 5.4 %, Nulojix, ondansetron, ondansetron HCl, paricalcitol, Perforomist, Premasol 10 %, Premasol 6 %, Procalamine 3%, Procrit, Prograf, Prosol 20%, Pulmicort, Pulmozyme, Rapamune, Recombivax HB (PF), Sandimmune, tacrolimus, Thymoglobulin, Tobi, Toposar, topotecan, TPN Electrolytes, Travasol 10 %, Treanda, TrophAmine 10 %, Trophamine 6%, vancomycin, vinblastine, Xopenex, Zemplar, Zortress

Covered Uses

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Other Criteria

PEGASYS

Drugs
Pegasys, Pegasys Convenience Pack, Pegasys ProClick

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

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

Other Criteria

PEGINTRON

Drugs
PegIntron, PegIntron Redipen

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

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

Other Criteria
DURATION OF COVERAGE WITH HCV PROTEASE INHIBITOR-Initial coverage duration with telapravir-8 weeks initially and if HCV RNA is greater than 1000u/ml at week 4 then no additional authorization as treatment is not effective. If HCV RNA is less than 1,000IU/ml at week 4 then 4 additional week. Initial coverage duration with boceprevir-12 weeks initially then based upon HCV RNA levels at weeks 4, 8 and 20 of boceprevir. Continued authorization-TREATMENT-NA?VE-If HCV RNA is greater than 100 IU/mL at week 8 of boceprevir then no additional authorization as treatment is not effective. If HCV RNA is less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks. If HCV RNA is greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment is not effective. If HCV RNA is less than 10 IU/mL at week 20 of boceprevir and HCV RNA was less than 10IU/ml(undetectable) at week 4 of boceprevir then no additional authorization as treatment is complete or if HCV RNA at week 4 of boceprevir was greater than 10IU/ml(detectable) then 8 additional weeks. PRIOR RELAPSERS OR PRIOR PARTIAL RESPONDERS-If HCV RNA greater than 100 IU/mL at week 8 of boceprevir then no additional authorization as treatment is not effective. If HCV RNA less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks. If HCV RNA is greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment is not effective. If HCV RNA is less than 10 IU/mL at week 20 of boceprevir 8 additional weeks. COMPENSATED CIRRHOSIS OR PRIOR NULL-RESPONDERS-If HCV RNA greater than 100 IU/mL at week 8 of boceprevir no additional authorization as treatment is not effective. If HCV RNA less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks then if HCV RNA greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment not effective or if HCV RNA is less than 10 IU/mL at week 20 of boceprevir then 20 additional weeks.

PITUITARY

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

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

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

Other Criteria

POMALYST

Drugs
Pomalyst

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

Exclusion Criteria

Required Medical Information
Documentation of recurrent multiple myeloma AND at least two prior therapies for multiple myeloma have been ineffective or not tolerated and these prior therapy regimens must have included both bortezomib, and an immunomodulator, unless contraindicated.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

PROMACTA

Drugs
Promacta

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

Exclusion Criteria

Required Medical Information
Diagnosis of chronic ITP made by or in consultation with a hematologist AND patient is at risk of spontaneous bleeding as demonstrated in chart notes by either platelet count less than 20,000/mm3 or platelet count less than 30,000/mm3 accompanied by symptoms of bleeding AND treatment with at least one of the following ITP treatments was ineffective or not tolerated: adequate course of systemic corticosteroids (such as, but not limited to, prednisone 1-2mg/kg for 2 to 4 weeks OR pulse dexamethasone 40mg daily for 4 days) OR immunoglobulin replacement therapy or splenectomy.

Age Restriction

Prescriber Restriction

Coverage Duration
Initial-3 months then every 6 months

Other Criteria

PROTON PUMP INHIBITORS

Drugs
lansoprazole

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

PROVIGIL

Drugs
Provigil

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

Exclusion Criteria

Required Medical Information
Excessive sleepiness associated with narcolepsy(diagnosed by the criteria of DSM-IV-TR, Appendix 1) when at least one generic or preferred brand medication, such as, but not limited to, methylphenidate or dextroamphetamine, has been ineffective or not tolerated OR documentation of residual excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome AND there is documentation that the patient has been compliant with CPAP or BiPAP for at least 2 months OR excessive sleepiness associated with shift-work disorder when diagnosis is made using the criteria from International Classification of Sleep Disorders(ICSD, Appendix 2) AND sleep disturbance causes measurable functional impairment in social, occupational or other important areas of functioning that has persisted for at least three months AND sleep disturbance is not due to otherwise reversible conditions AND non-pharmacologic therapies have been inadequate in improving functional impairments.

Age Restriction

Prescriber Restriction

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

Other Criteria

PULMONARY ANTIHYPERTENSIVES

Drugs
Letairis, Remodulin, Revatio, sildenafil, Tracleer, Ventavis

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

Exclusion Criteria

Required Medical Information
Diagnosis of World Health Organization (WHO) Group 1 pulmonary aterial hypertension (PAH).

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

QUALAQUIN

Drugs
Qualaquin

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
up to 10 days

Other Criteria

QUININE SULFATE

Drugs
quinine sulfate

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
up to 10 days

Other Criteria

RELISTOR

Drugs
Relistor

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Up to 4 months

Other Criteria

REMICADE

Drugs
Remicade

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

Exclusion Criteria

Required Medical Information
Rheumatoid Arthritis (RA)-diagnosis of RA or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of RA AND methotrexate has been ineffective after at least a 6-12 week treatment course based on documentation which includes one or more of the components of the American College of Rheumatology Assessment Components for Improvement in RA except if methotrexate is contraindicated or not tolerated based on clinical documentation AND infliximab administered with an oral DMARD (such as, but not limited to, methotrexate). Ankylosing spondylitis-diagnosis of ankylosing spondylitis. Crohn's Disease and Ulcerative Colitis-fistulizing Crohn's disease OR acute treatment of an exacerbation of Crohn's disease or ulcerative colitis where adequate course of systemic corticosteroids(such as, but not limited to, 40-60mg prednisone per day for 10-14 days) has been ineffective or contraindicated OR unable to taper off an adequate course of systemic corticosteroids without worsening or symptoms OR patient is experiencing breakthrough disease while stabilized for at least 2 months on an immunomodulatory medication (such as, but not limited to, azathioprine, mercaptopurine, cyclosporine or methotrexate). Plaque psoriasis-chart notes support a diagnosis of chronic plaque psoriasis involving at least 10% of the body surface area or causes significant functional impairment disability AND treatment with at least one oral systemic agent for psoriasis (such as, but not limited to, cyclosporine, methotrexate or acitretin) was ineffective or not tolerated, unless all are contraindicated.

Age Restriction

Prescriber Restriction
Plaque psoriasis-dermatologist or rheumatologist

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

Other Criteria

REVLIMID

Drugs
REVLIMID

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

Exclusion Criteria

Required Medical Information
Diagnosis of myelodysplastic syndrome(MDS)when patient is transfusion dependent(defined as administration of 2 or more units of red blood cells (RBCs) in the previous 8 weeks) AND patient has an absolute neutrophil count of at least 500/mm3 AND patient has a platelet count of at least 50,000/mm3. Diagnosis of multiple myeloma(MM) when lenalidomide is used in combination with corticosteroid (such as, but not limited to, dexamethasone)unless documentation is provided that a corticosteroid is contraindicated or is not tolerated AND patient has an absolute neutrophil count(ANC) of at least 1,000/mm3 AND patient has a platelet count of at least 30,000/mm3.

Age Restriction

Prescriber Restriction

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

Other Criteria

RITUXAN

Drugs
Rituxan

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

Exclusion Criteria

Required Medical Information
A diagnosis of refractory autoimmune hemolytic anemia (AIHA) when an adequate course of corticosteroids has been ineffective, are contraindicated, or not tolerated OR a diagnosis of multicentric Castleman?s disease (angiofollicular lymph node hyperplasia) OR a diagnosis of lymphocyte predominant Hodgkin?s lymphoma OR patients with refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) when a diagnosis of chronic ITP is made by, or in consultation with, a hematologist AND patient is at risk of spontaneous bleeding as demonstrated in chart notes by either one of the following criteria: platelet count is less than 20,000/mm3 OR platelet count is less than 30,000/mm3 accompanied by symptoms of bleeding AND at least two prior treatments for ITP were ineffective or not tolerated and one of those treatments must be an adequate course of systemic corticosteroids OR a diagnosis of chronic lymphocytic leukemia(CLL) OR a diagnosis of refractory Evan?s syndrome where at least two prior therapies have been ineffective, contraindicated, or not tolerated OR a diagnosis of relapsed or refractory Hairy Cell Leukemia when at least two courses of a purine analog (cladribine or pentostatin) are not effective, unless contraindicated, or not tolerated OR a diagnosis of primary central nervous system (CNS) lymphoma OR a diagnosis of CD20-positive B-cell non-Hodgkin?s lymphoma (NHL) OR a diagnosis of CD20-positive B-cell post-transplant lymphoproliferative disorder (B-PTLD) when tapering of immunosuppressive medications is not effective or is contraindicated OR diagnosis of Wegener's granulomatosis when prior therapy with cyclophosphamide plus corticosteroids has been ineffective, is contraindicated or not tolerated OR a diagnosis of Waldenstr?m?s macroglobulinemia

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
OR patients with moderately to severely active rheumatoid arthritis (RA) when the diagnosis has been established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of RA AND methotrexate is ineffective after at least a 6 to 12 week treatment course based on documentation which includes one or more of the assessment components of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except if methotrexate is contraindicated or not tolerated based on clinical documentation AND treatment with infliximab (Remicade)is contraindicated or has not been tolerated or has been ineffective after at least a 12-week treatment course AND rituximab is given in combination with methotrexate unless contraindicated or not tolerated.

SERUM IMMUNOGLOBULINS GAMMA

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

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

Exclusion Criteria

Required Medical Information
Acquired Factor VIII inhibitor-when conventional therapy (such as cyclophosphamide, corticosteroids or azathioprine) is ineffective or not tolerated. Allogeneic bone marrow transplant recipients who are 20 years of age or older for up to 4 months following transplantation. Autoimmune hemolytic anemia- warm type AIHA that does not respond to alternative therapies(such as corticosteroids, immunosuppressive agents, plasmapheresis, or splenectomy). Dermatomyositis-documented EMG abnormalities and/or increased CPK levels with associated severe disability when corticosteroid therapy is ineffective or not tolerated. Fetal alloimmune thrombocytopenia-documented diagnosis. HIV infected children(less than 13 years of age) when T4 cell count is greater than 200/mm3. Hypogammaglobulinemia(acquired) associated with either chronic B-cell lymphocytic leukemia or post allogeneic bone marrow transplant and documented with laboratory findings. Hypogammaglobulinemic neonates-low birth weight(less than 1500g) or in a setting with high baseline infection rate or morbidity. Inflammatory demyelinating polyneuropathy(acute) including Guillain-Barre' syndrome with deteriorating pulmonary function tests OR rapid deterioration with symptoms for less than 2 weeks OR rapidly deteriorating ability to ambulate OR inability to walk independently for 10 meters. Inflammatory demyelinating polyneuropathy(chronic, CIDP) with significant functional disability AND documentation of slowing of nerve conduction velocity on EMG/NCS AND documentation of elevated spinal fluid protein on lumbar puncture or a nerve biopsy confirming diagnosis. Acute idiopathic thrombocytopenia purpura (ITP)-when rapid increase in platelet count is necessary. Chronic ITP-platelets less than 30,000/mm3 in children or less than 20,000/mm3 in adults.ITP in pregnancy-refractory to steroids with platelet counts less than 10,000/mm3 in the 3rd trimester OR platelet less than 30,000/mm3 associated with bleeding before delivery

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

Prescriber Restriction

Coverage Duration
90 days to1 year depending on diagnosis

Other Criteria

SIMPONI

Drugs
Simponi

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

Exclusion Criteria

Required Medical Information
Diagnosis of ankylosing spondylitis or psoriatic arthritis when the diagnosis has been established by a rheumatologist or dermatologist. Diagnosis of rheumatoid arthritis when the diagnosis has been established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation AND golimumab(Simponi) is administered with an oral DMARD.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

SIMPONIA ARIA

Drugs
Simponi ARIA

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

Exclusion Criteria

Required Medical Information
Diagnosis of rheumatoid arthritis when the diagnosis has been established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation AND golimumab(Simponi) is administered with an oral DMARD.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

SPRYCEL

Drugs
Sprycel

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

Exclusion Criteria

Required Medical Information
Documentation of chronic or accelerated phase chronic myelogenous leukemia (CML) when there is documentation that the patient's CML is Philadelphia chromosome-positive (PH+) AND treatment with nilotinib(Tasigna) has been ineffective, not tolerated or contraindicated OR documentation of acute lymphoblastic leukemia (ALL) when there is documentation that the patient's ALL is Philadelphia chromosome-positive (PH+) AND treatment wtih imatinib (Gleevec) has been ineffective, not tolerated or contraindicated.

Age Restriction

Prescriber Restriction
Hematologist or oncologist

Coverage Duration
1 year

Other Criteria

STELARA

Drugs
Stelara

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

Exclusion Criteria

Required Medical Information
Diagnosis of moderate to severe psoriasis where chart notes support a diagnosis of chronic plaque psoriasis involving at least 10% of the body surface area or causes significant functional disability AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated.

Age Restriction

Prescriber Restriction
Dermatologist or rheumatologist

Coverage Duration
1 year

Other Criteria

STIVARGA

Drugs
Stivarga

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

Exclusion Criteria

Required Medical Information
Regorafenib (Stivarga) may be considered medically when the following criteria is met: A diagnosis of metastatic colorectal cancer AND Prior treatment with bevacizumab (Avastin) has been ineffective, contraindicated, or not tolerated AND Prior treatment with cetuximab (Erbitux) has been ineffective, contraindicated, or not tolerated when no KRAS mutation is present (for use with KRAS wild type tumors only).

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

SUTENT

Drugs
Sutent

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Hematologist or oncologist

Coverage Duration
1 year

Other Criteria

SYLATRON

Drugs
Sylatron

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

SYNAGIS

Drugs
Synagis

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

Exclusion Criteria

Required Medical Information
Infants with bronchopulmonary dysplasia who are less than 2 years of age at the start of the current RSV season and who have required medical therapy for bronchopulmonary dysplasia within 6 months of or during the RSV season or infants with bronchopulmonary dysplasia that required treatment with supplemental oxygen as neonates for at least 28 days OR infants less than or equal to 3 months of chronological age (post-natal age) at the onset of RSV season and with a history of premature birth between 32 0/7 weeks to 34 6/7 weeks gestation who have at least one of the following risk factors: childcare attendance or school aged siblings or siblings in the household who are less than 5 years of age OR infants less than or equal to 12 months of chronological age(post-natal age) with congenital abnormalities of the airway or neuromuscular disease OR infants less than or equal to 6 months chronological age(post-natal) at the onset of RSV season with a history of premature birth between 29 0/7 to 31 6/7 weeks with or without the presence of additional risk factors OR infants less than or equal to 12 months chronological age(post-natal) at the onset of RSV season and born at 28 6/7 weeks of gestation or earlier OR infants or children with hemodynamically significant congenital heart disease who are 24 months of age or younger at the onset of RSV season who: receive medication to control congestive heart failure OR have moderate to severe pulmonary hypertension OR have cyanotic heart disease.

Age Restriction
24 months or younger

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

SYNRIBO

Drugs
Synribo

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

Exclusion Criteria

Required Medical Information
Diagnosis of chronic myelogenous leukemia (CML) AND prior therapy with at least two tyrosine kinase inhibitors (TKIs) for CML is not effective or is not tolerated, unless all TKIs are contraindicated.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

TAFINLAR

Drugs
Tafinlar

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

Exclusion Criteria

Required Medical Information
A definitive diagnosis of unresectable or metastatic melanoma AND there is documentation of a BRAF V600E mutation as detected by a Food and Drug Administration (FDA) approved test.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
QLL: 120 per month

TARCEVA

Drugs
Tarceva

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

Exclusion Criteria

Required Medical Information
A diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) when at least one prior chemotherapy regimen prescribed for non-small cell lung cancer was not effective (documented disease progression either during or after treatment)or used as a single maintenance chemotherapy after four cycles of platinum-based chemotherapy or used as first-line therapy when an EGFR mutation is present OR a diagnosis of locally advanced, unresectable or metastatic pancreatic cancer when given in combination with gemcitabine.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

TASIGNA

Drugs
Tasigna

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Hematologist or oncologist

Coverage Duration
1 year

Other Criteria

TEKTURNA

Drugs
Tekturna

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
Treatment with two generic/preferred angiotensin II receptor blockers unless not tolerated, ineffective or contraindicated.

TRETINOIN TOPICAL PRODUCTS

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

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

TRIPTANS

Drugs
Relpax, zolmitriptan, Zomig, Zomig ZMT

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

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

TYKERB

Drugs
Tykerb

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis of HER 2 positive breast cancer.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

TYSABRI

Drugs
TYSABRI

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

Exclusion Criteria

Required Medical Information
Multiple Sclerosis-A definitive diagnosis of a relapsing form of multiple sclerosis(relapsing-remitting or secondary progressing multiple sclerosis) that has been established by a neurologist or multiple sclerosis physician specialist AND interferon beta product(Avonex, Rebif, Betaseron or Extavia) OR glatiramer acetate (Copaxone) was documented in clinical notes to be ineffective, contraindicated or not tolerated with ineffectiveness defined as meeting two of the following criteria: patient continues to have clinical relapses(at least two clinical relapses within the past 12 months) or patient continues to have CNS lesion progression as measured by MRI or patient continues to have worsening disability. Crohn's Disease-A diagnosis of Crohn?s disease when one of the following criteria are met: treatment with an adequate course of corticosteroids(such as, but not limited to 40-60mg prednisone per day for 7-14 days) has been ineffective or is contraindicated OR patient has been unable to taper off an adequate course of systemic corticosteroids without experiencing worsening of disease OR patient is experiencing breakthrough disease while stabilized for at least two months on an immunomodulatory medication (such as, but not limited to, azathioprine, mercaptopurine, cyclosporine or methotrexate) AND infliximab(Remicade) is not effective after at least an initial induction period (5mg/kg on weeks 0,2,6) except if not tolerated due to documented clinical side effects AND adalimumab(Humira) is not effective after at least an initial 3-dose induction period except if not tolerated due to documented clinical side effects AND patients have an elevated (greater than 6mg/dl) baseline C-reactive protein(CRP) level.

Age Restriction

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

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

Other Criteria

VELCADE

Drugs
Velcade

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

VICTOZA

Drugs
Victoza 3-Pak

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

VICTRELIS

Drugs
Victrelis

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

Exclusion Criteria

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

Age Restriction
Minimum 18 years of age

Prescriber Restriction

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

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

VOTRIENT

Drugs
Votrient

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
1 year

Other Criteria

XALKORI

Drugs
Xalkori

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

XENAZINE

Drugs
Xenazine

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

Exclusion Criteria

Required Medical Information
Diagnosis of Huntington's disease with presence of chorea symptoms as confirmed by a neurologist AND chart notes document that the patient is being monitored for symptoms of depression and if depression present that it is being addressed.

Age Restriction

Prescriber Restriction

Coverage Duration
Initially 3 months then every 6 months

Other Criteria

XOLAIR

Drugs
Xolair

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

XTANDI

Drugs
Xtandi

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

Exclusion Criteria

Required Medical Information
A diagnosis of metastatic castration-resistant prostate cancer AND prior treatment with taxane chemotherapy has been ineffective, contraindicated or not tolerated AND prior treatment with abiraterone (Zytiga) has been ineffective, contraindicated or not tolerated.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

XYREM

Drugs
Xyrem

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

YERVOY

Drugs
Yervoy

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

Exclusion Criteria

Required Medical Information
Diagnosis of unresectable or metastatic melanoma.

Age Restriction

Prescriber Restriction

Coverage Duration
4 infusions(one treatment course) then annually.

Other Criteria

ZALTRAP

Drugs
Zaltrap

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

Exclusion Criteria

Required Medical Information
Ziv-aflibercept (Zaltrap) may be considered medically when criteria A, B and C below are met: A. A diagnosis of metastatic colorectal cancer AND B. Prior treatment with an oxaliplatin (Eloxatin)-containing regimen has been ineffective or not tolerated AND C. Prior treatment with bevacizumab (Avastin) has been ineffective or not tolerated.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

ZAVESCA

Drugs
Zavesca

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

Exclusion Criteria

Required Medical Information
A diagnosis of type 1 Guacher disease.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

ZELBORAF

Drugs
Zelboraf

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

ZOLEDRONIC ACID

Drugs
zoledronic acid, zoledronic acid-mannitol-water, Zometa

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

Exclusion Criteria

Required Medical Information
Zoledronic acid may be considered medically necessary when one of the following criteria have been met: for the treatment of osteoporosis or in patients with osteopenia at high risk for fracture when an oral bisphosphonate (such as alendronate, ibandronate or risedronate) has been ineffective, not tolerated or contraindicated. Patients at high risk for fracture are defined by meeting one of the following criteria-have a bone mineral density that is 2.5 or more standard deviations below that of a young normal adult (T-score at or below -2.5) or have osteopenia (T-score between -1 and -2.5) and glucocorticoid use for at least 3 months at a dose of 5mg per day or greater(of prednisone or equivalent) or history of osteoporotic (fragility) fracture or men receiving hormone ablation[androgen deprivation therapy(ADT)] for prostate cancer or women receiving hormone ablation therapy for breast cancer or the probability is greater than or equal to 20% for the occurrence of a major osteoporotic fracture of greater than or equal to 3% for hip fracture based on the US-adapted WHO algorithm Fracture Risk Assessment Tool (FRAX tool) OR for the treatment of Paget?s disease OR for the prevention of skeletal related events (SREs such as fractures) in patients with multiple myeloma and bone metastases from breast cancer when pamidronate has been ineffective, not tolerated or contraindicated OR for the prevention of skeletal related events (SREs such as fractures) in patients with bone metastases from solid tumor cancers other than breast cancer OR for the treatment of hypercalcemia of malignancy.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

ZOLINZA

Drugs
Zolinza

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

Exclusion Criteria

Required Medical Information
A diagnosis of cutaneous T-cell lymphoma (CTCL) AND at least two prior system therapies [such as, but not limited to, all-trans retinoic acid (Vesanoid?), bexarotene (Targretin?), bortezomib (Velcade?), chlorambucil (Leukeran?), cyclophosphamide (Cytoxan?), denileukin diftitox (Ontak?), doxorubicin, liposomal (Doxil?), etoposide (VePesid?), gemcitabine (Gemzar?), interferon alfa (Intron? A), isotretinoin, methotrexate, pentostatin, pralatrexate (Folotyn?) or temozolomide (Temodar?)] have been ineffective or not tolerated.

Age Restriction

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

ZYTIGA

Drugs
Zytiga

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

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