Tufts Medicare Preferred
2012 Prior Authorization Criteria

Effective 01/01/2012 **Updated 06/01/2012**

ACTEMRA

Drugs
Actemra

Covered Uses
Rheumatoid arthritis and all other FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Member must have a documented diagnosis of rheumatoid arthritis AND documented inadequate response or inability to tolerate at least one tumor necrosis factor antagonist, Cimzia, Enbrel, Humira, Remicade or Simponi

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a rheumatologist.

Coverage Duration
Life of Plan

Other Criteria
None

AFINITOR

Drugs
Afinitor

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

Exclusion Criteria
None

Required Medical Information
For 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). For Subependymal Giant Cell Astrocytoma (SEGA), documented diagnosis of subependymal giant cell astrocytoma associated with tuberous sclerosis and 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

ALDURAZYME

Drugs
Aldurazyme

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

Exclusion Criteria
Not covered for Members mildly affected with the Scheie form of MPS 1

Required Medical Information
The Member must have the definitive diagnosis of the Hurler or Hurler-Scheie form of MPS I, or the Scheie form of MPS I with moderate to severe symptoms which include, but are not limited to, chronic rhinitis, recurrent ear infections, umbilical or inguinal hernia, above normal growth and head size, facial dysmorphisms, corneal clouding, skeletal deformities, developmental delay, valvular heart disease, joint stiffness

Age Restriction
None

Prescriber Restriction
The prescribing physician must specialize in metabolic disorders or genetics.

Coverage Duration
Life of Plan

Other Criteria
None

AMEVIVE

Drugs
Amevive

Covered Uses
Plaque psoriasis and all other FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
Member must have a definitive diagnosis of moderate-to-severe chronic plaque psoriasis and the member has failed to respond to, or has been unable to tolerate, Psoralens with UVA light and ONE of the following, Soriatane, Methotrexate or Cyclosporine

Age Restriction
16 years of age or older

Prescriber Restriction
The prescribing physician must be a dermatologist.

Coverage Duration
Life of Plan

Other Criteria
None

AMPYRA

Drugs
Ampyra

Covered Uses
To improve walking in patients with multiple sclerosis and all other FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a neurologist.

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

Other Criteria
None

ARCALYST

Drugs
Arcalyst

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

Exclusion Criteria
None

Required Medical Information
The Member has 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

ARZERRA

Drugs
Arzerra

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

Exclusion Criteria
None

Required Medical Information
Arzerra is covered for members with a documented diagnosis of chronic lymphocytic leukemia (CLL) refractory to fludarabine and alemtuzumab.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

BANZEL

Drugs
Banzel

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

Exclusion Criteria
None

Required Medical Information
The member has a documented diagnosis of Lennox-Gastaut Syndrome AND the Member has had an insufficient response or intolerance to at least one of the following medications: Valproic acid derivative (e.g. Depakene, Depakote), Topamax (topiramate), Lamictal (lamotrigine) and/or Felbatol (felbamate)

Age Restriction
None

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

BOTULINUM TOXINS

Drugs
Botox, Xeomin

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

Exclusion Criteria
Cosmetic Procedures

Required Medical Information
Documented response to injections following two sequential treatments or sets of injections in a 4 to 6 month period, using maximum dose for the size of the muscle

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Initial authorization will expire in 2 months from original authorization date for any diagnosis

Other Criteria
None

CARBAGLU

Drugs
Carbaglu

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

CELEBREX

Drugs
Celebrex

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

Exclusion Criteria
None

Required Medical Information
Celebrex is covered for members age 65 or greater, 50 years old or greater for those with Rheumatoid Arthritis, Previous or active GI bleeding or hemorrhage, GERD, PUD, Demonstrated lack of effectiveness or intolerace to a fair trial of at least 2 prescription non-COX2 inhibitor NSAIDS (e.g. diclofenac, fenoprofen, ibuprofen, naproxen, etc), Medical condition(s) that would constitute a predisposition to bleeding, Member is currently taking Anticoagulants, methotrexate, Imuran, oral corticosteriods, PPIs, H2 antagonists or Arthrotec.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

CIALIS

Drugs
Cialis

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

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

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

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

CIMZIA

Drugs
Cimzia, Cimzia Powder for Reconst

Covered Uses
Crohn's disease, rheumatoid arthritis and all other FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
For Crohn's disease, the Member has a documented diagnosis of Crohns disease and has demonstrated an inadequate response to an appropriate trial with two or more of the following agents, corticosteroids, 5-Aminosalicylates, 6-mercaptopurine and/or azathioprine or methotrexate or if the member demonstrates a failure or intolerance to Remicade (infliximab). For rheumatoid arthritis, the Member must have an inadequate response at optimal doses or an inability to take methotrexate.

Age Restriction
Member must be 18 years of age or older

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

CINRYZE

Drugs
Cinryze

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an immunologist.

Coverage Duration
Life of Plan

Other Criteria
None

DIFICID

Drugs
Dificid

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

EGRIFTA

Drugs
Egrifta

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

ENBREL

Drugs
Enbrel

Covered Uses
Ankylosing spondylitis, juvenile idiopathic arthritis, plaque psoriasis, psoriatic arthritis, rheumatoid arthritis and all other FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
For psoriasis, the member must have a definitive diagnosis of moderate-to-severe chronic plaque psoriasis and the member has failed to respond to, or have been unable to tolerate, Psoralens with UVA light and ONE of the following, Soriatane, methotrexate or cyclosporine. For rheumatoid arthritis and juvenile idiopathic arthritis, the member must have an inadequate response after three months at optimal doses or an inability to take methotrexate. For psoriatic arthritis, the member must have an inadequate response or inability to take methotrexate OR sulfasalazine at maximal doses for three months. Enbrel is covered for the diagnosis of ankylosing spondylitis.

Age Restriction
Member is 2 years of age or older

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

Coverage Duration
Life of Plan

Other Criteria
None

ERIVEDGE

Drugs
Erivedge

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

FABRAZYME

Drugs
Fabrazyme

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

Exclusion Criteria
None

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

Age Restriction
None

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

Coverage Duration
Life of Plan

Other Criteria
None

FIRAZYR

Drugs
Firazyr

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

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

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

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

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

Coverage Duration
Life of Plan

Other Criteria
None

FORTEO

Drugs
Forteo

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

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

Required Medical Information
Tufts Health Plan may authorize coverage of Forteo (teriparatide) for 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 above, 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, including 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

GAUCHER DISEASE TYPE 1 TREATMENTS

Drugs
Ceredase, Cerezyme, VPRIV

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

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

Required Medical Information
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
Multiple Sclerosis and all FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

GROWTH HORMONE REPLACEMENT THERAPY

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

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

Exclusion Criteria
None

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

Age Restriction
N/A

Prescriber Restriction
None

Coverage Duration
None

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

HUMIRA

Drugs
Humira, Humira Crohn's Dis Start Pck

Covered Uses
Ankylosing spondylitis, Crohn's disease, juvenile idiopathic arthritis, plaque psoriasis, psoriatic arthritis, rheumatoid arthritis and all other FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
For Crohn's disease, the Member has a documented diagnosis of Crohns disease and has demonstrated an inadequate response to an appropriate trial with two or more of the following agents, corticosteroids, 5-Aminosalicylates, 6-mercaptopurine and/or azathioprine or methotrexate or if the member demonstrates a failure or intolerance to Remicade (infliximab). For psoriasis, the member must have a definitive diagnosis of moderate-to-severe chronic plaque psoriasis and the member has failed to respond to, or have been unable to tolerate, Psoralens with UVA light and ONE of the following, Soriatane, Methotrexate or Cyclosporine. For rheumatoid arthritis and juvenile idiopathic arthritis, the Member must have an inadequate response after three months at optimal doses or an inability to take methotrexate. For psoriatic arthritis, the Member must have an inadequate response or inability to take methotrexate OR sulfasalazine at maximal doses for three months. For ankylosing spondylitis, the Member must have a diagnosis of ankylosing spondylitis.

Age Restriction
Member is 4 years of age or older

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

Coverage Duration
Life of Plan

Other Criteria
None

ILARIS

Drugs
Ilaris (PF)

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

INCIVEK

Drugs
Incivek

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

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

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

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

INCRELEX

Drugs
Increlex

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

Exclusion Criteria
Not covered for conditions resulting in secondary forms of IGFD that include, but are not limited to, GH deficiency, malnutrition, hypothyroidism, chronic steroid therapy

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

Age Restriction
Members age 2 to 18 years

Prescriber Restriction
The prescribing physician must be an endocrinologist.

Coverage Duration
6 months initial. Subsequent authorization are annual

Other Criteria
None

INJECTABLE DRUGS FOR ACROMEGALY

Drugs
Somatuline Depot, SOMAVERT

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

Exclusion Criteria
None

Required Medical Information
Physician-documented diagnosis of acromegaly AND the member has had a failure of, or is unable to tolerate, a treatment regimen that included octreotide AND the member is not a candidate for surgery and or radiation or has had an inadequate response to surgery and or radiation.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an endocrinologist.

Coverage Duration
Life of Plan

Other Criteria
None

INLYTA

Drugs
Inlyta

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

INTRAVENOUS IMMUNE GLOBULIN

Drugs
Carimune NF Nanofiltered, GamaSTAN S/D, Gammagard Liquid, Gammaplex, Gamunex-C, Hizentra, Privigen, Vivaglobin

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

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 Tinea (pedis, corporis) resistant to aggressive topical therapy.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

JAKAFI

Drugs
Jakafi

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
None

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

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

KALYDECO

Drugs
Kalydeco

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

Exclusion Criteria
None

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

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

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

KINERET

Drugs
Kineret

Covered Uses
Rheumatoid arthritis and all other FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
For rheumatoid arthritis and juvenile idiopathic arthritis, the Member must have an inadequate response at optimal doses or an inability to take methotrexate.

Age Restriction
Member is 18 years of age or older

Prescriber Restriction
The prescribing physician must be a rheumatologist.

Coverage Duration
Life of Plan

Other Criteria
None

KUVAN

Drugs
Kuvan

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

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

Required Medical Information
Tufts Medicare Preferred may cover Kuvan for members with a physician documented diagnosis of hyperphenylalaninemia (HPA) due to tetrahydrobiopterin-(BH4-) responsive phenylketonuria (PKU).

Age Restriction
None

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

Coverage Duration
Up to 8 weeks after initial approval.

Other Criteria
None

LIDODERM

Drugs
Lidoderm

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

Exclusion Criteria
None

Required Medical Information
For Neuropathic pain, the member must have had a failure, adverse reaction, or contraindication to gabapentin. For Non-neuropathic pain, the member must have had a failure, adverse reaction, or contraindication to two prescription analgesics, including a narcotic.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

MEDICATIONS FOR CHRONIC HEPATITIS B AND C INFECTION

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

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

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

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

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

Prescriber Restriction
None

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

Other Criteria
None

MEDICATIONS FOR THE TREATMENT OF PULMONARY HYPERTENSION

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

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

Exclusion Criteria
Tufts Health Plan will not authorize coverage of Flolan, Remodulin, Tracleer, Ventavis, or sildenafil for pulmonary hypertension secondary to the following conditions. Diseases of the left atrium and ventricle such as congestive heart failure (CHF) or cardiomyopathy, diseases of the mitral and aortic valves, chronic lung diseases such as COPD, restrictive pulmonary disease or interstitial pulmonary disease, obstructive sleep apnea or other sleep disorders involving breathing or alveolar hyperventilation disorders

Required Medical Information
Definitive diagnosis of pulmonary arterial hypertension diagnosed by a pulmonologist or cardiologist and confirmed by right heart catheterization

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a cardiologist or pulmonologist

Coverage Duration
Life of Plan

Other Criteria
None

MOZOBIL

Drugs
Mozobil

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

Exclusion Criteria
N/A

Required Medical Information
The member has been diagnosed with non-Hodgkin's lymphoma or multiple myeloma and Mozobil (plerixafor) is being used in combination with one of the following colony stimulating factors (Granulocyte colony stimulating factor (G-CSF) NeupogenR (filgrastim) or Granulocyte macrophage colony stimulating factor (GM-CSF) LeukineR (sargramostim)) and standard stem cell mobilization procedures utilizing one of the above medications alone have been unsuccessful.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an Oncologist

Coverage Duration
Life of Plan

Other Criteria
None

NEXAVAR

Drugs
Nexavar

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

Exclusion Criteria
None

Required Medical Information
Documented diagnosis of advanced Renal Cell Carcinoma and documented failure to or inability to tolerate treatment involving high-dose interleukin 2 or interferon therapy. Documented diagnosis of biopsy-proven, unresectable hepatocellular carcinoma.

Age Restriction
None

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

Coverage Duration
Life of Plan

Other Criteria
None

NUEDEXTA

Drugs
Nuedexta

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

Exclusion Criteria
N/A

Required Medical Information
Tufts Medicare Preferred may authorize coverage of Nuedexta (dextromethorphan/quinidine) for members with a documented diagnosis of pseudobulbar affect (PBA) secondary to amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), or bilateral stroke.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

ORENCIA

Drugs
Orencia

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

Exclusion Criteria
Not approved if administered concomitantly with another tumor necrosis factor antagonist or Kineret (anakinra)

Required Medical Information
For Rheumatoid Arthritis, the Member has a documented inadequate response or inability to tolerate at least one tumor necrosis factor antagonist, including Cimzia (certolizumab), Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab) or Simponi (golimumab). For juvenile idiopathic arthritis, the Member has a documented inadequate response or inability to tolerate Enbrel (etanercept) or Humira (adalimumab).

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a rheumatologist.

Coverage Duration
Life of Plan

Other Criteria
None

ORFADIN

Drugs
Orfadin

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

Exclusion Criteria
None

Required Medical Information
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

PRADAXA

Drugs
Pradaxa

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

PROLIA AND XGEVA

Drugs
Prolia, Xgeva

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

Exclusion Criteria
None

Required Medical Information
Tufts Health Plan may authorize coverage of Prolia (denosumab) for the treatment of postmenopausal women with osteoporosis when the following criteria are met. The member is at high risk of fracture defined as a history of osteoporotic fracture or multiple risk factors for fracture and a T score less than or equal to -2.0 as evidenced via bone density scan or the member has had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments [alendronate (Fosamax), calcitonin (Miacalcin), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel), zoledronic acid (Reclast)]. Tufts Health Plan may authorize coverage of Xgeva (denosumab) for prevention of skeletal-related events in patients with bone metastases from solid tumors only.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

PROMACTA

Drugs
Promacta

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

Exclusion Criteria
None

Required Medical Information
Tufts Health Plan may authorize coverage of Promacta for Members with a documented diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) and has had an insufficient response or intolerance to corticosteroids and/or immunoglobulins, OR the member has not responded to splenectomy.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

REMICADE

Drugs
Remicade

Covered Uses
Ankylosing spondylitis, Crohn's disease, juvenile idiopathic arthritis, plaque psoriasis, psoriatic arthritis, rheumatoid arthritis, ulcerative colitis and all other FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
For Crohn's disease or ulcerative colitis, the Member has a documented diagnosis of Crohns disease or ulcerative colitis and has demonstrated an inadequate response to an appropriate trial with two or more of the following agents, corticosteroids, 5-Aminosalicylates, 6-mercaptopurine and/or azathioprine or methotrexate. For psoriasis, the Member must have a definitive diagnosis of severe chronic plaque psoriasis AND has failed to respond to, or has been unable to tolerate phototherapy and one of the following therapeutically-similar medications, cyclosporine, methotrexate or Soriatane (acitretin). For rheumatoid arthritis and and psoriatic arthritis, the Member must have a documented diagnosis and an inadequate response or inability to take the DMARD methotrexate. For ankylosing spondylitis, the Member must have a documented diagnosis of ankylosing spondylitis.

Age Restriction
Adults 18 years or older exept for pediatric crohns disease, member must age 6 to 17 years

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

Coverage Duration
Life of Plan

Other Criteria
None

RESTASIS

Drugs
Restasis

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

Exclusion Criteria
None

Required Medical Information
The Member must have a definitive diagnosis of Keratoconjuctivitis Sicca or Sjogrens Syndrome

Age Restriction
16 years of age or older

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

RETINOIDS FOR THE TOPICAL TREATMENT OF ACNE VULGARIS AND PSORIASIS

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

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

Exclusion Criteria
Tufts Health Plan will not authorize coverage of topical acne products for cosmetic purposes

Required Medical Information
Physician-documented diagnosis of acne or comedones (white heads). For Tazorac, 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, or by the commissioner under the provisions of section 47L

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

REVLIMID

Drugs
REVLIMID

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

Exclusion Criteria
None

Required Medical Information
For Myelodysplastic Syndrome the member must have a documented diagnosis of transfusion dependent anemia due to myelodysplastic syndrome associated with the 5q-deletion cytogenetic abnormality. For Multiple Myeloma, the member must have a documented diagnosis of Multiple Myeloma and Revlimid must be used in combination with dexamethasone AND the Member has received and failed to respond to at least one prior therapy OR coverage for other cancer diagnoses may be authorized provided effective treatment with Revlimid is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner under the provisions of section 47L

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

Age Restriction
None

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

Coverage Duration
Life of Plan

Other Criteria
None

SIMPONI

Drugs
Simponi

Covered Uses
Ankylosing spondylitis, psoriatic arthritis, rheumatoid arthritis and all other FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
For Rheumatoid Arthritis, the member must have had an inadequate response to or an inability to take methotrexate at optimal doses. For Psoriatic Arthritis, the member must have had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses. For Ankylosing Spondylitis, the member has a documented diagnosis of Ankylosing Spondylitis.

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

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

Coverage Duration
Life of Plan

Other Criteria
None

SPRYCEL

Drugs
Sprycel

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

Exclusion Criteria
None

Required Medical Information
For Acute Lymphoblastic Leukemia (ALL), the member must have a documented diagnosis of Philadelphia chromosome–positive (Ph+) ALL with resistance or intolerance to prior therapy. For Chronic Myeloid Leukemia (CML), the member must have newly diagnosed Ph+ CML in chronic phase or chronic, accelerated, or myeloid or lymphoid blast phase Ph+CML with resistance or intolerance to prior therapy, including (Gleevec) imatinib.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

STELARA

Drugs
Stelara

Covered Uses
Plaque psoriasis and all other FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria
None

Required Medical Information
The Member must have a definitive diagnosis of moderate-to-severe chronic plaque psoriasis AND has failed to respond to, or has been unable to tolerate phototherapy and one of the following therapeutically-similar medications, cyclosporine, methotrexate or Soriatane (acitretin).

Age Restriction
18 years of age or older

Prescriber Restriction
The prescribing physician must be a dermatologist.

Coverage Duration
Life of Plan

Other Criteria
None

SUBOXONE

Drugs
Suboxone

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. Treatment of opioid dependence

Exclusion Criteria
Suboxone will not be covered to treat pain

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

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

SUTENT

Drugs
Sutent

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

Exclusion Criteria
None

Required Medical Information
For Advanced Renal Cell Carcinoma, the member must have a documented diagnosis. For Gastrointestinal Stromal Tumor, 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.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

SYLATRON

Drugs
Sylatron

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

Exclusion Criteria
None

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

Age Restriction
None

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

Coverage Duration
Life of Plan

Other Criteria
None

SYNAGIS

Drugs
Synagis

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

Exclusion Criteria
Use in the absence of chronic lung disease or pre-maturity as defined in the Required Medical Information section, experimental uses not approved by the FDA, use in months outside of the specified regional RSV season, infants with mild cardiomyopathy who are not receiving medical therapy, children with hemodynamically insignificant heart disease, such as secundum atrial septal defect, pulmonic stenosis, patent ductus arteriosus, small ventricular septal defect, uncomplicated aortic stenosis, mild aortic coarctation or S/P corrective surgery, unless continued treatment of congestive heart failure is required.

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

Age Restriction
None

Prescriber Restriction
None

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

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

TASIGNA

Drugs
Tasigna

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

Exclusion Criteria
None

Required Medical Information
For newly-diagnosed Philadelphia chromosome positive chronic myelogenous leukemia, the Member must have a documented diagnosis of Philadelphia chromosome positive chronic myelogenous leukemia in chronic phase. For resistant or intolerant Philadelphia chromosome positive chronic myelogenous leukemia, 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 OR documented diagnosis of other cancer provided effective treatment with Tasigna is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner under the provisions of section 47L

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

TYKERB

Drugs
Tykerb

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

Exclusion Criteria
Tykerb for advanced or metastatic breast cancer tumors that do not overexpress the HER2 protein or for monotherapy treatment of HER2 overexpressing advanced or metastatic breast cancer

Required Medical Information
Tufts Medicare Preferred may authorize coverage of Tykerb for members with advanced or metastatic breast cancer whose tumors overexpress human epidermal growth receptor type 2 (HER2) and is being used in combination with Xeloda (capecitabine), and who have received prior therapy including an anthracycline, a taxane, and Herceptin (trastuzumab), or in combination with (Femara) letrozole for the treatment of postmenopausal women with hormone receptor–positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

TYSABRI

Drugs
TYSABRI

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

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

Required Medical Information
For Multiple Sclerosis, the Member must have a definitive diagnosis of relapsing multiple sclerosis AND has a documented inadequate response or inability to tolerate an appropriate trial with Avonex, Betaseron, Copaxone, Extavia, Gilenya or Rebif. For Crohns Disease, the Member must have a definitive diagnosis of Crohns Disease AND has demonstrated an inadequate response to an appropriate trial with two or more of the following, Corticosteroids, 5-Aminosalicylates, 6-mercaptopurine and/or azathioprine, methotrexate OR the member has demonstrated an inadequate response to an appropriate trial with Cimzia, Humira or Remicade. An appropriate trial is defined as 30 or more days on a prerequisite treatment regimen.

Age Restriction
None

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

Coverage Duration
6 months

Other Criteria
None

VANDETANIB

Drugs
Caprelsa, vandetanib

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

Exclusion Criteria
None

Required Medical Information
The member must have a physician 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

VICTRELIS

Drugs
Victrelis

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

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

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

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

VIMPAT

Drugs
Vimpat

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

VOTRIENT

Drugs
Votrient

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

XALKORI

Drugs
Xalkori

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

XARELTO

Drugs
Xarelto

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

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

XENAZINE

Drugs
Xenazine

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of at least moderate chorea associated with Huntington's Disease.

Age Restriction
None

Prescriber Restriction
The prescribing physician must be a neurologist.

Coverage Duration
Life of Plan

Other Criteria
None

XIFAXAN

Drugs
Xifaxan

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

Exclusion Criteria
Not covered for treatment of diarrhea caused by pathogens other than E. coli, diarrhea complicated by fever or bloody stools, bacterial overgrowth or prevention of travelers diarrhea

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

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
This criteria only applies to the 550 mg strength of Xifaxan

XOLAIR

Drugs
Xolair

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

Exclusion Criteria
None

Required Medical Information
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 AND the member shows a definitive sensitivity on allergy testing to one or more perennial allergens AND has a pre-treatment serum IgE level equal to or greater then 30 IU/mL and less than or equal to 700 IU/mL.

Age Restriction
Member must 12 years of age or older.

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

Coverage Duration
Life of Plan

Other Criteria
None

ZAVESCA

Drugs
ZAVESCA

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

Exclusion Criteria
None

Required Medical Information
Documented diagnosis of Type 1 Gaucher Disease AND member cannot be treated with enzyme replacement therapy (Ceredase or Cerezyme)

Age Restriction
Member must be 18 years of age or older

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

ZELBORAF

Drugs
Zelboraf

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
The prescribing physician must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

ZOLINZA

Drugs
Zolinza

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

Exclusion Criteria
None

Required Medical Information
The member must have a documented diagnosis of advanced cutaneous T-cell lymphoma (Stage IIB and higher) and progressive, persistent or recurrent disease AND documented current or prior treatment or treatment failure with at least one (1) systemic chemotherapeutic agents for cutaneous T-cell lymphoma OR documented diagnosis of other cancer provided effective treatment with Zolinza is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature, or by the commissioner under the provisions of section 47L

Age Restriction
None

Prescriber Restriction
None

Coverage Duration
Life of Plan

Other Criteria
None

ZYTIGA

Drugs
Zytiga

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

Exclusion Criteria
None

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

Age Restriction
None

Prescriber Restriction
The prescriber must be an oncologist.

Coverage Duration
Life of Plan

Other Criteria
None

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