PA Criteria

Prior Authorization Group	ACNE
Drug Names	TRETINOIN
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: TRETINOIN (topical) is NOT covered for members with the following criteria: A. Cosmetic use for wrinkle reduction. B. If the patient also is taking drugs known to be photosensitizers (eg, thiazides, tetracyclines, fluoroquinolones, phenothiazines, sulfonamides) because of the possibility of augmented phototoxicity. C. Pregnancy.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Office visit notes confirming diagnosis.B.Confirm patient is not using medication for wrinkle reduction.C. Patient is not taking drugs known to be photosensitizers (eg, thiazides, tetracyclines, fluoroquinolones, phenothiazines, sulfonamides) because of the possibility of augmented phototoxicity.D.Patient is not pregnant.
Age Restrictions	APPROVE: 12 years and older
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: TRETINOIN is covered for members who meet the following criteria: A. FDA approved indications and no wrinkle reduction use.

Prior Authorization Group	ACTHAR
Drug Names	ACTHAR HP
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: ACTHAR is NOT covered for members who meet the following criteria: A. If Concomitant use of live or live attenuated vaccines when receiving immunosuppressive corticotropin dose. B. Uncontrolled hypertension (more than 170/100 mmHg). C. Congestive heart failure. D. Ocular herpes simplex infection. E. History or presence of peptic ulcers. F. Primary adrenocortical insufficiency or adrenocortical hyperactivity. G. Scleroderma. H. Sensitivity to porcine protein. I. Surgery within past 6 months. J. Systemic fungal infection. K. Osteoporosis. L. Being administered through intravenous route.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis. B. For diagnosis other than Infantile Spasms/West Syndrome a. Documentation of previous trial/failure of systemic corticosteriod therapy.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an appropriate specialist for the covered use or other qualified provider
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: ACTHAR is covered for members who meet the following criteria: A. Confirmed diagnosis. B. For diagnosis other than Infantile Spasms/West Syndrome a. Documentation of previous trial/failure to systemic corticosteriod therapy.

Prior Authorization Group	ADCIRCA
Drug Names	ADCIRCA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: ADCIRCA is NOT covered for members with the following criteria: A. Using any form of organic nitrate, regularly and/or intermittently.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Supporting Documentation verifying: 1. Diagnosis. 2. Blood pressure. 3. The dose does not exceed 40 mg daily. 4.CrCl less than 30 mL/min.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist and cardiologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: ADCIRCA is covered for members who meet the following criteria: A. Diagnosis for the treatment of pulmonary arterial hypertension to improve exercise ability.

Prior Authorization Group	ALPHA1-PROTEINASE INHIBITOR
Drug Names	GLASSIA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient has selective IgA deficiency with known antibodies against IgA.
Required Medical Information	All patients must have a deficiency of alpha1-proteinase inhibitor (also known as alpha1-antitrypsin) AND clinically evident emphysema. Patients initiating therapy for the first time must also meet the following criteria: 1) Pretreatment serum alpha1-proteinase inhibitor concentration less than 11 micromoles/L, 2) Post-bronchodilation FEV1 between 30% and 65% predicted OR if the FEV1 is greater than 65% predicted, then the patient has experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	AMPYRA
Drug Names	AMPYRA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria	NON COVERAGE: AMPYRA is NOT covered for members with the following criteria: A. History of seizure B.Moderate or severe renal impairment (Clcr less than or equal to 50 mL/minute). C. Administering dalfampridine with other forms of 4-aminopyridine (4-AP, fampridine).
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirmed diagnosis of multiple sclerosis (any form). B. Confirm patient is not restricted to a wheelchair. C. Confirm no history of seizures, nor moderate to severe renal impairment (CrClless than 50 ml/minute).
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or other qualified provider
Coverage Duration	Initial approval 4 mos Subsequent authorization for up to 12 mos if patient has documented response
Other Criteria	COVERAGE POLICY: AMPYRA is covered for members who meet the following criteria: A. Is only used to improve walking in patients with multiple sclerosis (MS). B. Prior to therapy with dalfampridine, a baseline 25-foot walking test of between 8 and 45 seconds must be conducted and documented and for initial approval for MS, may authorize 4 months. C. During the 4 months after starting therapy with dalfampridine, patient must demonstrate at least a 20% improvement in the 25-foot walking test in order for continued approval.
Prior Authorization Group	ANDROGEL
Drug Names	ANDRODERM, ANDROGEL
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON-COVERAGE: ANDROGEL is NOT covered for members with the following criteria: A. If indicated or reference to sexual dysfunction diagnosis. B. Testosterone levels within normal range (range for the lab doing the testing). C. Female patients. D. Men with carcinoma of the breast or suspected carcinoma of the prostate. E. Use for muscle building purposes.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Current diagnosis of primary hypogonadism (congenital or acquired) - testicular failure due to cryptochidism, bilateral torsion, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals, Hypogonadotropic hypogonadism (congenital or acquired) - idiopathic gonadotropin or LHRH deficiency, or pituitary hypothalamic injury from tumors, trauma, or radiation. B. New starts: Current lab results measuring total testosterone less than 300 ng/dL, morning free or bioavailable testosterone less than 5 ng/dL) or absence of endogenous testosterone. C. Non-New Start: Confirm start of testosterone therapy had low testosterone level (i.e. morning total testosterone less than 300 ng/dL, morning free or bioavailable testosterone less than 5 ng/dL) or absence of endogenous testosterone.

Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Initial approval: 3 months. Extended approval: Annual review will be based on response to therapy.
Other Criteria	COVERAGE POLICY: ANDROGEL is covered for members who meet the following criteria: A. Sexual dysfunction, or ED is NOT the primary diagnosis. B. Testosterone levels (total and free), low ranges as provided by office or clinic performing labs.
Prior Authorization Group	ARANESP
Drug Names	ARANESP ALBUMIN FREE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myelodysplastic syndromes (MDS).
Exclusion Criteria	Uncontrolled hypertension. Pts receiving chemotherapy with curative intent. Cancer pts not receiving concomitant myelosuppressive chemotherapy. Pts with myeloid cancer.
Required Medical Information	For all uses: 1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, 2) For reauthorizations (patient received erythropoietin in previous month), an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. Additional requirements for cancer: 1) For initial therapy, at least 2 more months of chemotherapy is expected, 2) For reauthorizations, current Hgb is less than 10 g/dL OR Hgb is greater than or equal to 10 but less than 11 g/dL AND patient has symptoms of anemia. Additional requirements for CKD: 1) For CKD not on dialysis reauthorization, current Hgb is less than or equal to 10 g/dL OR Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose, 2) For CKD on dialysis reauthorization, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, 2) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	Patients will be monitored for thrombotic and cardiac events. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).
Prior Authorization Group	ARCALYST
Drug Names	ARCALYST

Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Office visit notes to verify FDA approved diagnosis. B. Dose does not exceed FDA label maximum for the diagnosis.
Age Restrictions	APPROVE: 12 years and older
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: ARCALYST is covered for members who meet the following criteria: A. Determine Medicare Part B versus Part D coverage.

Prior Authorization Group	AVONEX
Drug Names	AVONEX
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Diagnosis
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or other qualified provider
Coverage Duration	Up to 24 months
Other Criteria	COVERAGE POLICY: AVONEX is covered for members who meet the following criteria: A. Avonex is approved for the diagnosis of multiple sclerosis, relapsing forms. B. For relapsing forms of multiple sclerosis: Patient must still either be able to walk at least a few steps or alternatively must have some functional arm/hand use consistent with performing activities of daily living. C. Refills will be approved if covered uses, exclusion criteria, required medical information, prescriber restriction are set, and the patient is experiencing a documented response to therapy. D. Determine Part B versus Part D. E. Applies to NEW STARTS only.

Prior Authorization Group	B VS. D

Drug Names	ACETYLCYSTEINE, ALBUTEROL SULFATE, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 8.5%/ELECTROL, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-PF 7%, ATGAM, AZATHIOPRINE, AZATHIOPRINE SODIUM, BONIVA, BUDESONIDE, CALCITRIOL, CELLCEPT, CELLCEPT INTRAVENOUS, CLADRIBINE, CROMOLYN SODIUM, CUBICIN, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE, CYTARABINE AQUEOUS, DACOGEN, DOXORUBICIN HCL, ETOPOSIDE, GENGRAF, HECTOROL, HEPARIN SODIUM, HEPARIN SODIUM/NACL 0.45%, HEPARIN SODIUM/SODIUM CHL, IBANDRONATE SODIUM, INTRALIPID, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, IXEMPRA KIT, LEVALBUTEROL, LEVALBUTEROL HCL, LIDOCAINE HCL, METHYLPREDNISOLONE SODIUM, MYCOPHENOLATE MOFETIL, MYFORTIC, NEBUPENT, NORMOSOL-R, NULOJIX, PERFOROMIST, RAPAMUNE, SIMULECT, TACROLIMUS, TOBI, TOPOTECAN HCL, TPN ELECTROLYTES, TRAVASOL, VANCOMYCIN HCL, VENTAVIS, ZEMPLAR, ZOMETA, ZORTRESS
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D or Part B.
Exclusion Criteria	NON COVERAGE: These drugs are NOT covered for members with the following criteria: A. Non-FDA approved indications.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. FDA approved Diagnosis.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 36 months
Other Criteria	COVERAGE POLICY: Requires diagnosis, information on location of medication administration, transplant payor information (where appropriate) and other information to determine Medicare Part B or Part D coverage. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., furnished from physician's supply incidental to a a physician service).
Prior Authorization Group	BENLYSTA
Drug Names	BENLYSTA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE

Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm diagnosis in office visit notes of active antibody-positive systemic lupus erythematosus in patients who are receiving standard therapy (Steroids, NSAID's, Antimalarial, etc.). B. Confirm history of use of standard of care (prednisone, non-steroidal anti-inflammatory agents, etc.).
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: BENLYSTA is covered for members who meet the following criteria: A. Diagnosis of active antibody-positive systemic lupus erythematosus. B. Live vaccines should not be given for 30 days before or concurrently with Benlysta (belimumab) as clinical safety has not been established. C. Use of Benlysta (belimumab) is not recommended in combination with biologic therapies or intravenous cyclophosphamide. D. Determine Part B versus Part D.

Prior Authorization Group	BOSULIF
Drug Names	BOSULIF
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm diagnosis. B Confirm elevations of liver transaminases are NOT greater than or equal to 3 x ULN with concurrent bilirubin elevation greater than 2 x ULN and alkaline phosphatase less than 2 x ULN.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or other qualified provider.
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: BOSULIF is covered for members who meet the following criteria: A. For retreatment, confirm satisfactory hematologic and cytogenic response. B. Applies to NEW STARTS only.

Prior Authorization Group	BUPHENYL
Drug Names	BUPHENYL
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: BUPHENYL is NOT covered for members with the following criteria: A. To treat acute hyperammonemia.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm diagnosis in office visit notes.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: BUPHENYL is covered for members who meet the following criteria: A. Diagnosis of cycle disorders: Adjunctive therapy in the chronic management of patients with urea cycle disorders involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamoylase (OTC), or argininosuccinic acid synthetase (AAS). It is indicated in all patients with neonatal-onset deficiency (complete enzymatic deficiency, presenting within the first 28 days of life). It is also indicated in patients with late-onset disease (partial enzymatic deficiency, presenting after the first month of life) who have a history of hyperammonemic encephalopathy.
Prior Authorization Group	BYETTA
Drug Names	BYETTA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: BYETTA is NOT covered for members with the following criteria: A. Type 1 Diabetes.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Diagnosis of Type-2 Diabetes. B. The patient has a creatinine clearance of greater than 30mL/minute or normal kidney function. C. The patient has had an inadequate treatment response, intolerance or contraindication to metformin and a sulfonylurea medication. D. If the patient has received previous Byetta therapy, the patient demonstrated a reduction in HbA1c since initiating Byetta therapy.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 24 months
Other Criteria	COVERAGE POLICY: BYETTA is covered for members who meet the following criteria: A. As adjunctive therapy to diet and exercise to improve glycemic control in adult patients with type 2 diabetes mellitus in multiple clinical settings. B. Patient's blood glucose is currently not controlled despite compliance with diabetic medication regimen for at least 3 months as evidenced by a HbA1C greater than 6.5%. C. Byetta will not be used to replace insulin. D. Patient will not be using insulin, Januvia, meglitinides (Prandin, Starlix), or alpha-glucosidase inhibitors (Precose, Glyset) concurrently with Byetta. E. Dose does not exceed FDA label maximum for the diagnosis. F. Confirm one of the following: 1. Byetta will be used in combination with either metformin, a sulfonylurea, or a thiozolidinedione (TZD), OR, 2. Byetta will be used in combination with metformin and a sulfonylurea, OR, 3. Byetta will be used in combination with metformin and a TZD. 4. Applies to NEW STARTS only.
Prior Authorization Group	CAMPRAL
Drug Names	CAMPRAL
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria	NON COVERAGE: CAMPRAL is NOT covered for members with the following criteria: A. If the patient has renal failure (CrCl 30 mL/min or less).
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation showing patient will receive psychosocial treatment concurrently. B. CrCl 30 mL/min or greater.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 6 months
Other Criteria	COVERAGE POLICY: CAMPRAL is covered for members who meet the following criteria: A. Is used for the maintenance of abstinence from alcohol in patients with alcohol dependence who are abstinent at treatment initiation. B. Treatment with acamprosate should be part of a comprehensive management program that includes psychosocial support.
Prior Authorization Group	CAPRELSA
Drug Names	CAPRELSA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: CAPRELSA is NOT covered for members with the following criteria: A. Patients with congenital long QT syndrome. Caprelsa should not be started in patients whose QTcF is greater than 450 ms. B. Caprelsa should not be given to patients who have a history of Torsades de pointes, bradyarrhymias, or uncompensated heart failure. C. Documentation of Liver Function. Caprelsa is not recommended for use in patients with moderate (Child-Pugh B) and severe (Child-Pugh C) hepatic Impairment (serum bilirubin 1.5 times the upper limit of normal d.2mg/dl .1-1mg/dl). Look to lab scales on patients' blood work for final range
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Appropriate diagnosis of Unresectable locally advanced or metastatic Medullary Thyroid Cancer B. Patient is registered in REMS Program that includes certified prescribers and pharmacies C. Documentation of no history of Congenital Long QT Syndrome, Torsades depointes, bradyarrhymias, or uncompensated heart failure D.. Documentation of no Congenital Long QT Syndrome history of Torsades de pointes, or bradyarrhymias E. Documentation of kidney function with by Normal Creatinine Clearance Starting dose should be reduced to 200 mg in patients with moderate (creatinine clearance e 30 to 50ml/min) and severe (creatinine clearance 30ml/min) renal impairment F. Documentation of Liver Function.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, endocrinologist or other qualified provider
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: CAPRELSA is covered for members who meet the following criteria: A. Normal dosage is 300mg/day taken orally B. Treatment should be continued until patients are no longer benefiting from treatment or unacceptable toxicity occurs. C. Applies to NEW STARTS only.

Prior Authorization Group	CARBAGLU
Drug Names	CARBAGLU
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: CARBAGLU is NOT covered for members with the following criteria: A. Normal plasma ammonia levels.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm the following treatment plan: Adjunctive therapy in the treatment of acute hyperammonemia and maintenance therapy of chronic hyperammonemia. B. Lab values confirming deficiency of the hepatic enzyme NAGS (N-acetylglutamate synthase) gene mutations by DNA testing. C. Plasma ammonia level (normal range of 5 to 50 micromoles/liter).
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider
Coverage Duration	Up to 3 months
Other Criteria	COVERAGE POLICY: CARBAGLU is covered for members who meet the following criteria: A. Diagnosis is documented. B. Concomitant administration of other ammonia-lowering therapies. C. Genetic Testing. D. Plasma ammonia level.

Prior Authorization Group	CAYSTON
Drug Names	CAYSTON
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	NON COVERAGE: CAYSTON is NOT covered for members with the following criteria: A. Hypersensitivity to aztreonam or any other component in the formulation.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. B. Confirmation of P. aeruginosa in cultures of the airways. C. For continuation of therapy in patients younger than 6 years of age, a clinical reason to continue therapy, such as symptomatic improvement, is required. D. For continuation of therapy in patients older than 6 years of age, pulmonary function tests have not deteriorated more than 10% from baseline or there is a clinical reason to continue therapy, such as symptomatic improvement. E. Confirm patient does not have Burkholderia cepacia.
Age Restrictions	APPROVE: 7 years or older
Prescriber Restrictions	NONE
Coverage Duration	Up to 28 days

Other Criteria	COVERAGE POLICY: CAYSTON is covered for members who meet the following criteria: A. Cayston is approved for the diagnosis of Cystic Fibrosis and P. aeruginosa. B. Must try/fail conventional treatment (e.g.TOBI). C. Determine Medicare Part B versus Part D coverage.

Prior Authorization Group	CEREZYME
Drug Names	CEREZYME
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation showing diagnosis as mild-to-moderate type-1 Gaucher disease. B. Documentation that diagnosis has been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%. C. Documentation showing the patient has at least one of the following conditions: Anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly. D. Documentation that if the patient has previously received 24 months of Cerezyme therapy, the patient must show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration since starting therapy.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: CEREZYME is covered for members who meet the following criteria: A. Diagnosis is documented as long-term enzyme replacement therapy with a confirmed diagnosis of type 1 Gaucher disease that results in 1 or more of the following conditions: anemia, bone disease, hepatomegaly or splenomegaly, and thrombocytopenia. B. If the patient has previously received 24 months of Cerezyme therapy, they must show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration since starting therapy. C. Determine Part B versus Part D.

Prior Authorization Group	CHANTIX
Drug Names	CHANTIX, CHANTIX STARTING MONTH PA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	NONE

Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of the stop smoking date. Varenicline dosing should start 1 week before targeted quit date. B. Documentation verifying the patient is enrolled in a behavioral support/modification program (e.g., community program, manufacturer sponsored program, counseling by the physician, internet, or telephone quitline). C. For continued therapy, documentation that member is not smoking and has had positive results during the last treatment cycle and confirm no depression as a result of Chantix treatment.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	NONE
Coverage Duration	Up to 4 months initially with an additional 4 months if needed.
Other Criteria	COVERAGE POLICY: CHANTIX is covered for members who meet the following criteria: A. The patient is diagnosed with nicotine addiction or withdrawal following cessation of smoking, AND, B. The patient is enrolled in a smoking cessation program. C. For continued therapy, documentation that member is not smoking and has had positive results during the last treatment cycle.
Prior Authorization Group	CIMZIA
Drug Names	CIMZIA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Crohns' Disease: 1. Documentation showing the diagnosis is Crohns Disease by significant clinical signs, symptoms, and radiologic reports documenting moderate to severely active disease such as frequent liquid stools greater than 4 times/day, presence of abdominal pain, presence of abdominal mass, extra-intestinal symptoms, need for opiates or diphenoxylate/atropine for diarrhea, anemia, and weight loss greater than 10%. 2. Documentation showing previous trial/failure of at least one (1) oral corticosteroid and a tried failed or intolerant to a 12-week trial of Enbrel or Humira. B. Rheumatoid Arthritis: 1. Documentation the patient has at least four (4) of the following symptoms: a. Morning stiffness. b. Arthritis of three (3) or more joint areas. c. Arthritis of hand joints. d. Symmetric arthritis. e. Rheumatoid nodules. f. Serum rheumatoid factor. g. Radiographic changes. 2. Documentation the patient has had at least an 8-week maximum tolerated dose trial and failure to at least one (1) of the following DMARDS listed: methotrexate, cyclosporine, azathioprine, sulfasalazine, leflunomide, aurothioglucose, auranofin, hydroxychoroquine and tried failed or intolerant to a 12-week trial of Enbrel or Humira. C. For retreatment,documentation if the patient has received previous Cimzia therapy, the patient must see an improvement.
Age Restrictions	APPROVE: 18 years or older

Prescriber Restrictions	NONE
Coverage Duration	Up to 24 months
Other Criteria	COVERAGE POLICY: CIMZIA is covered for members who meet the following criteria: A. Crohns disease: The patient has tried/failed and/or had an inadequate response to the following: At least one (1) oral corticosteroid and Enbrel or Humira or Remicade. B. Rheumatoid arthritis: 1. The patient has tried, failed and/or had an inadequate response to at least one (1) of the following: Methotrexate, cyclosporine, azathioprine, sulfasalazine, leflunomide, hydroxychoroquine. 2. AND the patient has tried, failed and/or had an inadequate response to at lease one (1) of the following: Enbrel or Humira. C. If the patient has received previous Cimzia therapy, the patient must see an improvement in clinical symptoms. D. Determine Part B versus Part D.
Prior Authorization Group	CINRYZE
Drug Names	CINRYZE
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D Hereditary angioedema (HAE), prophylaxis
Exclusion Criteria	NON COVERAGE: CINRYZE is NOT covered for members who meet the following criteria: A. Hypersensitivity to C1 esterase inhibitors. B. Currently taking an angiotensin converting enzyme inhibitor (ACEI) or estrogen replacement therapy
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation confirming the diagnosis of HAE by: a. Decreased serum levels of C4. AND b. Absence or marked decrease (less than 50% of laboratory's normal range) of the level or function of C1-INH. B. If being used as maintenance therapy, documentation supporting the need for prophylactic treatment: a. At least one laryngeal attack in the past OR history of at least one severe event per month OR disabling symptoms for at least 5 days per month. AND b. The patient has had inadequate response to, has been intolerant to, or has a contraindication to treatment with attenuated androgens (i.e. danazol, stanazol). C. If being used for prophylaxis due to surgical prodecure in a patient with confirmed HAE approve.
Age Restrictions	APPROVE: 9 years or older
Prescriber Restrictions	Prescribed by or in consultation with an appropriate specialist for the covered use (allergist, immunologist, hematologist)
Coverage Duration	Up to 6 months

Other Criteria	COVERAGE POLICY: CINRYZE is covered for members who meet the following criteria: A. Diagnosis of HAE has been confirmed through laboratory values of C4 and C1-INH. B. If being used as maintenance therapy member has had: a. At least one laryngeal attack in the past OR history of at least one severe event per month OR disabling symptoms for at least 5 days per month AND b. Has had inadequate response to, has been intolerant to, or has a contraindication to treatment with attenuated androgens (i.e. danazol, stanazol). C. If being used for prophylaxis due to surgical procedure in a patient with confirmed HAE approve. D. If the member has received previous Cinryze therapy, medical records documenting efficacy of medication: a. At least a 50% decrease in the frequency of HAE attacks. b. Significant improvement in severity and duration of attacks. c. Clinical documentation of functional improvement.
Prior Authorization Group	COMETRIQ
Drug Names	COMETRIQ
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Appropriate diagnosis of progressive, metastatic medullary thyroid cancer (MTC).
Age Restrictions	APPROVE: 18 years or older.
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, endocrinologist or other qualified provider.
Coverage Duration	Up to 12 months.
Other Criteria	COVERAGE POLICY: COMETRIQ is covered for members who meet the following criteria: A. Normal dosage is 140mg/day taken orally. B. Treatment should be continued until patients are no longer benefiting from treatment or unacceptable toxicity occurs. C. Applies to NEW STARTS only.
Prior Authorization Group	COPAXONE
Drug Names	COPAXONE
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE

Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documented diagnosis of definite or probable relapsing/remitting MS, secondary progressive MS with relapses, or progressive relapsing MS. May include a first MS attack with documented MRI scan abnormalities characteristic of MS, OR evaluation documenting EITHER: 1. history of at least two (2) focal neurological deficits (e.g. loss of vision, double vision, localized numbness or weakness), in which the first resolved and the second followed after a period of at least six (6) months, OR 2. history of one (1) focal neurological deficit which has resolved, and an MRI suggestive of MS.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or other qualified provider
Coverage Duration	Up to 24 months
Other Criteria	COVERAGE POLICY: COPAXONE is covered for members who meet the following criteria: A. Copaxone is approved for the diagnosis of Multiple sclerosis, Relapsing forms. B. For relapsing forms of multiple sclerosis: Patient must still either be able to walk at least a few steps or alternatively must have some functional arm/ hand use consistent with performing activities of daily living. C. Refills will be approved if covered uses, exclusion criteria, required medical information, prescriber restriction set and the patient is experiencing a documented response to therapy. D. Determine Part B versus Part D.E.Applies to NEW STARTS only.

Prior Authorization Group	CYKLOKAPRON
Drug Names	TRANEXAMIC ACID
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: Documentation confirming no exclusions.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 1 month
Other Criteria	COVERAGE POLICY: CYKLOKAPRON, TRANEXAMIC ACID is covered for members who meet the following criteria: A. Patient is diagnosed with an FDA approved indication. B. Determine Part B versus Part D.

Prior Authorization Group	CYSTAGON
Drug Names	CYSTAGON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Documented history of hypersensitivity to penicillamine.
Required Medical Information	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing.
Age Restrictions	
Prescriber Restrictions	

Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	DRONABINOL
Drug Names	DRONABINOL
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. The diagnosis is documented as anorexia associated with weight loss in a patient with AIDS. 1. AND, the patient has had an involuntary weight loss of greater than 10% of pre-illness baseline body weight or a body mass index (BMI) less than 20kg/m2 in the absence of a concurrent illness or medical condition other than HIV that may cause weight loss. 2. AND, the patient has failed to respond to a 30-day drug regimen of megestrol (Megace). 3. AND, if the patient has received previous dronabinol therapy, he/she must show a positive response to therapy by maintaining or increasing their initial weight and/or muscle mass before initiating dronabinol therapy. B. The diagnosis is documented as nausea and vomiting associated with cancer chemotherapy in a cancer patient. 1. AND, the patient is receiving a chemotherapy or radiation regimen. 2. AND, the patient has had a full trial and failure through at least one cycle of chemotherapy with IV ondansetron, and at least one of the following oral anti-emetic agents: metoclopramide, promethazine, prochlorperazine, meclizine, trimethobenzamide, oral 5-HT3 receptor antagonists. 3. If the patient has received previous dronabinol therapy, he/she must show a positive response by showing a reduced incidence of emesis and/or nausea.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or other qualified provider
Coverage Duration	Up to 6 months for N/V and up to 3 months for anorexia in HIV positive patients
Other Criteria	COVERAGE POLICY: DRONABINOL is covered for members who meet the following criteria: A. AIDS wasting or cachexia related to cancer: Dose does not exceed FDA label maximum for the diagnosis. B. Chemotherapy-induced nausea and vomiting (CINV): 1. Diagnosis is CINV greater than 48 hours after chemotherapy, AND 2. The number of capsules requested does not exceed the amount needed to treat CINV while patient continues to receive the chemotherapy regimen, AND 3. Dose does not exceed FDA label maximum for the diagnosis. C. Determine Part B versus Part D (if Dronabinol is used as a full replacement of IV antiemetic administration and the treatment is or will be within 48 hours of CA treatment, Medicare Part B will pay for the treatment.). D. Trial of ONE of the following formulary drugs prior to approval: ondansetron, granisetron, etc..

Prior Authorization Group	EMEND
Drug Names	EMEND
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Prevention of chemotherapy-induced nausea and vomiting (CINV): 1. Confirm diagnosis is delayed CINV. 2. Patient is receiving one or more anticancer chemotherapy agents considered moderately or highly emetogenic. 3. Emend is being used in combination with an 5-HT3 antagonist and dexamethasone (3-drug antiemetic regimen). 4. The dose does not exceed FDA label maximum for the diagnosis. B. Confirm prevention of postoperative nausea and vomiting (PONV): 1. Patient cannot use any one intravenous antiemetic prior to surgery because of history of treatment failure or intolerance. 2. Request is for 40mg orally within 3 hours of induction of anesthesia.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 3 days per chemotherapy cycle, up to 12 months-CINV, Up to One day per procedure-PONV
Other Criteria	COVERAGE POLICY: EMEND is covered for members who meet the following criteria: A. Is prescribed for: 1. Chemotherapy-induced nausea and vomiting due to highly to moderately emetogenic chemotherapy. 2. Postoperative nausea and vomiting. B. Determine Part B versus Part D.

Prior Authorization Group	ENBREL
Drug Names	ENBREL
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Negative TB test (must be done yearly). B. For diagnosis of ankylosing spondylitis, must have presence of active disease for at least 4 weeks, BASDAI score of at least 4. C. For diagnosis of moderate to severe plaque psoriasis, must have involvement of greater than 10% of body surface area (unless hands, feet, head, neck, or genitalia are involved).
Age Restrictions	APPROVE:Adults (18 years or older), Children (2 years or older) for polyarticular juvenile idiopathic arthritis.
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: ENBREL is covered for members who meet the following criteria: A. Rheumatoid arthritis, psoriatic arthritis, or juvenile rheumatoid arthritis: Must have failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance from standard doses of either methotrexate OR two (2) or more alternate DMARDs (azathioprine, sulfasalazine, hydroxychloroquine, leflunomide). B. Plaque psoriasis: Extensive disease and has failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance from at least one (1) systemic agent (e.g., acitretin, cyclosporine, methotrexate) OR phototherapy. C. Anklyosing spondylitis: failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance from maximally tolerated doses of two NSAIDS (e.g., naproxen, diclofenac, sulindac, celecoxib). D. Determine Part B versus Part D. E. Applies to NEW STARTS only.
Prior Authorization Group	EPLERENONE
Drug Names	EPLERENONE
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: EPLERENONE is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: hyperkalemia or renal failure. B. If the patient is taking/receiving any of the following: Itraconazole, Ketoconazole, Nefazodone, Nelfinavir, Potassium Salts, Potassium-sparing diuretics.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Diagnosis of hypertension or post-myocardial infarction with LVEF less than or equal to 40% and clinical evidence of CHF after an acute MI. B. A serum potassium level less than 5.5 mEq/L. C. For diagnosis of post MI with LVEF less than or equal to 40% and clinical evidence of CHF after an acute MI, the patient must meet the following requirement: creatinine clearance greater than 30 mL/min. D. For the diagnosis of hypertension, the patient must meet the following requirements: the patient does not have Type-2 diabetes with microalbuminuria AND the patient has a creatinine clearance greater than 50 mL/min AND the patient had an inadequate treatment response to maximum tolerated doses of a 60-day trial, or had unacceptable toxicity to, spironolactone therapy.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: EPLERENONE is covered for members who meet the following criteria: A.The diagnosis is hypertension or post-myocardial infarction. B. Tried/failed maximum tolerated doses of a 20-day trial or had unacceptable toxicity to spironolactone. C. Previous eplerenone therapy, must show a decrease in systolic and diastolic blood pressure since initiating therapy.
Prior Authorization Group	ERIVEDGE
Drug Names	ERIVEDGE
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: ERIVEDGE is NOT covered for members who meet the following criteria: A. Are Pregnant.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Supporting Documentation confirming treatment of adults with metastatic basal cell carcinoma, or with locally advanced basal cell carcinoma that has recurred following surgery or who are not candidates for surgery, and who are not candidates for radiation. B. Verify pregnancy status prior to the initiation of vismodegib. C. Confirm 150 mg taken orally once daily.
Age Restrictions	"APPROVE: 18 years or older "
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: ERIVEDGE is covered for members who meet the following criteria: A. Confirmed diagnosis of metastatic basal cell carcinoma, or with locally advanced basal cell carcinoma that has recurred following surgery or who are not candidates for surgery, and who are not candidates for radiation B. Prior authorization applies to new starts only.
Prior Authorization Group	EXJADE
Drug Names	EXJADE
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: EXJADE is NOT covered for members with the following criteria: A. If the patient is taking/receiving any of the following: Deferoxamine, Iron Dextran, Iron Salts, Iron Sucrose, Polysaccharide-Iron Complex or Sodium Ferric Gluconate Complex. B. Patient with severe renal insufficiency. C. Patient with Hepatitis.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm diagnosis of treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis). B. Documentation of feritin levels within the last 60 days of at least 1000 ng/mL. C. If New start, confirm patient should have documentation of auditory and ophthalmic testing prior to starting Exjade treatment.

Age Restrictions	APPROVE: 2 years or older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or other qualified provider
Coverage Duration	Up to 3 months
Other Criteria	COVERAGE POLICY: EXJADE is covered for members who meet the following criteria: A. Evidence of chronic iron overload (eg, transfusion of 100 mL/kg of packed RBCs [20 units for a 40 kg individual] and serum ferritin consistently greater than1000 mcg/L). C. For renewals:Confirm serum ferritin levels persistently less than 2500 mcg/L and decreasing over time.

Prior Authorization Group	EXTAVIA
Drug Names	EXTAVIA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documented diagnosis of definite or probable relapsing-remitting MS, secondary progressive MS with relapses, or progressive relapsing MS. May include a first MS attack with document MRI scan abnormalities characteristic of MS, OR evaluation documenting EITHER: history of at least two focal neurological deficits (e.g. loss of vision, double vision, localized numbness or weakness), in which the first resolved and the second followed after a period of at least 6 months, OR history of one focal neurological deficit which has resolved, and an MRI suggestive of MS.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or other qualified provider
Coverage Duration	Up to 24 months
Other Criteria	COVERAGE POLICY: EXTAVIA is covered for members who meet the following criteria: A. Refills will be approved if covered uses, exclusion criteria, required medical information, prescriber restriction set and the patient is experiencing a documented response to therapy. B. Cover under Medicare Part B if the patients meets the above criteria and the medication is being procured by and administered in the doctor's office or ambulatory setting and the physician has certified that the patient is unable to self-administer or the medication is not indicated for self-administration.

Prior Authorization Group	FORTEO
Drug Names	FORTEO
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE

Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation 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. B. 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 Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider
Coverage Duration	Up to 12 months, not to exceed 24 months of life-time therapy.
Other Criteria	COVERAGE POLICY: FORTEO is covered for members who meet the following criteria: A. High risk for fracture and has a T score less than or equal to -2.0 as evidenced via bone density scan OR has had one or more osteoporotic fractures. B. 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). C. For non-new start approve, not to exceed 24 months. D. Determine Part B versus Part D.
Prior Authorization Group	GILENYA
Drug Names	GILENYA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: GILENYA is NOT covered for members with the following criteria: A. Concurrent use of Avonex, Rebif, Betaseron, Extavia, Copaxone or Tysabri. B. Treatment of primary progressive MS is not covered.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of Multiple sclerosis, Relapsing forms. B. Confirm varicella zoster virus has been administered at least one month prior to start of drug or confirm history of chickenpox. C. Before initiating fingolimod or if fingolimod was discontinued for more than 2 weeks and will be restarted, confirm an electrocardiogram (ECG) in patients without a recent ECG (for example, within 6 months) was obtained.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or other qualified provider
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: GILENYA is covered for members who meet the following criteria: A. Gilenya is approved for the diagnosis of Multiple sclerosis, Relapsing forms. B. Tried, failed or intolerant to at least one conventional treatments (Rebif, Betaseron, Avonex, Extavia). C. REMS protocol must be followed. D. For relapsing forms of multiple sclerosis: Patient must still either be able to walk at least a few steps or alternatively must have some functional arm/ hand use consistent with performing activities of daily living.

Prior Authorization Group	GILOTRIF
Drug Names	GILOTRIF
Covered Uses	Patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R). substitution mutations
Exclusion Criteria	None.
Required Medical Information	The following copies of chart notes/laboratory reports are required: FDA-approved test detecting EGFR mutations in NSCLC.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or other qualified provider.
Coverage Duration	Up to 12 months.
Other Criteria	COVERAGE POLICY: Gilotrif is covered for members who meet the following criteria: diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations B. detected by an FDA-approved test.

Prior Authorization Group	GONADOTROPIN
Drug Names	CHORIONIC GONADOTROPIN
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: GONADOTROPIN is covered for members who meet either of the following criteria: A. In a Male patient: 1. If the patient has a diagnosis of prepubertal cryptochidism not due to anatomic obstruction or hypogonadism secondary to a pituitary deficiency. 2. AND If the patient does not have any signs of the following diagnoses: a. Precocious puberty, or b. Prostatic carcinoma or other androgen dependent neoplasm. 3. AND is not being used in the treatment of obesity. B. Determine Part B versus Part D.

Prior Authorization Group	GRANISETRON
Drug Names	GRANISETRON HCL
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation showing patient is experiencing Chemotherapy-induced, Postoperative or Radiation-induced nausea and vomiting.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 6 months
Other Criteria	COVERAGE POLICY: GRANISTRON is covered for members who meet the following criteria: A. Verification of B vs D criteria as per CMS regulations. B. Chemotherapy-induced nausea and vomiting (CINV): 1. The number of tablets requested does not exceed the amount needed to treat CINV, AND 2. The dose does not exceed the FDA label maximum for the diagnosis, AND 3. One of the following: a. Patient had already been started on granisetron, OR b. Patient has a contraindication, treatment failure or intolerance to ondansetron. B. Prevention of nausea and vomiting associated with radiation therapy, or the treatment or prevention of post-operative nausea and vomiting (PONV): 1. The dose does not exceed the FDA label maximum for the diagnosis, AND 2. One of the following: a. Patient had already been started on granisetron, OR b. Patient has a contraindication, treatment failure or intolerance to ondansetron.

Prior Authorization Group	HEPSERA
Drug Names	HEPSERA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of positive HBsAg OR liver biopsy showing chronic hepatitis. B. Documentation of Hepatitis B viral load greater than 100000 copies/mL. C. Documentation of elevated liver enzymes showing AST greater than 69 units/L AND ALT greater than 71 units/L.
Age Restrictions	APPROVE: 12 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, Infectious Disease physician or other qualified provider
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: HEPSERA is covered for members who meet the following criteria: A. Diagnosed with chronic hepatitis B. B. Has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis.(Pt has a HBsAg serological marker for greater than 6 months or a positive liver biopsy by reviewing the patients drug history or chart). C. Has a Hepatitis B viral load greater than 100,000 copies per ml. D. Has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal. E. Has been tested for HIV. (Hepsera therapy can cause HIV resistance in untreated HIV infection). F. Previous Hepsera TX, there is documented clinical improvement shown by a drop in viral load or reduction in the patients liver aminotransferases. G. Not receiving duplicate therapy that includes Baraclude, Tyzeka, Epivir, Intron A and/or Infergen. H. Evidence of diagnosis, serological markers, liver biopsy, viral load, and liver aminotransferases is documented in patients chart.

Prior Authorization Group	HIGH RISK MEDICATION
Drug Names	TRANSDERM-SCOP
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	HIGH RISK MEDICATIONS - AMPHETAMINES
Drug Names	AMPHETAMINE/DEXTROAMPHETA, DEXMETHYLPHENIDATE HCL, DEXTROAMPHETAMINE SULFATE, METHYLPHENIDATE HCL, METHYLPHENIDATE HCL ER
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. FDA approved Diagnosis.
Age Restrictions	APPROVE:Patients aged less than 65 years. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: Selected AMPHETAMINES are covered for members who meet the following criteria: A. Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

Prior Authorization Group	HIGH RISK MEDICATIONS - ANTIHISTAMINES
Drug Names	CLEMASTINE FUMARATE, CYPROHEPTADINE HCL, DIPHENHYDRAMINE HCL, HYDROXYZINE HCL, HYDROXYZINE PAMOATE, PROMETHAZINE HCL
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. FDA approved Diagnosis.
Age Restrictions	APPROVE:Patients aged less than 65 years. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: Selected ANTIHISTAMINES are covered for members who meet the following criteria: A. Approve if the patient has tried a prescription oral second generation antihistamine product (cetirizine, fexofenadine, desloratadine, levocetirizine, fexofenadine/pseudoephedrine, or desloratadine/pseudoephedrine) for the current condition. B. Approve promethazine hydrochloride tablets or syrup if the patient has tried a prescription oral anti-emetic agent (ondansetron, granisetron, dolasetron, palonosetron, aprepitant) for the current condition. C. Approve diphenhydramine (capsules or elixir) if the patient has tried at least two other FDA-approved products for the management of insomnia. D. Approve hydroxyzine hydrochloride (tablets and syrup) or hydroxyzine pamoate (capsules) if the patient has tried at least two other FDA-approved products for the management of anxiety. E. Approve for age 64 years of age and younger. F. For all, prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

Prior Authorization Group	HIGH RISK MEDICATIONS - ANTIPSYCHOTICS,TYPICAL
Drug Names	THIORIDAZINE HCL
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. FDA approved Diagnosis.
Age Restrictions	APPROVE:Patients aged less than 65 years. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: Selected ANTIPSYCHOTICS,TYPICAL are covered for members who meet the following criteria: A. Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

Prior Authorization Group	HIGH RISK MEDICATIONS - ESTROGENS
Drug Names	ESTROPIPATE, FEMHRT LOW DOSE, JINTELI, PREMARIN, PREMPHASE, PREMPRO
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. FDA approved Diagnosis.
Age Restrictions	APPROVE:Patients aged less than 65 years. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: Selected ESTROGENS are covered for members who meet the following criteria: A. If the patient has tried one other therapy (i.e. estradiol) for the current condition. B. Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

Prior Authorization Group	HIGH RISK MEDICATIONS - OTHERS
Drug Names	CHLORPROPAMIDE, DIPYRIDAMOLE, MEPERITAB
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. FDA approved Diagnosis.
Age Restrictions	APPROVE:Patients aged less than 65 years. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	NONE
Coverage Duration	Up to 3 months
Other Criteria	COVERAGE POLICY: Selected URINARY ANTI-INFECTIVES are covered for members who meet the following criteria: A. Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

Prior Authorization Group	HIGH RISK MEDICATIONS - SKELETAL MUSCLE RELAXANTS
Drug Names	CARISOPRODOL, CHLORZOXAZONE, CYCLOBENZAPRINE HCL, METHOCARBAMOL, ORPHENADRINE CITRATE ER, ORPHENADRINE/ASA/CAFFEINE
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. FDA approved Diagnosis.

Age Restrictions	APPROVE:Patients aged less than 65 years. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	NONE
Coverage Duration	Up to 3 months
Other Criteria	COVERAGE POLICY: Selected SKELETAL MUSCLE RELAXANTS are covered for members who meet the following criteria: A. Approve if the patient has tried two other therapies for the current condition. B. Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

Prior Authorization Group	HIGH RISK MEDICATIONS - URINARY ANTI-INFECTIVES
Drug Names	MACRODANTIN, NITROFURANTOIN, NITROFURANTOIN MACROCRYST
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. FDA approved Diagnosis.
Age Restrictions	APPROVE:Patients aged less than 65 years. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	NONE
Coverage Duration	Up to 14 days
Other Criteria	COVERAGE POLICY: Selected URINARY ANTI-INFECTIVES are covered for members who meet the following criteria: A. Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.

Prior Authorization Group	HUMIRA
Drug Names	HUMIRA, HUMIRA PEN-CROHNS DISEASE
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Negative TB test (must be done yearly). B. For diagnosis of Ankylosing Spondylitis, must have presence of active disease for at least 4 weeks, BASDAI score of at least 4. C. For diagnosis of moderate to severe plaque psoriasis, must have involvement of greater than 10% of body surface area (unless hands, feet, head, neck, or genitalia are involved). D. For Crohn's disease, documentation must include response to or an intolerance to conventional therapy.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist, dermatologist, gastroenterologist or other qualified provider
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: HUMIRA is covered for members who meet the following criteria: A. Rheumatoid arthritis, psoriatic arthritis, or juvenile rheumatoid arthritis: must have failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance from standard doses of either methotrexate OR two (2) or more alternate DMARDs (azathioprine, sulfasalazine, hydroxychloroquine, leflunomide). B. Plaque psoriasis: Has extensive disease, defined as BSA > 10 or PASI > 10, and has failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance from at least one systemic agent (acitretin, cyclosporine, methotrexate) OR phototherapy. C. Anklyosing spondylitis: failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance from maximally tolerated doses of two NSAIDS (e.g., naproxen, diclofenac, sulindac, celecoxib). D. Crohn's disease - intolerance to two different drug classes (e.g. corticosteroids and immunomodulators such as AZA or 6-MP). Clinical signs and symptoms such as frequent liquid stools greater than 4 times/day, presence of abdominal pain, need for opiates or diphenoxylate/atropine for diarrhea, anemia, and weight loss greater than 10%. E. Determine Part B versus Part D. F. Applies to NEW STARTS only.
Prior Authorization Group	ICLUSIG
Drug Names	ICLUSIG
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documented diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL). B. Documented resistance or intolerance to prior tyrosine kinase inhibitor therapy.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, endocrinologist or other qualified provider
Coverage Duration	Up to 12 months.
Other Criteria	COVERAGE POLICY: ICLUSIG is covered for members who meet the following criteria: A. A. Documented diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL). B. Documented resistance or intolerance to prior tyrosine kinase inhibitor therapy. C. Applies to New Starts only.
Prior Authorization Group	IMMUNE GLOBULIN
Drug Names	CARIMUNE NANOFILTERED, GAMMAGARD LIQUID, GAMUNEX-C
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria	NON COVERAGE: IMMUNE GLOBULIN is NOT covered for members who meet the following criteria: A. Patients hypersensitive to immune globulin or any component of the formulation. B.Patient has selective IgA deficiency. C.Patient has hyperprolinemia (Hizentra, Privigen). D.Patient has severe thrombocytopenia or coagulation disorders.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Chronic inflammatory demyelinating polyneuropathy (CIDP): Initial Authorization: 1. Diagnosis confirmed by electrodiagnostic criterion and meets two of the following criteria: a. Motor or sensory dysfunction of greater than one limb loping over 2 months. b. Arflexia. c. Nerve biopsy showing unequivocal evidence of demyelination and remyelination. d. CSF cell count less then 10/mm3 (if HIV positive then CSF count less than 50/mm-3). B. Idiopathic Thrombocytopenic Purpura (ITP): Initial Authorization: 1. Platelet count is less than 50 x 109/L , AND 2. Total dose does not exceed 2000mg/kg given over 2-5 days. Determine Part B versus Part D.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with a neurologist for CIDP.
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: IMMUNE GLOBULIN is covered for members who meet the following criteria: A. Chronic inflammatory demyelinating polyneuropathy (CIDP): Initial Authorization: 1. Diagnosis confirmed by electrodiagnostic criterion and meets two of the following criteria: a. Motor or sensory dysfunction of greater than one limb loping over 2 months. b. Arflexia. c. Nerve biopsy showing unequivocal evidence of demyelination and remyelination. d. CSF cell count less then 10/mm3 (if HIV positive then CSF count less than 50/mm-3). B. Idiopathic Thrombocytopenic Purpura (ITP): Initial Authorization: 1. Platelet count is less than 50 x 109/L , AND 2. Total dose does not exceed 2000mg/kg given over 2-5 days. C. Determine Part B versus Part D.
Prior Authorization Group	INCIVEK
Drug Names	INCIVEK
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: INCIVEK is NOT covered for members with the following criteria: A. Decompensating liver disease or with moderate or severe hepatic impairment (Child-Pugh B or C, score of 7 or higher). B. Women who are or may become pregnant men whose female partners are pregnant. C. Coadministration with alfuzosin, rifampin, ergot derivatives (eg, dihydroergotamine, ergonovine, ergotamine, methylergonovine), cisapride, St. John's wort, HMG-CoA reductase inhibitors (eg, atorvastatin, lovastatin, simvastatin), pimozide, sildenafil (Revatio) or tadalafil (Adcirca) when used for the treatment of pulmonary hypertension, midazolam oral, and triazolam.

Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation indicating the treatment of Genotype 1 chronic hepatitis C in combination with peginterferon alfa and ribavirin in adult patients with compensated liver disease, including cirrhosis, who are treatment-naive or who have previously been treated with interferon-based treatment, including prior null responders, partial responders, and relapsers. B. Documentation showing baseline HCV RNA levels that are dated within the last 90 days. C. Discontinue treatment if Week 4 or 12: HCV-RNA 1,000 units/mL. D. Discontinue Treatment if Week 24: HCV-RNA detectable.
Age Restrictions	APPROVE:18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an infection disease physician, gastroenterologist, or other qualified provider
Coverage Duration	Up to 4 months initially, then up to 24-48 weeks.
Other Criteria	COVERAGE POLICY: INCIVEK is covered for members who meet the following criteria: A. Must also administer peginterferon alfa and ribavirin with Incivek. B. Chronic Hepatitis C Virus (HCV) with Genotype 1. C. Initial authorization will be given for 12 weeks. At 12 weeks, an early viral response (EVR) must be shown with greater than 2 log reduction in viral load, therapy may be continued up to a total of 24-48 weeks treatment. For patients who fail to achieve a 2 log reduction, treatment should be discontinued. D. Retreatment allowed in those who did not receive optimal HCV treatment. E. Patient must be treatment naïve to Incivek. F. Incivek must not be used as monotherapy, and must be initiated at the start of peginterferon and ribavirin therapy.
Prior Authorization Group	INCRELEX
Drug Names	INCRELEX
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: INCRELEX is not covered for members who meet the following criteria: A. If the patient has any of the following contraindications: benzyl alcohol hypersensitivity, epiphyseal closure, intravenous administration, neonates or neoplastic disease.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation showing patients epiphyses are NOT closed. B. Documentation showing patient has NO active malignancy. C. Documentation of IGF-1 standard deviation score of less than -2.9 based on lab reference for age and sex. D. If requesting retreatment: 1. Documentation of an increase in height velocity greater than 2.5 cm total growth in one year. 2. Documentation patient has NOT met final expected adult height based on mid-parental height calculation
Age Restrictions	APPROVE: 2 and 20 years old
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider

Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: INCRELEX is covered for members who meet the following criteria: A. Patient is not being treated with chronic anti-inflammatory steroids. B. Diagnosis is documented as the TX of growth failure in a child with severe primary IGF-1 deficiency or with GH gene deletion who have developed neutralizing antibodies to growth hormone. C. Basal IGF-1 standard deviation score Less than or equal to -3 based on lab reference for age and sex. AND D. the patient has a normal or elevated GH level that has been confirmed with at least one GH stimulation test. E. Has severe growth retardation with a height standard deviation (SDS) score more than 3 SDS below the mean for chronological age and sex and their target height based on mid-parental height calculation. F. All indications of secondary IGF-1 have been ruled out such as GH hormone deficiency, hypothyroidism and malnutrition. G. Is not taking or has no plans to receive GH therapy in combination with Increlex therapy. H. If the patient has received previous mescasermin therapy, must meet all of the following criteria: 1. Increase in height velocity greater than 2.5 cm total growth in one year of therapy. 2. No evidence of epiphyseal closure. 3. Has NOT met their expected final adult height or targeted height based on mid-parental height calculation or their current absolute height is Less than or equal to 25th percentile (defined as 68 inches in males and 63 inches in females.
Prior Authorization Group	INLYTA
Drug Names	INLYTA
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: INLYTA is NOT covered for members who meet the following criteria:A. Concomitant use of strong cytochrome P450 inhibitors (eg, atazanavir, clarithromycin, indinavir, itraconazole, ketoconazole, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin, voriconazole). B.Concomitant use of strong CYP3A4/5 inducers (eg, carbamazepine, dexamethasone, phenobarbital, phenytoin, rifabutin, rifampin, rifapentine, St. John's wort).
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation confirming the treatment of advanced renal cell carcinoma. 2. Confirm failure of 1 prior systemic therapy like sunitinib, bevacizumab with interferon alpha, temsirolimus, or cytokines (interferon alpha or interleukin-2).
Age Restrictions	"APPROVE: 18 years or older "
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist or other qualified provider
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: INLYTA is covered for members who meet the following criteria: A.Advanced renal cell carcinoma: For the treatment of advanced renal cell carcinoma after failure of 1 prior systemic therapy.B. Prior authorization applies to new starts only.
Prior Authorization Group	ITRACONAZOLE
Drug Names	ITRACONAZOLE
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: ITRACONAZOLE is NOT covered for members with the following criteria: A. pregnant women or women contemplating pregnancy do not use for the treatment of onychomycosis (capsules). B. Ventricular dysfunction (eg, congestive heart failure (CHF) or history of CHF) except for life-threatening or serious infections (oral solution) do not use for the treatment of onychomycosis (capsules).
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation that patient is not pregnant (if female). B. Confirm dose does not exceed the FDA label maximum for the diagnosis. C. One of the following conditions must be documented: 1. Diagnosis of systemic fungal infection with Blastomycosis, Histoplasmosis, Sporotrichosis, Aspergillosis, OR 2. Diagnosis is prophylaxis of Aspergillosis in an immunosuppressed or immunocompromised patient, OR 3. Diagnosis of tinea fungal infection and treatment failure, intolerance or contraindication with one formulary alternative (Tinea Capitas: oral terbinafine, Tinea Corporus, Curis, Pedis or Manuum: topical antifungal, oral terbinafine or oral Diflucan, Tinea Versicolor: topical ketoconazole or oral Diflucan, Onychomycosis: Has a positive KOH test and oral terbinafine), OR 4. Diagnosis of ABPA and itraconazole is being used to taper oral corticosteroids, OR 5. Diagnosis is prophylaxis of candidiasis, cryptococcosis, or coccidioidomycosis in an immunosuppressed or immunocompromised patient with treatment failure, intolerance or contraindication to fluconazole.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 4 months

Other Criteria	COVERAGE POLICY: ITRACONAZOLE is covered for members who meet the following criteria: A. Diagnosis of systemic fungal infection with Blastomycosis, Histoplasmosis, Sporotrichosis, Aspergillosis,prophylaxis of Aspergillosis in an immunosuppressed or immunocompromised patient, tinea fungal infection and treatment failure, intolerance or contraindication with one formulary alternative (Tinea Capitas: oral terbinafine, Tinea Corporus, Curis, Pedis or Manuum: topical antifungal, oral terbinafine or oral Diflucan, Tinea Versicolor: topical ketoconazole or oral Diflucan, Onychomycosis: oral terbinafine), prophylaxis of candidiasis, cryptococcosis, or coccidioidomycosis in an immunosuppressed or immunocompromised patient with treatment failure, intolerance or contraindication to fluconazole. B. Reauthorization for tinea unguium (onychomycosis) fungal infection: Dose does not exceed the FDA label maximum for the diagnosis.
Prior Authorization Group	KADCYLA
Drug Names	KADCYLA
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documented diagnosis Metastatic breast cancer, HER2 overexpression. B. Documented trial of at least one prior traztuzumab and/or taxane therapy.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, endocrinologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: Kadcyla is covered for members who meet the following criteria: A. Documented diagnosis Metastatic breast cancer, HER2 overexpression. B. Documented trial of at least one prior traztuzumab and/or taxane therapy. C. Applies to NEW STARTS only.
Prior Authorization Group	KETEK
Drug Names	KETEK
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria	NON COVERAGE: KETEK is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: macrolide hypersensitivity, history of macrolide induced hepatitis/jaundice, myasthenia gravis, QT prolongation, torsade de pointes. B. If the patient is taking/receiving any of the following: Antiarrhythmic agents (eg, amiodarone, bretylium, disopyramide, dofetilide, procainamide, quinidine, and sotalol), arsenic trioxide, chlorpromazine, cisapride, dolasetron, droperidol, mefloquine, mesoridazine, moxifloxacin, pentamidine, pimozide, tacrolimus, thioridazine, and ziprasidone.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis. B. Documentation of previous trial/failure on azithromycin or a fluoroquinolone.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 10 days
Other Criteria	COVERAGE POLICY: KETEK is covered for members who meet the following criteria: A. The patient is diagnosed with community-acquired pneumonia. B. and the patient has had previous failure of one of the following therapies 1. azithromycin or 2. fluoroquinolone.
Prior Authorization Group	KINERET
Drug Names	KINERET
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis. B. For rheumatoid arthritis , prior treatment with at least one DMARD (azathiaprine, cyclosporine, hydroxychloroquine, leflunomide, or methotrexate).
Age Restrictions	APPROVE: RA and Still's disease, 18 years or older
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: KINERET is covered for members who meet the following criteria: A. RA. Approve if the patient has tried at least one DMARD (azathiaprine, cyclosporine, hydroxychloroquine, leflunomide, or methotrexate). B. Determine Part B versus Part D.
Prior Authorization Group	KORLYM
Drug Names	KORLYM
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	KORLYM is NOT covered for members who meet the following criteria: A. Pregnant. B. Taking simvastatin, lovastatin, and cytochrome P450 isoenzyme.

Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm Diagnosis with office visit notes.B. Confirmation of failed surgery or are not candidates for surgery.
Age Restrictions	None.
Prescriber Restrictions	None.
Coverage Duration	Up to 12 months.
Other Criteria	COVERAGE POLICY: KORLYM is covered for members who meet the following criteria: A. Taking to control hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance. AND B.Have failed surgery or are not candidates for surgery
Prior Authorization Group	KUVAN
Drug Names	KUVAN
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: KUVAN is NOT covered for members with the following criteria: A. Dosing that exceeds 20 mg/kg/day.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis. B. For initial therapy the recommended starting dose of sapropterin is 10 mg/kg once daily and blood phenylalanine levels should be checked after one week of therapy and periodically for one month (greater than 10mg/dl). C. If blood phenylalanine levels do not decrease after one month, the dose should be increased to 20 mg/kg daily. D. If blood phenylalanine levels do not decrease after one month of therapy with 20 mg/kg daily, sapropterin should be discontinued. E. Reauthorization: confirm 20 percent reduction from initial baseline. F. Documentation of phenylalanine (Phe) restricted diet. G. The most commonly reported blood phenylalanine (Phe) recommendations is to 6 mg/dL for patients less than 12 years and 2 to 10 mg/dL for those greater than 12 years of age. The Recommended Maintenance Phenylalanine Levels for Classical PKU According to the National Institutes of Health (NIH) Consensus Statement. Neonates through 12 years of age: 120-360 ¼mol/L (2-6 mg/dL), Greater than 12 years of age: 120-900 ¼mol/L (2-15 mg/dL) and During pregnancy: 120-360 ¼mol/L (2-6 mg/dL).
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Initial authorization: 1 month, then may approve up to 12 months
Other Criteria	COVERAGE POLICY: KUVAN is covered for members who meet the following criteria: A. To reduce blood phenylalanine (Phe) levels in patients with hyperphenylalaninemia caused by tetrahydrobiopterin (BH4)-responsive phenylketonuria.
Prior Authorization Group	LETAIRIS/TRACLEER
Drug Names	LETAIRIS, TRACLEER

Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. For the FDA-approved indication of pulmonary arterial hypertension. B. Patients not currently on Letairis or Tracleer are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. C. For the FDA-approved indication of pulmonary arterial hypertension, patients currently on Letairis or Tracleer may continue therapy if they have a diagnosis of PAH.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, pulmonologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: LETAIRIS/TRACLEER are covered for members who meet the following criteria: A. Diagnosis is is supported by the FDA.
Prior Authorization Group	LEUKINE
Drug Names	LEUKINE
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: LEUKINE is NOT covered for members with the following criteria: A. Concomitant use with chemotherapy or radiotherapy or use within 24 hours. B. Excess leukemic myeloid blasts in the bone marrow or blood (10% or greater). C. Hypersensitivity to granulocyte-macrophage colony-stimulating factor, yeast-derived products, or any component of the product.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm use following induction or consolidation chemotherapy in AML: there are less than 10% leukemic myeloid blasts in bone marrow or peripheral blood. B. Confirm for patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Leukine may be used for the prevention of chemotherapy-induced neutropenia if the regimen has a 20% or more risk of neutropenia OR the patient experienced febrile neutropenia with a previous chemotherapy cycle. C. Confirm patients without severe risk for neutropenia may also receive Leukine for prophylaxis if there is a risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy to prolong survival or cure the disease. D. Leukine is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Leukine (or Neupogen) OR in patients at risk for infection-related complications. E. Leukine is allowable for patients with neutropenia due to myelodysplastic syndrome if they have a history or recurrent or resistant infections. F. Confirm all patients must receive baseline and regular monitoring of complete blood counts and platelet counts.

Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist, hematologist, infectious disease or other qualified provider
Coverage Duration	Up to 6 months
Other Criteria	COVERAGE POLICY: LEUKINE is covered for members who meet the following criteria: A. Refills will be approved if all criteria are met. B. Use Following Induction Chemotherapy in Acute Myelogenous Leukemia. C. Use in Mobilization and Following Transplantation of Autologous Peripheral Blood Progentior Cells. D. Use in Myeloid Reconstitution after Autologous Bone Marrow Transplantation. E. Use in Myeloid Reconstitution after Allogeneic Bone Marrow Transplantation. F. Failure or clinically significant adverse effects to Neupogen is required for approval. G. Determine Part B versus Part D.

Prior Authorization Group	LIDODERM
Drug Names	LIDODERM
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: LIDODERM is NOT covered for members who meet the following criteria: A. If the patient has a known history of sensitivity to local anesthetics (amide type).
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of trial and failure of the following: gabapentin or capsaicin. B. Documentation of diagnosis.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: LIDODERM is covered for members who meet the following criteria: A. Diagnosis is documented as postherpetic neuralgia. B. Patient has completed a documented trial and failure of the either medications: gabapentin or capsaicin.

Prior Authorization Group	LOTRONEX
Drug Names	LOTRONEX
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: LOTRONEX is NOT covered for members who meet the following criteria: A. If the patient is a Male. B. Concurrently has ischemic colitis, Crohn's disease or ulcerative colitis, diverticulitis. C. If patient is constipated. D. Concurrent use of fluvoxamine.

Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of IBS symptoms generally lasting 6 months or longer. B. Documentation of the failure to at least one antispasmodic agent or one antidiarrheal agent. C. Confirmation of the prescriber be specially certified in the Prescribing Program for Lotronex (PPL).
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	NONE
Coverage Duration	Initial authorization: 1 month, then may approve up to 12 months
Other Criteria	COVERAGE POLICY: LOTRONEX is covered for members who meet the following criteria for Initial authorization: A. Patient is female. B. Failed at least one antispasmodic agent or one antidiarrheal agent. Reauthorization: A. Patient's IBS symptoms are adequately being controlled by Lotronex and patient currently does not have constipation nor had any while taking Lotronex. B. Dose does not exceed FDA label maximum for the diagnosis.

Prior Authorization Group	LUMIZYME
Drug Names	LUMIZYME
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation that the diagnosis of Pompe Disease has been confirmed by an enzymatic assay showing a deficiency in acid alpha glucosidase. B. Determine who is administering this medication and if the prescriber is registered under the Lumizyme ACE Program.
Age Restrictions	APPROVE: 8 years or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: LUMIZYME is covered for members who meet the following criteria: A. Treatment of late-onset Pompe disease with no evidence of cardiac hypertrophy. B. Determine Part B versus Part D.

Prior Authorization Group	MEKINIST
Drug Names	MEKINIST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients who have received prior BRAF-inhibitor therapy (e.g., Zelboraf, Tafinlar)
Required Medical Information	Patient has a diagnosis of unresectable or metastatic melanoma AND the tumor is positive for either BRAF V600E or V600K mutation.
Age Restrictions	None.
Prescriber Restrictions	None.
Coverage Duration	Plan Year.
Other Criteria	

Prior Authorization Group	MEPRON

Drug Names	MEPRON
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: MEPRON is NOT covered for members with the following criteria: A. Concurrent pulmonary conditions such as bacterial, viral, or fungal pneumonia or mycobacterial diseases. B. Coadministration of rifampin.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of a trial and failure of trimethoprim-sulfamethoxazole (TMP-SMZ) unless TMP-SMZ is otherwise contraindicated.
Age Restrictions	APPROVE: 13 years or older
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: MEPRON is covered for members who meet the following criteria: A. For the prevention of Pneumocystis carinii pneumonia (PCP) in patients who are intolerant to trimethoprim-sulfamethoxazole (TMP-SMZ). B. For the acute oral treatment of mild-to-moderate PCP in patients who are intolerant to TMP-SMZ.

Prior Authorization Group	MYOZYME
Drug Names	MYOZYME
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Diagnosis confirmed by an enzymatic assay showing a deficiency in acid alpha glucosidase or DNA testing. B. LFTs. C. IgG antibiodies every 3 months
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: MYOZYME is covered for members who meet the following criteria: A. Determine Part B versus Part D.

Prior Authorization Group	NAGLAZYME
Drug Names	NAGLAZYME
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis. B. If the patient has previously received Naglazyme therapy, documentation that they have shown an improvement in walking and/or stair-climbing capacity since initiating therapy.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider

Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: NAGLAZYME is covered for members who meet the following criteria: A. Diagnosis is documented as Maroteaux-Lamy syndrome. B. And if the patient has previously received Naglazyme therapy, they must show an improvement in walking and/or stair-climbing capacity since initiating therapy. C. Confirm Part B versus Part D.
Prior Authorization Group	NEULASTA
Drug Names	NEULASTA
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: NEULASTA is NOT covered for members with the following criteria: A. Hypersensitivity to pegfilgrastim or filgrastim.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation from medical record of diagnosis and complete blood count (CBC) prior to initiation of therapy.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or other qualified provider
Coverage Duration	Up to 6 months
Other Criteria	COVERAGE POLICY: NEULASTA is covered for members who meet the following criteria: A.Determine Part B versus Part D.
Prior Authorization Group	NEUMEGA
Drug Names	NEUMEGA
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: NEUMEGA is NOT covered for members with the following criteria: A. Hypersensitivity to oprelvekin. B. Indication of myeloablative chemotherapy.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation from the medical record of diagnosis and lab data reflecting platelet count.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 6 months
Other Criteria	COVERAGE POLICY: NEUMEGA is covered for members who meet the following criteria: A. Neumega is considered medically necessary for patients that have experienced severe thrombocytopenia (platelet count less than or equal to 20,000 mcg/L) from previous chemotherapy or patients considered to be at high risk for the development of severe thrombocytopenia. B. Determine Part B versus Part D.
Prior Authorization Group	NEUPOGEN
Drug Names	NEUPOGEN

Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: NEUPOGEN is NOT covered for members with the following criteria: A. Hypersensitivity to E. coli-derived proteins, filgrastim, or any component of the product.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation from medical record of diagnosis and complete blood count (CBC) prior to initiation of therapy.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 6 months
Other Criteria	COVERAGE POLICY: NEUPOGEN is covered for members who meet the following criteria: A. Myelosuppressive chemotherapy: Decrease the incidence of infection, as manifested by febrile neutropenia, with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs assoc with a significant incidence of severe neutropenia with fever. B. Acute myeloid leukemia (AML): To reduce the time to neutrophil recovery and the duration of fever following induction or consolidation chemotherapy treatment of adults with AML.C.Bone marrow transplant (BMT): To reduce the duration of neutropenia and neutropenia-related clinical sequelae (e.g., febrile neutropenia) in patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by BMT.D.Peripheral Blood Progenitor Cell (PBPC) Collection: For the mobilization of hematopoietic progenitor cells into the peripheral blood for leukapheresis collection. Mobilization allows for collection of increased progenitor cell numbers capable of engraftment compared with collection by leukapheresis without mobilization or bone marrow harvest. After myeloablative chemotherapy, the transplantation of an increased number of progenitor cells can lead to more rapid engraftment, decreasing the need for supportive care. E. Severe chronic neutropenia (SCN): Chronic administration to reduce the incidence and duration of sequelae of neutropenia in symptomatic patients with congenital, cyclic or idiopathic neutropenia. F. Determine Part B versus Part D.

Prior Authorization Group	NICOTROL
Drug Names	NICOTROL NS
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: NICOTROL is NOT covered for members who meet the following criteria: A. Hypersensitivity to nicotine or any other product component.

Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation indicating the patient must be enrolled in a behavioral support/ modification program (e.g., community program, manufacturer sponsored program, counseling by the physician, internet, or telephone quitline).
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 6 months
Other Criteria	COVERAGE POLICY: NICOTROL is covered for members who meet the following criteria: A. The patient is diagnosed with nicotine addiction or withdrawal following cessation of smoking. B. Enrolled in a behavioral support/ modification program (e.g., community program, manufacturer sponsored program, counseling by the physician, internet, or telephone quitline). C. For continued therapy, documentation that member has had positive results during the last treatment cycle.

Prior Authorization Group	ORENCIA
Drug Names	ORENCIA
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis. B. Documentation of past therapies and outcomes. C. For RA and JIA: Require a failure of methotrexate (or other tolerated DMARD should methotrexate be contraindicated) AND either Humira or Enbrel (unless both Humira and Enbrel are otherwise contraindicated).
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: ORENCIA is covered for members who meet the following criteria: A. For RA and JIA: Require a failure of methotrexate (or other tolerated DMARD should methotrexate be contraindicated) AND either Humira or Enbrel (unless both Humira and Enbrel are otherwise contraindicated). B. Determine Part B versus Part D.

Prior Authorization Group	OXSORALEN
Drug Names	OXSORALEN, OXSORALEN ULTRA
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: OXSORALEN is NOT covered for members who meet the following criteria: A. Idiosyncratic reactions to psoralen compounds. B. Aphakia. C. Invasive squamous cell carcinomas, melanoma, or a history of melanoma.

Required Medical Information	The following copies of chart notes/laboratory reports are required: A. If diagnosis is psoriasis, the patient must have previous trial and failure or contraindication to at least one topical steroid.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist, oncologist, or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: OXSORALEN is covered for members who meet the following criteria: A. The patient must be diagnosed with T-cell lymphoma, psoriasis, or vitiligo. B. If diagnosis is psoriasis, the patient must have previous trial and failure or contraindication to at least one topical steroid.
Prior Authorization Group	PEG-INTRON
Drug Names	PEG-INTRON, PEG-INTRON REDIPEN
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: PEG-INTRON is NOT covered for members with the following criteria: A. Anaphylaxis, history to peginterferon alfa-2b or interferon alfa-2b. B. Hemoglobinopathies (eg, thalassemia major and sickle-cell anemia [in combination with ribavirin]). C. Hepatic decompensation (Child-Pugh score greater than 6 [class B or C]). D. Hepatic decompensation (Child-Pugh score greater than 6 [class B or C] in patients with cirrhotic chronic hepatitis C before or during therapy. E. Hepatitis, autoimmune. F. Hypersensitivity reaction (urticaria, angioedema, bronchoconstriction, anaphylaxis, Stevens-Johnson syndrome, toxic epidermal necrolysis) to interferon alfa or to any component of the product. G. Pregnancy or pregnant partner of male patient: may cause birth defects and death of the exposed fetus (in combination with ribavirin). H. Renal function impairment (CrCl less than 50 mL/min (in combination with ribavirin).
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis. B. If patient is diagnosed with Hepatitis C: 1.Documentation showing Hepatitis C genotype, 2. Documentation showing baseline HCV RNA levels that are dated within the last 90 days. C. If request is for treatment for Hepatitis C beyond initial 12 weeks: Documentation of Early Viral Response (EVR) showing at least a 2 log reduction from baseline HCV RNA levels. D. If request is for Hepatitis B: 1. Confirm positive HBsAg OR liver biopsy showing chronic hepatitis, 2. Confirm Hepatitis B viral load greater than 100000 copies/mL., 3. Documentation of elevated liver enzymes showing AST greater than 69 units/L AND ALT greater than 71 units/L.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an infection disease physician, gastroenterologist, or other qualified provider
Coverage Duration	Initial authorization: 4 months, then up to 12 months

Other Criteria	COVERAGE POLICY: PEG-INTRON is covered for members who meet the following criteria: A. Chronic Hepatitis C Virus (HCV) with Genotype 1 or 4. Initial authorization will be given for 12 weeks. At 12 weeks, an early viral response (EVR) must be shown with greater than 2 log reduction in viral load, therapy may be continued up to a total of 48 weeks treatment. For patients who fail to achieve a 2 log reduction, treatment should be discontinued. B. HCV with Genotype 2,3, 5, or 6. Initial authorization will be given for 12 weeks. At 12 weeks, an EVR must be shown with greater than 2 log reduction in viral load, therapy may be continued up to a total of 24 weeks treatment. For patients who fail to achieve a 2 log reduction, treatment should be discontinued. C. Retreatment allowed in those who did not receive optimal HCV treatment.
Prior Authorization Group	PEGASYS
Drug Names	PEGASYS, PEGASYS PROCLICK
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: PEGASYS is NOT covered for members with the following criteria: A. Anaphylaxis, history to peginterferon alfa-2b or interferon alfa-2b. B. Hemoglobinopathies (thalassemia major and sickle-cell anemia [in combination with ribavirin]). C. Hepatic decompensation (Child-Pugh score greater than 6 [class B or C]). D. Hepatic decompensation (Child-Pugh score greater than 6 [class B or C] in patients with cirrhotic chronic hepatitis C before or during therapy. E. Hepatitis, autoimmune. F. Hypersensitivity reaction (urticaria, angioedema, bronchoconstriction, anaphylaxis, Stevens-Johnson syndrome, toxic epidermal necrolysis) to interferon alfa or to any component of the product. G. Pregnancy or pregnant partner of male patient: may cause birth defects and death of the exposed fetus (in combination with ribavirin). H. Renal function impairment (CrCl less than 50 mL/min (in combination with ribavirin).
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of diagnosis. B. If patient is diagnosed with Hepatitis C: 1. Documentation showing Hepatitis C genotype. 2. Documentation showing baseline HCV RNA levels that are dated within the last 90 days. C. If request is for treatment for Hepatitis C beyond initial 12 weeks: Documentation of Early Viral Response (EVR) showing at least a 2 log reduction from baseline HCV RNA levels. D. If request is for Hepatitis B: 1..Confirm positive HBsAg OR liver biopsy showing chronic hepatitis. 2. Confirm Hepatitis B viral load greater than 100000 copies/mL.. 3. Documentation of elevated liver enzymes showing AST greater than 69 units/L AND ALT greater than 71 units/L.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an infection disease physician, gastroenterologist, or other qualified provider
Coverage Duration	Initial authorization: 4 months, then up to 12 months

Other Criteria	COVERAGE POLICY: PEGASYS is covered for members who meet the following criteria: A. Chronic Hepatitis C Virus (HCV) with Genotype 1 or 4. Initial authorization will be given for 12 weeks. At 12 weeks, an early viral response (EVR) must be shown with greater than 2 log reduction in viral load, therapy may be continued up to a total of 48 weeks treatment. For patients who fail to achieve a 2 log reduction, treatment should be discontinued. B. HCV with Genotype 2,3, 5, or 6. Initial authorization will be given for 12 weeks. At 12 weeks, an EVR must be shown with greater than 2 log reduction in viral load, therapy may be continued up to a total of 24 weeks treatment. For patients who fail to achieve a 2 log reduction, treatment should be discontinued. C. Retreatment allowed in those who did not receive optimal HCV treatment.
Prior Authorization Group	PERJETA
Drug Names	PERJETA
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	PERJETA is NOT covered for members who meet the following criteria: A. Pregnancy B. Prior therapy for metastatic disease.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation confirming the treatment of HER2-positive metastatic breast cancer. B. Confirm PERJETA will be used in combination with trastuzumab and docetaxel.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an appropriate specialist for the covered use (oncologist)
Coverage Duration	Up to 12 months.
Other Criteria	COVERAGE POLICY: PERJETA is covered for members who meet the following criteria: A. Documentation confirming the treatment of HER2-positive metastatic breast cancer. B. Confirm PERJETA will be used in combination with trastuzumab and docetaxel. C. Patients with no prior therapy for metastatic disease.
Prior Authorization Group	PHENOBARBITAL
Drug Names	PHENOBARBITAL
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm diagnosis.
Age Restrictions	APPROVE:Patients aged less than 65 years. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: PHENOBARBITAL is covered for members who meet the following criteria:A. Confirm FDA or Compendial diagnosis.B. Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Prior Authorization Group	POMALYST
Drug Names	POMALYST
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documented diagnosis of multiple myeloma. B. Documented trial of at least 2 prior therapies including lenalidomide and bortezomib. C. demonstrated disease progression on or within 60 days of completion of the last therapy.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, endocrinologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: POMALYST is covered for members who meet the following criteria: A. Documented diagnosis of multiple myeloma. B. Documented trial of at least 2 prior therapies including lenalidomide and bortezomib. C. demonstrated disease progression on or within 60 days of completion of the last therapy. D. Applies to NEW STARTS only.
Prior Authorization Group	PRADAXA
Drug Names	PRADAXA
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: PRADAXA is NOT covered for members who meet the following criteria: A. Patients with active pathological bleeding. B. Patients on Dialysis. C. 2011 ACCF/AHA/HRS atrial fibrillation guidelines: Not recommended for patients with coexisting prosthetic heart valve or hemodynamically significant valve disease, severe renal failure (Clcr 15 mL/minute), or advanced liver disease (impaired baseline clotting function).
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm diagnosis of non- valvular atrial fibrillation. Confirm creatinine clearance of greater that 15 L/min (If CRCl is not available, eGFR 59) within past year Oral: 150 mg twice daily Oral: 75mg twice daily if CRCl is (15L/min to 30L/min) QLL of 60 tablets per 30 days
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: PRADAXA is covered for members who meet the following criteria: A. An FDA-approved patient medication guide, which is available with the product information and at http://www.fda.gov/downloads/Drugs/DrugSafety/UCM231720.pdf, must be dispensed with this medication.

Prior Authorization Group	PROCRIT
Drug Names	PROCRIT
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Must have current documented Hemoglobin (HGB) 10g/dl to less than or equal to 13g/dl in surgical patients. Must have current document Hemoglobin (HGB) less than 10g/dl in chronic kidney disease patients or cancer patients receiving chemotherapy. Hematocrit levels of less than or equal to 30% within 30 days prior to initiation of therapy except for Preoperative use in anemic patients scheduled for elective hip or knee surgery in which HGB should be between 10 and 13 g/dL.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 4 months
Other Criteria	COVERAGE POLICY: PROCRIT is covered for members who meet the following criteria: A. Treatment of Anemia in Chronic Renal Failure (CRF): Procrit may be covered under Part B. B. For use in an anemic patient prior to surgery, the patient must also receive concomitant iron supplementation. C. For other indications, all of the following criteria are required: 1. The pretreatment Hgb is less than or equal to 10 g/dL for initial authorization, 2. The patient is receiving concomitant iron supplementation if iron stores are inadequate, 3. The Hgb is maintained at or below 12 g/dL once on therapy, 4. Once on therapy for 12 weeks, the hemoglobin must increase at least 1g/dL in response to epoetin alfa. D. If treatment of anemia in an ESRD patient, Procrit may be covered under a bundle payment. Verify if the phyisican receives a monthly capitation for providing for ESRD patients. E. Determine Part B versus Part D.

Prior Authorization Group	PROLASTIN
Drug Names	PROLASTIN-C
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Office visit notes to verify FDA approved diagnosis and verify yearly physician appointments. B. Lab report measuring elevations in serum and lung fluid levels of alpha-1 antitrypsin.

Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: PROLASTIN is covered for members who meet the following criteria: A. Congenital alpha1-proteinase inhibitor (alpha1-PI alpha1-antitrypsin) deficiency. B. Determine Part B versus Part D.
Prior Authorization Group	PROMACTA
Drug Names	PROMACTA
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: PROMACTA is NOT covered for members with the following criteria: A. To normalize platelet counts. B. If ALT levels are 3 times the upper limit of normal (ULN) and are progressive.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Lab values indicating platlet counts less than 50 x 10(9)/L. B. ALT, AST and Bilirubin within normal limits of the lab performing the test. B. Documentation that the patient had an insufficient response to corticosteroids.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Physicians enrolled in Promacta Cares program
Coverage Duration	Up to 6 months
Other Criteria	COVERAGE POLICY: PROMACTA is covered for members who meet the following criteria: A. For the treatment of thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who have had an insufficient response to corticosteroids.
Prior Authorization Group	PULMOZYME
Drug Names	PULMOZYME
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: PULMOZYME is NOT covered for members with the following criteria: A. Hypersensitivity to dornase alpha or product components.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Office visit notes to verify FDA approved diagnosis for cystic fibrosis.
Age Restrictions	APPROVE: 5 years or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: PULMOZYME is covered for members who meet the following criteria: A. Patients using a medication with a nebulizer are covered under Medicare Part B, unless patient is LTC.
Prior Authorization Group	REGRANEX

Drug Names	REGRANEX
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: REGRANEX is NOT covered for members who meet the following criteria: A. Hypersensitivity to any component of the product, including parabens. B. Neoplasm at the application site.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation verifying the ulcer extends into subcutaneous tissue and the tissue has adequate blood supply. B. Documentation verifying the patient has concurrent good ulcer treatment practices including: 1. Debridgement. 2. Pressure relief. 3. Infection relief. C. Documentation verifying the ulcer is less than 10cm2 in size. D. greater than or equal to 2 on the Wagner Classification System. F. Diagnosis of diabetes.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 3 months
Other Criteria	COVERAGE POLICY: REGRANEX is covered for members who meet the following criteria: A. Must be used for treatment of lower-extremity diabetic ulcers. B. AND the ulcer must extend into subcutaneous tissue. C. AND the tissue must have an adequate blood supply. D. AND the patient must have concurrent good ulcer treatment practices including ALL of the following: 1. Debridgement. 2. Pressure relief. 3. Infection relief. E. AND the above good ulcer treatment practices must be documented through chart notes F. AND the ulcer must be less than 10 cm2 in size. G. AND the ulcer must be greater than or equal to 2 on the Wagner Classification System.

Prior Authorization Group	REMICADE
Drug Names	REMICADE
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: REMICADE is NOT covered for members who meet the following criteria: A. Administration of doses greater than 5 mg/kg to patients with moderate to severe heart failure. B. Readministration to patients who have experienced a severe hypersensitivity reaction to infliximab. C. Known hypersensitivity to inactive components of the product or to any murine proteins.

Required Medical Information	The following copies of chart notes/laboratory reports are required: A. For rheumatoid arthritis: 1. Documentation showing the patient has RA, 2. Documentation showing that the pt has tried, failed or intolerant to at least one of the following: Methotrexate, cyclosporine, azathioprine, or leflunomide. B. For psoriatic arthritis: 1. Documentation showing the patient has at least one of the following symptoms: i. Three (3) or more swollen joints, ii. Three (3) or more tender joints. C. For active ankylosing spondylitis: Documentation showing the patient has tried, failed or is intolerant to at least one NSAIDs. D. For plaque psoriasis: 1. Documentation showing the involvement of plaque psoriasis is 10% or greater of the patient's total body surface area (BSA) OR the plaque psoriasis must involve areas that will prevent the patient from performing crucial daily functions such as walking (feet), 2. Documentation showing the patient has tried, failed or intolerant to one of the following: High potency topical steroid treatment, calcipotriene, phototherapy, retinoids, methotrexate,cyclosporine. E. For Ulcerative colitis: Documentation showing the patient has tried, failed or intolerant to at least one of the following: mesalamine, methotrexate, mercaptopurine. F. For all diagnoses: Must have a negative TB test yearly.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist, dermatologist, gastroenterologist, or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: REMICADE is covered for members who meet the following criteria: A. Rheumatoid /Psoriatic Arthritis in patients who have tried, failed or are intolerant to methotrexate (MTX) OR at least 1 alternative disease modifying antirheumatic drugs (DMARDs [ex: plaquenil, sulfasalzine, Arava]). B. Juvenile Rheumatoid Arthritis in patients who have tried and failed at least 1 DMARDs (ex: plaquenil, sulfasalzine, Arava). Approve without trying MTX if the patient has an absolute contraindication to MTX (ex: pregnancy, alcoholic liver disease, immunodeficiency syndrome). C. Ankylosing Spondylitis in patients who have tried and failed at least 1 non-steroidal anti-inflammatory drugs (ex:Ibuprofen, diclofenac), corticosteroids (ex:prednisone), OR sulfasalazine. D. Plaque psoriasis in patients who have had chronic conditions for at least 1 year , minimum body surface area (BSA) involvement of greater than or equal to 10%, OR involvement of the palms, soles, head, neck or genitalia, tried and failed a topical agent (ex:calcipotriene, tazarotene) AND tried and failed one (1) systemic therapy (ex: MTX, azathioprine, cyclosporine, Soriatane) OR phototherapy (UVB, OR oral methoxsalen plus UVA light (PUVA)). E. Moderate to severe Crohn's Disease or ulcerative colitis in patients who have tried and failed at least 1 of the following: immunomodulators (ex: MTX, azathioprine), corticosteroids (ex: 5-ASA, prednisone), or aminosalicylates (ex: Asacol, Pentasa). F. AND have a negative TB test yearly. G. Determine Part B versus Part D.

Prior Authorization Group	REMODULIN
Drug Names	REMODULIN
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Diagnosis of PAH has been confirmed via right heart catheterization demonstrating a mean pulmonary artery pressure (mPAP) greater than 25 mm Hg, a pulmonary capillary wedge pressure (PCWP), left atrial pressure, or left ventricular end-diastolic pressure (LVEDP) less than or equal to 15 mm Hg, and a pulmonary vascular resistance (PVR) greater than 3 Wood units.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist, cardiologist, or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: REMODULIN is covered for members who meet the following criteria: A. Treatment of pulmonary arterial hypertension (PAH) in patients with NYHA Class II-IV symptoms, to diminish symptoms associated with exercise. B. Diagnosis of PAH has been confirmed via right heart catheterization demonstrating a mean pulmonary artery pressure (mPAP) greater than 25 mm Hg, a pulmonary capillary wedge pressure (PCWP), left atrial pressure, or left ventricular end-diastolic pressure (LVEDP) less than or equal to 15 mm Hg, and a pulmonary vascular resistance (PVR) greater than 3 Wood units. C. Determine Part B versus Part D.

Prior Authorization Group	REVATIO
Drug Names	REVATIO
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: REVATIO is NOT covered for members with the following criteria: A. IF the patient has any of the following contraindications: Current therapy with organic nitrates or known hypersensitivity to sildenafil.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation verifying: a. The patient does NOT have pulmonary veno-occlusive disease (PVOD), (contraindicated). B. The patient will NOT receive combination therapy with a prostacyclin (Ventavis, Remodulin) or an endothelin antagonist (Tracleer) or a phosphodiesterase type-5 inhibitor (Viagra or Letairis) agent. Combination therapy has not been approved by the FDA. (Please verify that the patient is not on duplicate therapy by reviewing the patients drug history or chart). C. The diagnosis is documented as pulmonary arterial hypertension class I-IV defined by the World Health Organization (WHO). D. Therapy is being prescribed to improve exercise ability. E. The dose does not exceed 20 mg three times a day.

Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist, cardiologist, or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: REVATIO is covered for members who meet the following criteria: Treatment of pulmonary arterial hypertension (WHO Group I). WHO Group I includes: Idiopathic PAH, Familial (FPAH), associated with (APAH) connective tissue disease, congenital systemic-to pulmonary shunts, portal hypertension, HIV Infection, drugs and toxins,pulmonary veno-occlusive disease (PVOD),pulmonary capillary haemangiomatosis (PCH) or persistant pulmonary hypertension of the newborn (PPNH).
Prior Authorization Group	RIBAVIRIN
Drug Names	RIBASPHERE, RIBAVIRIN
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: RIBAVIRIN is NOT covered for members who meet the following criteria: A. Ribavirin monotherapy for the treatment of chronic hepatitis C virus (HCV) infection. B. Using Ribavirin with other than interferon alfa-2b or peginterferon alfa-2b for treatment of chronic hepatitis C virus (HCV) infection. C. Who meet the following Contraindications and Cautions: 1. Severe thrombocytopenia, 2. Decompensated cirrhosis, 3. Pregnancy, or unwillingness to use effective contraception, 4. Renal insufficiency, 5. Severe heart disease, 6. CrCL less than 50ml/min.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm ANY OF THE FDA approved indications not otherwise excluded from Part D. B. If the patient is diagnosed with Hepatitis C: 1. Documentation showing hepatitis C genotype. 2. Documentation showing baseline HCV RNA levels that are dated within the last 90 days. 3. Confirm combination therapy with interferon alfa-2b (Intron® A) or peginterferon alfa-2a (Pegasys®) injection C. If request is for treatment for hepatitis C beyond initial 12 weeks: Documentation of Early Viral Response (EVR) showing at least a 2 log reduction from baseline HCV RNA levels.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an infection disease physician, gastroenterologist, or other qualified provider
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: RIBAVIRIN is covered for members who meet the following criteria: A. If diagnosis is Hepatitis C, chronic, may approve the following dosages through the end of the contract year or weeks approved of Interferon: Genotype 1, 4 less than 75kg = 1,000mg per day or Genotype 1, 4 greater than 75kg = 1,200mg per day or Genotype 2, 3 800mg per day or Genotype 5, 6 between 800mg and 1,200mg per day.

Prior Authorization Group	RITUXAN
Drug Names	RITUXAN
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of FDA or compendia approved diagnosis B. For RA, previous trial/failure of at least one of the following: DMARD (ex: Methotrexate, Imuran, Arava) and an inadequate response to either Enbrel or Humira are required. For continuation of RA therapy, improvement in clinical symptoms that may include improvement in tender and swollen joint count, mobility, or stiffness, or delay in progression of disease is required.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist, oncologist, or other qualified provider
Coverage Duration	Up to 6 months
Other Criteria	COVERAGE POLICY: RITUXAN is covered for members who meet the following criteria: A. Chronic lymphoid leukemia, In combination with fludarabine and cyclophosphamide. B. Microscopic polyarteritis nodosa, in combination with glucocorticoids. C. Non-Hodgkin's lymphoma, diffuse, large B-cell, CD20-positive, in combination for first-line treatment. D. Non-Hodgkin's lymphoma,follicular, CD20-positive, B-cell, in combination with first-line chemotherapy and as single-agent maintenance. E. Non-Hodgkin's lymphoma, low-grade, CD20-positive, B-cell, stable or responsive to prior CVP (cyclophosphamide, vincristine, and prednisone) chemotherapy. F. Non-Hodgkin's lymphoma, relapsed or refractory, low-grade or follicular, CD20-positive, B-cell. G. Rheumatoid arthritis (moderate to severe), in combination with methotrexate, in patients who had an inadequate response to one or more tumor-necrosis-factor antagonist therapies(ex:Enbrel, Humira) H.Wegener's granulomatosis,in combination with glucocorticoids.

Prior Authorization Group	SAIZEN
Drug Names	SAIZEN, SAIZEN CLICK.EASY
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE

Required Medical Information	The following copies of chart notes/laboratory reports are required:A.Confirm the pt does NOT have any evidence of active malignancy. B.GH deficiency in adults:1.Confirm pt has a negative response to two STD GH stimulation tests (Max peak less than 5ng/mL by RIA or less than 2.5 ng/mL by IRMA) OR an IGF-1 level that is two STD deviations below normal for the patient's age group.2.GH deficiency is due to pituitary or hypothalamus surgery, OR disease, OR injury, OR radiation therapy, OR GH deficiency during childhood.3.Confirm symptoms of GH deficiency that include one of the following:Reduced bone density of more than one STD deviation below the age and gender-specific mean, OR reduced ejection fracture of less than 50%.
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: SAIZEN is covered for members who meet the following criteria: A. Diagnosis is is supported by the FDA B. Determine Part B versus Part D.

Prior Authorization Group	SAMSCA
Drug Names	SAMSCA
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: SAMSCA is NOT covered for members with the following criteria: A. Concurrently taking Ketoconazole. B. Patients who are anuric.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Serum sodium of less than 125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction. B. Coverage must be initiated or reinitated in a hospital.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: SAMSCA is covered for members who meet the following criteria: A. Samsca is approved for the diagnosis of hypervolemic and euvolemic hyponatremia. B. Serum sodium of less than 125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction. C. CONFIRM hospitalization for initiation and reinitiation of therapy to evaluate the therapeutic response.

Prior Authorization Group	SANCUSO
Drug Names	SANCUSO
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE

Required Medical Information	The following copies of chart notes/laboratory reports are required: Documentation showing that the patient has had a previous trial/failure to oral Ondansetron or Granisetron.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: SANCUSO is covered for members who meet the following criteria: A. Patient must have previous trial/failure on oral Ondansetron OR Granisetron. B. Determine Part B versus Part D.

Prior Authorization Group	SOMATULINE
Drug Names	SOMATULINE DEPOT
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: SOMATULINE is covered for members who meet the following criteria: A. Diagnosis is documented as acromegaly. B. Determine Part B versus Part D.

Prior Authorization Group	SOMAVERT
Drug Names	SOMAVERT
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: SOMAVERT is covered for members who meet the following criteria: A. Diagnosis is acromegaly. B. The patient has tried and failed Sandostatin or octreotide or Somatuline (lanveotide), AND, C. The patient will not receive combination therapy that can include Sandostatin, octreotide or Somatuline. D. For retreatment, reduction in IGF-1 level from baseline. E. Determine Part B versus Part D.

Prior Authorization Group	SORITANE
Drug Names	ACITRETIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, prevention of non-melanoma skin cancers in high risk individuals.

Exclusion Criteria	A. Severely impaired liver function. B. Severely impaired kidney function. C. Chronic abnormally elevated blood lipid values. D. Patient currently taking methotrexate or tetracycline.
Required Medical Information	A. If the patient is female and able to bear children (e.g., no hysterectomy, not reached menopause, has achieved menses). AND B. The patient is unresponsive to other therapies for the covered diagnoses OR the other therapies for the treatment of the covered diagnoses are contraindicated due to the clinical condition of the patient. AND C. Pregnancy has been excluded as confirmed by 2 negative urine or serum pregnancy tests with a sensitivity of at least 25 mIU/mL. AND D. the patient has chosen to use any of the following methods of contraception: one primary form (e.g., tubal ligation, partner's vasectomy, intrauterine devices, birth control pills, injectable/implantable/insertable/topical hormonal birth control products) plus one secondary form (e.g., diaphragms, latex condoms, cervical caps) used in combination with a spermicide OR absolute abstinence. AND E. The patient has agreed to use her chosen form of contraception for at least 1 month before initiation of Soriatane therapy, during Soriatane therapy, and for at least 3 years after discontinuation of therapy. AND F. The patient has been advised that ethanol must not be ingested by female patients during Soriatane treatment and for 2 months following therapy. AND G. The patient will have a negative pregnancy test on a monthly basis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	Female patient or guardian signed a Patient Agreement/Informed Consent.
Prior Authorization Group	STIVARGA
Drug Names	STIVARGA
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Appropriate diagnosis of metastatic colorectal cancer. B. Documented previous treatment with fluropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if KRAS wild type, an anti-EGFR therapy.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, endocrinologist or other qualified provider.
Coverage Duration	Up to 12 months

Other Criteria	"COVERAGE POLICY: STIVARGA is covered for members who meet the following criteria: A. A. Appropriate diagnosis of metastatic colorectal cancer. B. Documented previous treatment with fluropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if KRAS wild type, an anti-EGFR therapy. C. Applies to NEW STARTS only."
Prior Authorization Group	SUBOXONE
Drug Names	BUPRENORPHINE HCL/NALOXON, SUBOXONE
Covered Uses	FDA approved indications: A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: SUBOXONE is NOT covered for members with the following criteria: A. Hypersensitivity to buprenorphine or naloxone
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm treatment of opiod dependence. B. Confirm narcotic dependence treatment plan. C. Documentation that the member is not receiving other opioids.
Age Restrictions	NONE
Prescriber Restrictions	Prescribers must be certified through CSAT (The Center for Substance Abuse Treatment) of SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Suboxone.
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: SUBOXONE is covered for members who meet the following criteria: A. Treatment of opioid dependence. B. Not receiving other opioids.
Prior Authorization Group	SYNRIBO
Drug Names	SYNRIBO
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Appropriate diagnosis of chronic or accelerated phase chronic myeloid leukemia. B. Documented resistance and/or intolerance to two or more tyrosine kinase inhibitors.
Age Restrictions	APPROVE: 18 years or older.
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, endocrinologist or other qualified provider.
Coverage Duration	Up to 12 months.
Other Criteria	COVERAGE POLICY: SYNRIBO is covered for members who meet the following criteria: A. Appropriate diagnosis of chronic or accelerated phase chronic myeloid leukemia. B. Documented resistance and/or intolerance to two or more tyrosine kinase inhibitors. C. Applies to NEW STARTS only.
Prior Authorization Group	TAFINLAR
Drug Names	TAFINLAR

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None.
Required Medical Information	Patient has a diagnosis of unresectable or metastatic melanoma AND the tumor is positive for BRAF V600E mutation.
Age Restrictions	None.
Prescriber Restrictions	None.
Coverage Duration	Plan Year.
Other Criteria	None.

Prior Authorization Group	TESTOSTERONE INJECTABLE
Drug Names	TESTOSTERONE CYPIONATE, TESTOSTERONE ENANTHATE
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	NON COVERAGE: TESTOSTERONE is NOT covered: A. If indicated, or reference to sexual dysfunction diagnosis. B. Testosterone levels are within normal range (range for the lab doing the testing) for new starts. C. Female patients. D. Use for muscle building purposes.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Current diagnosis of primary hypogonadism (congenital or acquired) testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchidectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals, hypogonadotropic hypogonadism (congenital or acquired) - idiopathic gonadotropin or LHRH deficiency, or pituitary hypothalamic injury from tumors, trauma, or radiation. B. New starts: Current lab results measuring total testosterone less than 300 ng/dL or absence of endogenous testosterone. C. Non-New Start: Confirm start of testosterone therapy had low testosterone level (i.e. morning total testosterone less than 300 ng/dL or absence of endogenous testosterone).
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 3 months initially, then up to 12 months.
Other Criteria	COVERAGE POLICY: TESTOSTERONE is covered for members who meet the following criteria: A. Sexual dysfuntion, or ED, is NOT the primary diagnosis. B. Testosterone levels (total and free), low ranges as provided by office or clinic performing labs. B. Drug is being self administered, otherwise is Part B.

Prior Authorization Group	TEV-TROPIN
Drug Names	TEV-TROPIN
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NONE
Required Medical Information	NONE
Age Restrictions	NONE

Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	NONE

Prior Authorization Group	TYZEKA
Drug Names	TYZEKA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	NON COVERAGE: TYZEKA is NOT covered for members who meet the following criteria: A. If the patient has any of the following contraindications: hypersensitivity to telbivudine or any component of the product. B. Concomitant use with pegylated interferon alfa-2a.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Diagnosis of chronic hepatitis B. B..Evidence of a positive HBsAg (+ or -) serological marker for more than 6 months or evidence by a liver biopsy showing chronic hepatitis. C. Hepatitis B viral load greater than 20,000 IU/ml (100,000 copies/ml) except if for HBeAg-negative HBV, the viral load is greater than 2,000 IU/ml (10,000 copies/ml). D. Elevations in liver aminotransferases (ALT or AST) that are 2 times greater than normal or normal liver aminotransferase levels with evidence of significant disease found on biopsy. E.Patient has been tested for HIV and is negative. F. Documentation showing that the patient is not receiving duplicate therapy that includes Hepsera, Baraclude, Epivir, Intron A and/or Infergen. G. If the patient has received previous Tyzeka treatment, documentation showing a clinical improvement shown by a drop in viral load or reduction in the patients liver aminotransferases.
Age Restrictions	APPROVE: 16 years or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease physician, gastroenterologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: TYZEKA is covered for members who meet the following criteria: A. Diagnosis of chronic hepatitis B. B. Evidence of a positive HBsAg (+ or -) serological marker for more than 6 months or evidence by a liver biopsy showing chronic hepatitis C.Hepatitis B viral load greater than 20,000 IU/ml (100,000 copies/ml), except if for HBeAg-negative HBV, the viral load is greater than 2,000 IU/ml (10,000 copies/ml). D. Elevations in liver aminotransferases (ALT or AST) that are 2 times greater than normal or normal liver aminotransferase levels with evidence of significant disease found on biopsy. E. Patient has been tested for HIV and is negative. F. Documentation showing that the patient is not receiving duplicate therapy that includes Hepsera, Baraclude, Epivir, Intron A and/or Infergen. G. If the patient has received previous Tyzeka treatment, documentation showing a clinical improvement shown by a drop in viral load or reduction in the patients liver aminotransferases.

Prior Authorization Group	VFEND
Drug Names	VFEND, VORICONAZOLE
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: VFEND is NOT covered for members who meet the following criteria: If the patient is taking/receiving any of the following: Astemizole, Atorvastatin, Barbiturates, Carbamazepine, Cisapride, Ergot Alkaloids, Pimozide, Quinidine, Ranolazine, Red Yeast Rice, Rifabutin, Rifampin, Rifapentine, Ritonavir, Sirolimus, St. John's Wort, Hypericum perforatum, Terfenadine or Vinca alkaloids.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation showing the patients trial/failure to itraconazole for aspergillosis. B. Documentation showing the patients trial/failure to fluconazole and itraconazole for candidiasis. C. Documentation of diagnosis for furariosis or Scedosporium sp.
Age Restrictions	NONE
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: VFEND is covered for members who meet the following criteria: A. The patient is diagnosed with invasive aspergillosis. B. AND the patient has had previous trial and failure or contraindication to itraconazole. *If aspergillosis infection is extrapulmonary no previous trial is required. C. AND chart notes documenting trial and failure or contraindication to itraconazole are received. D. OR the patient is diagnosed with candidiasis. E. AND the patient has previous trial and failure or contraindication to BOTH fluconazole and itraconazole. F. AND chart notes documenting trial and failure or contraindication to itraconazole are received. G. OR the patient is diagnosed with furariosis or Scedosporium sp. H. AND Vfend is being used as salvage therapy due to failure of other therapies. I. AND chart notes documenting previous treatment failures is received

Prior Authorization Group	VICTOZA
Drug Names	VICTOZA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	NONE
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Diagnosis of type 2 diabetes mellitus B. Patient has tried, failed or been intolerant to two of the following: metformin, sulfonylurea, Thiazolidinedione C. Confirm not using as first-line agent in patients who have inadequate glycemic control on diet and exercise .
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: VICTOZA is covered for members who meet the following criteria: A. Do not have a personal or family history of medullary thyroid carcinoma or in patients with MEN2. B. Determine Part B versus Part D.

Prior Authorization Group	XALKORI
Drug Names	XALKORI
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: XALKORI is NOT covered for members with the following criteria: A. XALKORI is NOT covered for members who meet the following criteria: A. AST or ALT greater than 2.5 × ULN, or greater than 5 × ULN if due to liver metastases. B. Patients with total bilirubin greater than 1.5 × ULN. C. Grade 4 QTc prolongation.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A.Medical Records confirming diagnosis. B. Confirmation of Complete blood cell counts, including differential white blood cell counts C. Confirm CrCl is greater than 30 mL/min. D. Member must have an Eastern Cooperative Oncology Group (ECOG) performance score between 0 and 3.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: XALKORI is covered for members who meet the following criteria: A. Confirmed diagnosis. B. For new starts, approve 14 days to ensure tolerability. C. Applies to NEW STARTS only.

Prior Authorization Group	XENAZINE
Drug Names	XENAZINE
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: XENAZINE is NOT covered for members with the following criteria: A. Hepatic function impairment. B. Patients who are actively suicidal or who have untreated or inadequately treated depression. C. Patients taking monoamine oxidase inhibitors (MAOIs) or reserpine.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Baseline and any subsequent total Chorea Score or the Unified Huntington's Disease Rating Scale (UHDRS). B. No impairment of liver function
Age Restrictions	NONE
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, psychiatrist or other qualified provider
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: XENAZINE is covered for members who meet the following criteria: A. The patient has a diagnosis of chorea associated with Huntington's disease. B. If the patient has a diagnosis of depression or suicidal ideation, the patient is being treated for depression. C. The patient is not receiving a monoamine oxidase inhibitor (MAOI). D. The patient is not receiving reserpine or patient's reserpine will be discontinued at least 20 days before starting Xenazine therapy. E. The patient does not have impaired hepatic function.

Prior Authorization Group	XIFAXAN
Drug Names	XIFAXAN
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: XIFAXAN is NOT covered for members who meet the following criteria: A.Hypersensitivity to rifaximin, any component of the product, or other rifamycin antimicrobial agents.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirm diagnosis.
Age Restrictions	APPROVE: Hepatic encephalopathy - 18 years or older, Traveler's diarrhea - 12years or older
Prescriber Restrictions	NONE
Coverage Duration	Up to 6 months - Hepatic encephalopathy
Other Criteria	COVERAGE POLICY: XIFAXAN is covered for members who meet the following criteria: A. Diagnosis is is supported by the FDA.

Prior Authorization Group	XOLAIR
Drug Names	XOLAIR
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	"NON COVERAGE: XOLAIR is NOT covered for members with the following criteria: A. Severe hypersensitivity to omalizumab or any component of the product.B.Patient with Acute bronchospasm, status asthmaticus.

Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation of the patients peak expiratory flow [PEF] before and after bronchodilator challenge. B. The pretreatment IgE level at least 30 IU. C. The patient's weight is at least 30 kg. D. Allergic asthma has been confirmed by skin testing or in vitro reactivity (RAST) testing. E. Documentation showing that the patient has been compliant and maintained on standard inhaled corticosteroid therapy for at least 6-months and still remains inadequately controlled. F. Documentation showing that the patient has had a 3-month trial and failure or intolerant to a long acting beta agonist agent that can Include Symbicort, Foradil, Serevent, or Advair. G. Documentation showing that the patient has experienced a reduction in symptoms and improvement in their FEV1 or PEF before initiation of re-treatment.
Age Restrictions	APPROVE: 12 years or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist, allergist, immunologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: XOLAIR is covered for members who meet the following criteria: A. The pretreatment IgE level is at least 30 IU, AND, B. The member's weight is at least 30 kg, AND, C. Allergic asthma has been confirmed by skin testing or in vitro reactivity (RAST) testing. D. Determine Part B versus Part D.
Prior Authorization Group	XTANDI
Drug Names	XTANDI
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: Xtandi is NOT covered for members who meet the following criteria: A. Pregnant
Required Medical Information	The following copies of chart notes/laboratory reports are required: A.Confirm Diagnosis. B. Confirm previously received docetaxel.
Age Restrictions	18 years or older
Prescriber Restrictions	Oncologist or other qualified prescriber.
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: Xtandi is covered for members who meet the following criteria: A. Confirm New Start.
Prior Authorization Group	XYREM
Drug Names	XYREM
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D

Exclusion Criteria	NON COVERAGE: XYREM is NOT covered for members with the following criteria: A. Succinic semialdehyde dehydrogenase deficiency. B. If the patient is taking/receiving any of the following: anxiolytics, sedatives, hypnotics, barbiturates, benzodiazepines or ethanol.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. The diagnosis is documented as excessive daytime sleepiness with symptoms that limit their ability to perform normal daily activities. B. AND the diagnosis is documented as cataplexy (a condition characterized by weak or paralyzed muscles) in patients with narcolepsy as confirmed by MSLT indicating sleep latency of less than 8 minutes. C. AND if the patient has received prior treatment with Xyrem, the patient must experience a decrease in daytime sleepiness and/or cataplexy in a narcoleptic patient.
Age Restrictions	APPROVE: 16 years or older
Prescriber Restrictions	Prescribed by or in consultation with a physician registered with the Xyrem Patient Success Program
Coverage Duration	Up to 3 months
Other Criteria	COVERAGE POLICY: XYREM is covered for members who meet the following criteria: A. The prescriber has documented that the patient is enrolled in the Xyrem Success Program, AND, B. The patient does not have succinic semialdehyde dehydrogenase deficiency, AND, C. The patient is not being treated with a sedative hypnotic agent, AND, D. The patient does not have a history of substance abuse.
Prior Authorization Group	ZALTRAP
Drug Names	ZALTRAP
Covered Uses	FDA approved indications A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The following copies of chart notes/laboratory reports are required: A.Confirm diagnosis. B. Confirm used In combination with 5-fluorouracil, leucovorin, irinotecan (FOLFIRI), in patients whose disease is resistant to or has progressed following an oxaliplatin-based regimen.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by Oncologist or other qualified prescriber
Coverage Duration	Up to 12 months.
Other Criteria	COVERAGE POLICY: Zalrap is covered for members receving it in combination with 5-fluorouracil, leucovorin, irinotecan (FOLFIRI), in patients whose disease is resistant to or has progressed following an oxaliplatin-based regimen. A. Confirm new start
Prior Authorization Group	ZAVESCA
Drug Names	ZAVESCA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria	NON COVERAGE: ZAVESCA is NOT covered for members with the following criteria: A. If the patient has any of the following contraindications: pregnancy, labor, obstetric delivery or renal failure.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Documentation showing that the diagnosis has been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%. B. Documentation showing that the patient has a hemoglobin concentration above 9 g/dL or a platelet count above 50 x109/L or active bone disease. C. Documentation showing that the patient has tried and failed enzyme replacement therapy. D. If the patient is female and of childbearing years, documentation showing that she is NOT pregnant, has NO plans for pregnancy, is on a form of contraception or has NO ability to conceive and has been educated on the potential dangers of Zavesca therapy. E. If the patient has previously received 24 months of Zavesca therapy, documentation showing that they show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: ZAVESCA is covered for members who meet the following criteria: A. Diagnosis is documented as mild-to-moderate type-1 Gaucher disease. B. AND diagnosis has been confirmed by bone marrow histology, DNA testing or measurement of b-glucocerebrosidase enzyme activity less than 30%. C. AND the patient has a hemoglobin concentration above 9 g/dL or a platelet count above 50 x109/L or active bone disease. (Zavesca has not been evaluated in patients with severe disease). D. AND the patient has tried and failed enzyme replacement therapy (e.g. Ceredase, Cerezyme) or is not a therapeutic option (e.g. allergy, hypersensitivity). (Please verify trial in the patient s drug history or chart). E. AND if the patient is female and of childbearing years, she is NOT pregnant, has NO plans for pregnancy, is on a form of contraception or has NO ability to conceive and has been educated on the potential dangers of Zavesca therapy. F. If the patient has previously received 24 months of Zavesca therapy, the patient must show a decrease in liver and spleen volume and/or increases in platelet count and/or increases in hemoglobin concentration.
Prior Authorization Group	ZELBORAF
Drug Names	ZELBORAF
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria	NON COVERAGE: ZELBORAF is NOT covered for members with the following criteria: A. ZELBORAF is NOT covered for members who meet the following criteria: A. In patients with wild-type BRAF melanoma. B. Patients who are pregnant. C. Negative Cobas Test.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A.Documented and confirmed diagnosis B. Member must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1. C. Baseline ECG, electrolytes (including potassium, magnesium, and calcium), liver enzymes (transaminass and alkaline phophtase), and bilirubin baseline values must be within clinically acceptable limits D. Confirmation of positive test for the BRAF V600E mutation using the Cobas 4800 BRAF V600E Mutation Test.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: ZELBORAF is covered for members who meet the following criteria: A. Diagnosis of unresectable or metastatic melanoma. B. Tests positive for the BRAF V600E mutation using the Cobas 4800 BRAF V600 Mutation Test. C. Member must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1. D. Baseline ECG, electrolytes (including potassium, magnesium, and calcium), liver enzymes (transaminass and alkaline phophtase), and bilirubin baseline values must be within clinically acceptable limits. E. Applies to NEW STARTS only.

Prior Authorization Group	ZOMETA
Drug Names	ZOMETA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: ZOMETA is NOT covered for members with the following criteria: A. Pregnancy. B. Hypersensitivity to zoledronic acid or any component of the product.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Supporting documentation indicating diagnosis is required AND trial and failure of one preferred oral bisphosphonate AND Boniva Injectable for the diagnosis of osteoporosis and osteoporosis prophylaxis. Preferred oral bisphosphonates: alendronate, Boniva (oral) Approve for the indications of: 1. Hypercalcemia of malignancy 2. Patients with multiple myeloma and patients with documented bone metastases from solid tumors, in conjunction with standard antineoplastic therapy. Prostate cancer should have progressed after treatment with at least one hormonal therapy Important limitation of use: The safety and efficacy of Zometa has not been established for use in hyperparathyroidism or nontumorrelated hypercalcemia.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	NONE
Coverage Duration	Up to 12 months

Other Criteria	COVERAGE POLICY: ZOMETA is covered for members who meet the following criteria: A. Prior authorization applies to new starts only. B. Determine Part B versus Part D. C. Applies to NEW STARTS only.
Prior Authorization Group	ZYTIGA
Drug Names	ZYTIGA
Covered Uses	FDA approved indications. A. All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	NON COVERAGE: ZYTIGA is NOT covered for members with the following criteria: A. Women who are or may become pregnant. B. ALT greater than 5 X ULN during treatment of Zytiga. C. AST greater than 5 X ULN during treatment of Zytiga. D. Total bilirubin greater than 3 X ULN.
Required Medical Information	The following copies of chart notes/laboratory reports are required: A. Confirmation of diagnosis of metastatic castration-resistant prostate cancer who have received prior chemotherapy containing docetaxel. B. Confirm co-administration with prednisone. C. Must have serum prostate-specific antigen (PSA) greater than or equal to 5 mg/mL.
Age Restrictions	APPROVE: 18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist, urologist, or other qualified provider
Coverage Duration	Up to 12 months
Other Criteria	COVERAGE POLICY: ZYTIGA is covered for members who meet the following criteria: A. Confirmation of diagnosis of metastatic castration-resistant prostate cancer who have received prior chemotherapy containing docetaxel. B. Confirm co-administration with prednisone. C. Must have serum prostate-specific antigen (PSA) greater than or equal to 5 mg/mL.D. Applies to NEW STARTS only.