

Brand Name: Abilify
Generic Name: Aripiprazole

Abilify (aripiprazole) PA Criteria:

- Abilify Low-Dose (2mg and 5mg) Prior Authorization Criteria:
 - Abilify 2mg and 5mg in members 18 to 60 years of age will be approved via prior authorization for Food and Drug Administration (FDA) approved indications, which include:
 - Bipolar Disorder
 - Major Depressive Disorder
 - Schizophrenia
 - If the member is an adult with Major Depressive Disorder, Abilify will be approved at this dose if they are also taking a SSRI or SNRI antidepressant. Abilify is approved for adults diagnosed with major depressive disorder as an adjunctive treatment and should not be used as monotherapy.
- Abilify in Children Less than 6 years of age Prior Authorization Criteria:
 - Coverage is provided for the following diagnoses when the medication is being prescribed by an appropriate specialist (including a Pediatric Neurologist, a Child and Adolescent Psychiatrist, or a Child Development Pediatrician) and chart documented evidence is provided of a comprehensive evaluation by the prescriber or in conjunction with a specialist listed above.
 - Autism, OR
 - Mental retardation, OR
 - Oppositional Defiant Disorder (ODD) with aggression, OR
 - Bipolar Disease, OR
 - Tourette's Syndrome, OR
 - Transient Encephalopathy
- Benefit is approved for 12 months.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Aricept
Generic Name: Donepezil HCl

Aricept (donepezil) PA Criteria:

- Benefit coverage is provided for all severities of Alzheimer's type dementia.
- Benefit coverage is not provided for combination use among the Alzheimer's agents (except for donepezil and memantine).
- If the 23mg strength is being requested, the patient should have a documented history of at least a three month trial of the 10mg with no improvement.
- Benefit coverage is for 12 months.
- Benefit renewal coverage is provided in situations where therapy continues to provide clinical benefit.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Avonex
Generic Name: Interferon Beta-1A

Avonex (interferon beta-1a) PA Criteria:

- Coverage provided for:
 - Treatment at time of first demyelinating event to delay development or progression to multiple sclerosis
 - Relapsing-remitting multiple sclerosis
 - Secondary-progressive multiple sclerosis
 - Progressive-relapsing multiple sclerosis
- Coverage is not provided for primary progressive MS.
- Coverage provided for situations in which there is functional status that can be preserved. 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.
- Coverage is provided for 12 months.
- Combination therapy with Avonex (Interferon beta-1a) and Copaxone (glatiramer acetate) is not covered.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Copaxone
Generic Name: Glatiramer Acetate

Copaxone (glatiramer acetate) PA Criteria:

- Coverage provided for:
 - Treatment at time of first demyelinating event to delay development or progression to multiple sclerosis
 - Relapsing-remitting multiple sclerosis
 - Secondary-progressive multiple sclerosis
 - Progressive-relapsing multiple sclerosis
- Coverage is not provided for primary progressive MS.
- Coverage provided for situations in which there is functional status that can be preserved. 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.
- Coverage is provided for 12 months.
- Combination therapy with Avonex (Interferon beta-1a) and Copaxone (glatiramer acetate) is not covered.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Elidel
Generic Name: Pimecrolimus

Elidel (pimecrolimus) PA Criteria:

- Coverage is provided for Elidel (pimecrolimus) for the treatment of mild to moderate atopic dermatitis.
- Elidel (pimecrolimus) is not approved in patients less than 2 years of age.
- Patients between 2 and 17 years of age must have experienced an inadequate response or intolerance from treatment with a trial of at least one topical corticosteroid.
- Patients 18 years of age and older must have experienced an inadequate response to a trial of at least two topical corticosteroids or intolerance (e.g., skin atrophy) from treatment with a topical corticosteroid.
- Coverage duration is 3 months.
- Physician office will be notified over the phone of the potential risk of lymph node or skin cancer associated with Elidel and will be referred to the FDA website for information regarding this black box warning.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Enbrel
Generic Name: Etanercept

Enbrel (etanercept) PA Criteria:

- Coverage is provided for the treatment of rheumatoid or psoriatic arthritis in the following situations:
 - Patient has experienced a therapeutic failure with methotrexate or has had an inadequate response to methotrexate
 - Patient is unable to receive methotrexate (e.g., use of methotrexate is contraindicated in the patient)
 - Patient requires Enbrel (etanercept) treatment for rapidly advancing, progressive disease
- Coverage is not provided for use of Enbrel (etanercept) in combination with Kineret (anakinra), Humira (adalimumab), or Remicade (infliximab)
- Coverage is provided for the treatment of ankylosing spondylitis in the following situations:
 - Patient has active disease for at least 4 weeks with a BASDAI score \geq 4cm and a Physician Global Assessment score of > 2 on the Likert scale.
 - Patients with peripheral, axial and enthesitis have had an inadequate response or intolerability to two NSAIDs and patients with peripheral disease have also failed at least one DMARD.
- Coverage is provided for the treatment of plaque psoriasis when patients have a PASI score \geq 10 and have failed to respond to two or more of the following therapies:
 - Topical therapy
 - Phototherapy
 - Oral retinoids
 - DMARD
 - Cyclosporine
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Exelon
Generic Name: Rivastigmine Tartrate

Exelon (rivastigmine) PA Criteria:

- Benefit coverage is provided for all severities of Alzheimer's type dementia
- Benefit coverage is provided for mild to moderate dementia associated with Parkinson's disease.
- Benefit coverage is not provided for combination use among the Alzheimer's agents (except for donepezil and memantine).
- Benefit coverage is for 12 months.
- Benefit renewal coverage is provided in situations where therapy continues to provide clinical benefit.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Geodon
Generic Name: Ziprasidone HCl

Geodon (ziprasidone) PA Criteria:

- Geodon (20mg) Low Dose Prior Authorization Criteria:
 - Geodon 20mg in members 18 to 60 years of age will be approved via prior authorization for Food and Drug Administration (FDA) approved indications, which include:
 - Bipolar Mania
 - Schizophrenia
- Geodon in Children Less than 6 years of age Prior Authorization Criteria:
 - Coverage is provided for the following diagnoses when the medication is being prescribed by an appropriate specialist (including a Pediatric Neurologist, a Child and Adolescent Psychiatrist, or a Child Development Pediatrician) and chart documented evidence is provided of a comprehensive evaluation by the prescriber or in conjunction with a specialist listed above.
 - Autism, OR
 - Mental retardation, OR
 - Oppositional Defiant Disorder (ODD) with aggression, OR
 - Bipolar Disease, OR
 - Tourette's Syndrome, OR
 - Transient Encephalopathy
- Benefit is approved for 12 months.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Gleevec
Generic Name: Imatinib Mesylate

Gleevec (imatinib) PA Criteria:

- Benefit coverage is provided for the following conditions:
 - Acute lymphoblastic leukemia (ALL):
 - Aggressive systemic mastocytosis (ASM):
 - Chronic myeloid leukemia (CML)
 - Dermatofibrosarcoma protuberans (DFSP):
 - GI stromal tumors (GIST)
 - Hypereosinophilic syndrome (HES) and/or Chronic eosinophilic leukemia (CEL)
 - Myelodysplastic/myeloproliferative diseases (MDS/MPD)
- Treatment must be initiated by a hematologist-oncologist.
- Benefit coverage duration is 12 months.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Humira
Generic Name: Adalimumab

Humira (adalimumab) PA Criteria:

- Coverage is provided for rapidly advancing, progressive disease Rheumatoid or Psoriatic Arthritis in patients who have experienced a failure, an inadequate response, or is unable to receive methotrexate or other DMARDs.
- Coverage is provided for a diagnosis of Crohn's Disease who have had an inadequate response to conventional therapy listed below:
 - Must have tried/failed or have a contraindication to conventional treatments including:
 - Aminosalicylates, 5-ASAs (i.e., Sulfasalazine, Pentasa[®], Asacol[®], Colazal[®]).
 - Antibiotics (i.e., Metronidazole, Ciprofloxacin).
 - Steroids (i.e., prednisone, Entocort[®]).
 - Immunomodulators (i.e., Azathioprine[®], 6-Mercaptopurine, Methotrexate[®])
- Coverage is provided for a diagnosis of moderate to severe plaque psoriasis defined as 10% or more body surface area (BSA) affected or BSA involvement of < 10% in critical areas (palms, soles, or face) that interferes with daily activities
 - Must have tried/failed or has a contraindication to systemic/phototherapy treatments including:
 - Phototherapy (i.e. PUVA photochemotherapy with Psoralens (methoxsalen (8-MOP), trioxsalen) or UVB phototherapy)
 - Immunomodulators (i.e. Methotrexate, Cyclosporine, Amevive, Raptiva, Enbrel, Remicade)
 - Retinoids (i.e. Soriatane)
- Coverage is provided for moderate to severe active Polyarticular Juvenile Idiopathic Arthritis in children at least 4 years of age and older in patients who have experienced a failure, an inadequate response, or are unable to receive methotrexate. The patient may continue on methotrexate with Humira.
- Coverage is provided for Ankylosing Spondylitis if the patient has active disease and they have tried and failed conventional treatment of NSAIDs or DMARDs 40mg every other week in the following situations:
 - Humira is being requested by a rheumatologist
 - If the patient has peripheral arthritis, they must have had an inadequate response or intolerability to at least two NSAIDs for at least a three month trial and had a lack of response or intolerability to one or more DMARDs (i.e. sulfasalazine, methotrexate).
 - If the patient has axial arthritis or enthesitis, they must have had an inadequate response or intolerability to at least two NSAIDs for at least a three month trial.
- Coverage is not provided for use of:
 - Once weekly doses of Humira (adalimumab) in combination with methotrexate
 - Humira (adalimumab) in combination with Enbrel (etanercept), Kineret (anakinra), or Remicade (infliximab).
 - Humira in children less than four years of age
- The prescriber must consider and screen the patient for the presence of latent TB infection and provide date and results of the test.
- The prescribing physician must be a Rheumatologist, Gastroenterologist or Dermatologist.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Incivek
Generic Name: Telaprevir

Incivek (telaprevir) Prior Authorization Criteria

- Benefit is approved when the following criteria is met:
 - The patient has Hepatitis C Virus, genotype 1 with compensated liver disease.
 - They do not have a co-infection with HIV and have not used Incivek or Victrelis in the past.
 - The patient's HCV RNA levels prior to treatment, their treatment status (naïve, partial responder, relapser, or null responder), and the start date of triple therapy with ribavirin and peginterferon alfa will be documented
- Benefit is approved for 12 weeks in duration at a dose of 750mg (two 375mg tablets) three times a day.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Lupron
Generic Name: Leuprolide acetate

Lupron (leuprolide) PA Criteria:

- Benefit coverage is provided for use in:
 - The treatment of advanced prostatic cancer
 - Endometriosis confirmed by laparoscopy resistant to conventional treatment in females 18 years of age and older
 - Uterine leiomyomata resistant to conventional treatment
 - Central precocious puberty
 - Confirmed by baseline LH and FSH measurements in the pubertal range, a pubertal response to a GnRH/Lupron stimulation test, and advanced bone age (defined as ≥ 2 standard deviations above the gender/age related mean)
 - Documentation of the age of onset of secondary sexual characteristics occurred
 - Any other clinically relevant tests to rule out other diagnoses
 - Premenopausal women with advanced breast cancer
 - Pelvic pain without a diagnosis of endometriosis resistant to conventional treatment
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must over ride criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Lupron Depot
Generic Name: Leuprolide acetate

Lupron Depot (leuprolide) PA Criteria:

- Benefit coverage is provided for use in:
 - The treatment of advanced prostatic cancer
 - Endometriosis confirmed by laparoscopy resistant to conventional treatment in females 18 years of age and older
 - Uterine leiomyomata resistant to conventional treatment
 - Central precocious puberty
 - Confirmed by baseline LH and FSH measurements in the pubertal range, a pubertal response to a GnRH/Lupron stimulation test, and advanced bone age (defined as ≥ 2 standard deviations above the gender/age related mean)
 - Documentation of the age of onset of secondary sexual characteristics occurred
 - Any other clinically relevant tests to rule out other diagnoses
 - Premenopausal women with advanced breast cancer
 - Pelvic pain without a diagnosis of endometriosis resistant to conventional treatment
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must over ride criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Neupogen
Generic Name: Filgrastim

Neupogen (filgrastim) PA Criteria:

- Coverage for Neupogen (filgrastim) is provided for the following conditions:
 - Neutropenia due to antineoplastic chemotherapy agents
 - Neutropenia due to other chemotherapy agents
 - Neutropenia due to radiotherapy
 - Neutropenia due to malignancy
 - Neutropenia due to AIDS/HIV
 - Neutropenia due to myelodysplasia
 - Severe chronic neutropenia (i.e. cyclic neutropenia)
 - BMT (bone marrow transplant)
 - Current or post peripheral blood progenitor cell (PBPC) mobilization/transplantation
 - Neutropenia due to acute leukemia (AML & ALL)
 - Neutropenia due to peginterferon (Hepatitis C) therapy
- Coverage is provided for secondary prevention of antineoplastic chemotherapy related neutropenia (situation where the patient has previously experienced neutropenia from antineoplastic agents).
- Coverage is provided for primary prevention of antineoplastic chemotherapy related neutropenia (i.e. patient has not previously developed neutropenia from antineoplastic agents) in situations where the patient may be at high risk for developing antineoplastic chemotherapy induced neutropenia.
- Coverage is provided in cases where ANC (absolute neutrophil count) is $\leq 1000/\text{mm}^3$ for BMT or myelodysplasia related neutropenia; $\leq 500/\text{mm}^3$ for AIDS/HIV related neutropenia; $\leq 1500/\text{mm}^3$ for severe chronic neutropenia or for use with PBPC transplantation.
- Coverage is provided in cases for neutropenia due to peginterferon therapy in those with Hepatitis C in accord with the following:
 - ANC $\leq 250/\text{mm}^3$ OR ANC $\leq 500/\text{mm}^3$ with one of the following risk factors for developing infection:
 - Cirrhosis
 - Pre- or post-liver transplant
 - HIV/HCV coinfection
 - Neutropenia still persists within 2 weeks after reducing the dose of peginterferon (recommended dose reductions: Peginterferon alfa 2a reduction from 180 mcg/week to 135mcg/week; Peginterferon alfa 2b reduction from 1.5mcg/kg/week to 1.0 mcg/kg/week) OR patient has a viral genotype 1 or 4 AND had a high viral load > 2 million copies or more than 800,000 IU/mL prior to the start of peginterferon therapy, and therefore dose reduction is inadvisable.
 - Neupogen dose should be initiated at 300 mcg once a week.
- Coverage duration:
 - Severe chronic neutropenia, acute leukemia or malignancy/chemotherapy/radiotherapy related neutropenia – 6 months
 - Myelodysplasia or AIDS/HIV related neutropenia – 4 months
 - BMT or PBPC mobilization/transplantation – 1 month
 - Peginterferon (Hepatitis C) therapy -3 months and renewable with adequate response ANC between 500-1000/ mm^3 . If ANC $> 1000/\text{mm}^3$ Neupogen should be discontinued.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must over ride criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Norditropin
Generic Name: Somatropin

Norditropin (somatropin) PA Criteria:

- Coverage is provided for pediatric growth hormone deficiency in the presence of the following:
 - Patient's height must be below the third percentile for their age and gender related height
 - Growth velocity subnormal (*i.e.*, ≥ 2 standard deviations below the age related mean)
 - Delayed skeletal maturation (demonstrated through bone age estimated from an x-ray of the left wrist and hand) ≥ 2 standard deviations below the age/gender related mean
 - Epiphyses confirmed as open in patients ≥ 10 years of age
 - 2 provocative stim tests producing peak growth hormone concentrations $< 10\text{ng/ml}$
 - Insulin growth factor-1 (IGF-1) a.k.a. somatomedin C, or IGF binding protein-3 (IGFBP-3) levels 2 standard deviations below the mean for age and sex
 - A growth response of ≥ 4.5 cm/yr (pre-pubertal growth phase) or ≥ 2.5 cm/yr (post-pubertal) must occur for continuation of coverage
- Coverage is also provided for:
 - Pediatric growth failure due to chronic renal failure (in situations where the patient has not undergone a renal transplant)
 - Growth failure in children born small for gestational age (SGA) who fail to manifest catch up growth by age 2 defined as having a birth weight < 2500 g at a gestational age > 37 weeks, or weight or length at birth below the 3rd percentile for gestational age.
 - Pediatric growth failure due to Turner's syndrome
 - Treatment of Prader-Willi syndrome
 - A sleep study is required at initial request to rule out sleep apnea.
 - If sleep apnea is found, must be treated prior to initiation of growth hormone.
 - Treatment of Noonan's Syndrome
 - Insulin growth factor-1 (IGF-1) a.k.a. somatomedin C, or IGF binding protein-3 (IGFBP-3) levels 2 standard deviations below the mean for age and sex
 - Cardiology consult with echocardiogram monitoring the status of any cardiac defect.
- Coverage is provided for adult growth hormone deficiency, in the presence of a growth hormone stimulation test with peak growth hormone concentrations $< 5\text{ng/ml}$ as a result of:
 - Childhood onset growth hormone deficiency
 - Pituitary or hypothalamic disease
 - Surgery or radiation therapy
 - Trauma
- Coverage Duration:
 - Pediatric human growth hormone deficiency, growth failure in children SGA, growth failure due to Turner's syndrome or chronic renal failure
 - Benefit approved for 12 months and is renewable in the presence of open epiphyses and a growth response of ³ 4.5 cm/yr (pre-pubertal growth rate) or ³ 2.5 cm/yr (post-pubertal growth rate).
 - Adult growth hormone deficient syndrome
 - Benefit approved for 6 months and is renewable in the presence of clinical benefit (*i.e.*, increase in total lean body mass, increase in IGF-1 and IGFBP-3 levels, or increase in exercise capacity)
 - Prader-Willi Syndrome
 - Benefit approved for 6 months and is renewable in the presence of an increase in tone or weight loss
 - Noonan's Syndrome
 - Benefit approved for 12 months and is renewable in the presence of clinical benefit and absence of worsening of any cardiac defect.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must over ride criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: PEG-Intron
Generic Name: Peginterferon Alfa-2B

Peg-Intron (peginterferon alfa-2b) PA Criteria:

- Coverage is provided for treatment of the following conditions:
 - Chronic hepatitis C as indicated by a positive hepatitis C viral load in accord with the following:
 - Evidence of liver injury as determined by biopsy in situations where biopsy is not contraindicated or in situations where there are increased liver function tests (LFTs)
 - In the absence of contraindications to interferon therapy such as decompensated liver disease (i.e., situations where the liver associated side effects of interferon could potentially worsen a patient's condition)
- Peg-Intron (peginterferon alfa-2b) is covered for the treatment of chronic hepatitis C.
- Coverage is not provided for concurrent use of more than one interferon product.
- Coverage is provided for 12 months for the treatment of chronic hepatitis C.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must over ride criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Pegasys
Generic Name: Peginterferon Alfa-2A

Pegasys (peginterferon alfa-2a) Prior Authorization Criteria

- Coverage is provided for treatment of the following conditions:
 - Chronic Hepatitis B or Chronic hepatitis C in accord with the following:
 - Evidence of viral replication
 - Evidence of liver injury as determined by biopsy in situations where biopsy is not contraindicated or in situations where there are increased liver function tests (LFTs)
 - In the absence of contraindications to interferon therapy such as decompensated liver disease (i.e., situations where the liver associated side effects of interferon could potentially worsen a patient's condition)
- Coverage is not provided for concurrent use of more than one interferon product.
- Coverage is provided for 12 months for the treatment of chronic hepatitis C and for the treatment of chronic hepatitis B.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must over ride criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Procrit
Generic Name: Epoetin Alfa

Procrit (epoetin alfa) PA Criteria:

- Coverage for an erythropoietin product is provided for the following indications:
 - Anemia secondary to chronic renal failure or chronic renal insufficiency in accord with the following:
 - Hematocrit must be $\leq 33\%$ or hemoglobin ≤ 11 g/dL OR
 - Patient is symptomatic or has required transfusion
 - Benefit renewal coverage provided for hematocrit $\leq 36\%$ or hemoglobin ≤ 12 g/dL
 - For hematocrit $> 36\%$ or hemoglobin > 12 g/dL, physician must indicate that dose of erythropoietin is being held or titrated downward
 - Coverage duration is 6 months and is renewable
 - Secondary to HIV infection or HIV drug therapy in accord with the following:
 - Hematocrit must be $\leq 33\%$ or hemoglobin ≤ 11 g/dL OR
 - Patient is symptomatic or has required transfusion AND erythropoietin level is < 500 units/L
 - Benefit renewal coverage provided for hematocrit $\leq 36\%$ or hemoglobin ≤ 12 g/dL
 - For hematocrit $> 36\%$ or hemoglobin > 12 g/dL, physician must indicate that dose of erythropoietin is being held or titrated downward
 - Coverage duration is 4 months and is renewable
 - Chemotherapy induced anemia in accord with the following:
 - Hematocrit $\leq 30\%$ or hemoglobin ≤ 10 gm/dL
 - For hematocrit $> 36\%$ or hemoglobin > 12 gm/dL, the physician must indicate that dose of darbepoetin alfa is being held or titrated downward.
 - Coverage duration is 4 months and is renewable.
 - Anemia due to myelodysplasia in accord with the following:
 - Physician indicates that diagnosis of myelodysplasia is confirmed by bone marrow biopsy
 - Hematocrit must be $\leq 33\%$ or hemoglobin ≤ 11 g/dL
 - Coverage duration is 3 months and renewable in the presence of therapeutic benefit (e.g., improvement in symptoms), or if the hematocrit has increased or stabilized, or if the need for transfusions has decreased
 - Therapy to reduce the need for allogeneic blood transfusions in surgery patients in accord with the following:
 - Therapy must be for elective non-vascular or non-cardiac surgery
 - Patient refuses or cannot undergo autologous blood donation prior to surgery
 - Hemoglobin must be ≤ 13 gm/dL
 - Coverage duration is 1 month
 - Anemia due to ribavirin therapy in those with Hepatitis C in accord with the following:
 - Hgb level < 10 g/dL OR Hgb < 11 g/dL and symptomatic
 - Patient has been evaluated for iron deficiency anemia.
 - Anemia still persists within 2 weeks after reducing the dose of ribavirin OR patient has viral genotype 1 or 4 AND had a high viral load (> 2 million copies or more than 800,000 IU/mL) prior to the start of ribavirin therapy, and therefore dose reduction is inadvisable.
 - Epogen therapy should be initiated at a dose of 40,000 units weekly.
 - Coverage duration is 3 months and renewable in the presence of therapeutic benefit (e.g. improvement in symptoms), or if the hemoglobin level has increased or stabilized.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Pulmozyme
Generic Name: Dornase Alfa

Pulmozyme (dornase alfa) PA Criteria:

- Benefit coverage is provided for:
 - Use in the management of cystic fibrosis
 - Situations in which Pulmozyme (recombinant dornase alfa) is used in conjunction with standard therapies such as mechanical drainage or chest physiotherapy.
- Coverage duration is 12 months.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Razadyne
Generic Name: galantamine HBr

Razadyne (galantamine) PA Criteria:

- Benefit coverage of the generic is provided for palliative treatment of a progressive-type dementia (e.g., Alzheimer's type dementia).
- Benefit coverage is not provided for combination use among the Alzheimer's agents (except for galantamine HBr and Namenda (memantine)).
- Benefit coverage of the generic is for 12 months.
- Benefit renewal coverage is provided in situations where therapy continues to provide clinical benefit.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Remicade
Generic Name: Infliximab

Remicade (infliximab) PA Criteria:

- Prior to treatment, the patient must have been evaluated and where warranted, screened for the presence of latent TB infection (dates and results required)
- Coverage for Remicade (infliximab) is considered for the treatment of patients with:
 - Moderate to severe active Rheumatoid arthritis
 - If the patient has tried methotrexate with an inadequate response
 - If the patient has a contraindication to methotrexate
 - If the patient has tried/failed a DMARD other than methotrexate (eg: sulfasalazine, Plaquenil)
 - Psoriatic Arthritis
 - Moderate to severe Crohn's Disease
 - If the patient has tried/failed two or more of the following medications:
 - Aminosalicylates, 5-ASAs (*i.e.*, Sulfasalazine, Pentasa[®], Asacol[®], Colazal[®]).
 - Antibiotics (*i.e.*, Metronidazole, Ciprofloxacin).
 - Steroids (*i.e.*, prednisone, Entocort[®]).
 - Immunomodulators (*i.e.*, Azothioprine[®], 6-Mercaptopurine, Methotrexate[®])
 - Fistulizing Crohn's Disease
 - Ulcerative Colitis
 - Ankylosing Spondylitis
 - The patient must have active disease for at least four weeks as defined by both a sustained Bath AS Disease Activity Index (BASDAI) \geq 4cm and a Physician Global Assessment of 2 or greater on the Likert Scale.
 - If the patient has peripheral arthritis and has had an inadequate response or intolerability to at least two NSAIDs and had a lack of response or intolerability to one or more DMARDs (*i.e.*, sulfasalazine, methotrexate)
 - If the patient has axial or enthesitis and has had an inadequate response or intolerability to at least two NSAIDs
 - Coverage authorized for 8 weeks
 - Moderate to Severe Plaque Psoriasis
 - Coverage is provided if:
 - At least 10 to 100% of the patient's body is affected by the psoriasis, AND
 - The patient has tried at least two or more of the following treatments:
 - Topical therapy (*i.e.*, corticosteroids, coal tar, anthralin)
 - Phototherapy
 - Oral retinoid (*i.e.*, Soriatane, Tegison)
 - DMARD (*i.e.*, methotrexate, sulfasalazine)
 - Cyclosporine
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Remicade
 Generic Name: Infliximab

Remicade (infliximab) PA Criteria:

- Prior to treatment, the patient must have been evaluated and where warranted, screened for the presence of latent TB infection (dates and results required)
- Coverage for Remicade (infliximab) is considered for the treatment of patients with:
 - Moderate to severe active Rheumatoid arthritis
 - If the patient has tried methotrexate with an inadequate response
 - If the patient has a contraindication to methotrexate
 - If the patient has tried/failed a DMARD other than methotrexate (eg: sulfasalazine, Plaquenil)
 - Psoriatic Arthritis
 - Moderate to severe Crohn's Disease
 - If the patient has tried/failed two or more of the following medications:
 - Aminosalicylates, 5-ASAs (*i.e.*, Sulfasalazine, Pentasa[®], Asacol[®], Colazal[®]).
 - Antibiotics (*i.e.*, Metronidazole, Ciprofloxacin).
 - Steroids (*i.e.*, prednisone, Entocort[®]).
 - Immunomodulators (*i.e.*, Azathioprine[®], 6-Mercaptopurine, Methotrexate[®])
 - Fistulizing Crohn's Disease
 - Ulcerative Colitis
 - Ankylosing Spondylitis
 - The patient must have active disease for at least four weeks as defined by both a sustained Bath AS Disease Activity Index (BASDAI) \geq 4cm and a Physician Global Assessment of 2 or greater on the Likert Scale.
 - If the patient has peripheral arthritis and has had an inadequate response or intolerability to at least two NSAIDs and had a lack of response or intolerability to one or more DMARDs (*i.e.*, sulfasalazine, methotrexate)
 - If the patient has axial or enthesitis and has had an inadequate response or intolerability to at least two NSAIDs
 - Coverage authorized for 8 weeks
 - Moderate to Severe Plaque Psoriasis
 - Coverage is provided if:
 - At least 10 to 100% of the patient's body is affected by the psoriasis, AND
 - The patient has tried at least two or more of the following treatments:
 - Topical therapy (*i.e.*, corticosteroids, coal tar, anthralin)
 - Phototherapy
 - Oral retinoid (*i.e.*, Soriatane, Tegison)
 - DMARD (*i.e.*, methotrexate, sulfasalazine)
 - Cyclosporine
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Risperdal
 Generic Name: Risperidone

Risperdal (risperidone) PA Criteria:

- Risperdal (risperidone) 0.25mg, 0.5mg, and 1mg Low Dose Prior Authorizaion Criteria:
 - Risperidone 0.25mg, 0.5mg, or 1mg in members 18 to 60 years of age will be approved via prior authorization for Food and Drug Administration (FDA) approved indications, which include:
 - Bipolar Mania
 - Irritability associated with autistic disorder in children
 - Schizophrenia
- Risperdal (risperidone) in Children Less than 6 years of age Prior Authorization Criteria:
 - Coverage is provided for the following diagnoses when the medication is being prescribed by an appropriate specialist (including a Pediatric Neurologist, a Child and Adolescent Psychiatrist, or a Child Development Pediatrician) and chart documented evidence is provided of a comprehensive evaluation by the prescriber or in conjunction with a specialist listed above.
 - Autism, OR
 - Mental retardation, OR
 - Oppositional Defiant Disorder (ODD) with aggression, OR
 - Bipolar Disease, OR
 - Tourette's Syndrome, OR
 - Transient Encephalopathy
- Benefit is approved for 12 months.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Seroquel
Generic Name: Quetiapine Fumarate

Seroquel (quetiapine) PA Criteria:

- Seroquel 25mg, 50mg, and 100mg Low Dose Prior Authorization Criteria:
 - Seroquel 25mg, 50mg, or 100mg in members 18 to 60 years of age will be approved via prior authorization for Food and Drug Administration (FDA) approved indications, which include:
 - Bipolar Disorder
 - Schizophrenia
- Seroquel in Children Less than 6 years of age Prior Authorization Criteria:
 - Coverage is provided for the following diagnoses when the medication is being prescribed by an appropriate specialist (including a Pediatric Neurologist, a Child and Adolescent Psychiatrist, or a Child Development Pediatrician) and chart documented evidence is provided of a comprehensive evaluation by the prescriber or in conjunction with a specialist listed above.
 - Autism, OR
 - Mental retardation, OR
 - Oppositional Defiant Disorder (ODD) with aggression, OR
 - Bipolar Disease, OR
 - Tourette's Syndrome, OR
 - Transient Encephalopathy
- Benefit is approved for 12 months.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Suboxone
Generic Name: Buprenorphine/Naloxone

Suboxone (buprenorphine/naloxone) PA Criteria:

- Coverage is provided for the treatment of opioid dependence in the following situations:
 - The member is => 16 years of age
 - The member has been evaluated for any mental health conditions or there is evidence the member is actively filling behavioral health medications through pharmacy claims
 - The member has been referred or is participating in a substance abuse or behavioral health treatment program, behavioral health counseling, or an addictions recovery program. (During the initial course of treatment, referral and enrollment must be with a licensed Drug and Alcohol or behavioral health provider)
- Coverage duration is for 6 months dispensed at a maximum of 1 month intervals
- Benefit renewal is provided when:
 - The member has been consistently taking their Suboxone during the prior 6 months
 - The member had regular urine tests since the previous authorization (dates must be provided)
 - The member had consistent participation in a substance abuse or behavioral health treatment program, behavioral health counseling, or an addictions recovery program
 - If the member has a documented mental health condition, they are continuing to see behavioral health professional(s) and/or filling their behavioral health medications (through pharmacy claims) to address these conditions
- Benefit approved for an additional 6 months
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Subutex
Generic Name: Buprenorphine

Subutex (buprenorphine) PA Criteria:

- Coverage is provided for initial requests of Subutex when the member:
 - Has a diagnosis of Opioid Dependence
 - Is 16 years of age or older
 - The member has been evaluated for any mental health conditions or there is evidence the member is actively filling behavioral health medications through pharmacy claims
 - The member has been referred or is participating in a substance abuse or behavioral health treatment program, behavioral health counseling, or an addictions recovery program. (During the initial course of treatment, referral and enrollment must be with a licensed Drug and Alcohol or behavioral health provider)
- Coverage duration is for a maximum of up to 4 weeks

- Benefit renewal is provided when the member:
 - Has been consistently taking their Subutex during the prior 4 weeks
 - Received regular urine drug screens since the previous authorization (dates must be provided)
 - The member has had consistent participation in a substance abuse or behavioral health treatment program, behavioral health counseling, or an addictions recovery program
 - If the patient has a documented mental health condition, they are continuing to see behavioral health professional(s) and/or filling their behavioral health medications (through pharmacy claims) to address these conditions
- Benefit approved for an additional 1 month
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Synagis
Generic Name: Palivizumab

Synagis (palivizumab) PA Criteria:

- Benefit coverage is provided for the prevention of RSV infections in high-risk pediatric patients for:
 - A 5 months maximum (but auth should not exceed through March 31):
 - Infants =< 28 weeks, 6 days gestational at birth and <12 months of age on November 1
 - Infants between 29 weeks, 0 days and 31 weeks, 6 days gestational age at birth and < 6 months of age on November 1
 - Infants =< 34 weeks, 6 days gestational age at birth and < 12 months of age on November 1 with a congenital abnormality of the airway or neuromuscular condition that compromises respiratory secretions
 - Infants 2 years of age or younger with Chronic Lung Disease (CLD) and has required medical therapy (supplemental oxygen, bronchodilator, diuretic or corticosteroid therapy) for CLD within the past 6 months
 - Infants 2 years of age or younger and is diagnosed with hemodynamically significant Congenital Heart Disease (i.e. receiving medications to control CHF, moderate to severe pulmonary hypertension, cyanotic heart disease)
 - A 3 month maximum (but auth should not exceed through March 31). Prophylaxis would be discontinued at 3 months or 90 days old:
 - Infants between 32 weeks, 0 days and 34 weeks, 6 days gestational age at birth (and is =< 3 months of age on November 1) with at least one of the following risk factors:
 - Daycare attendance
 - Siblings < 5 years of age
- If any of the above requirements are met:
 - The initial authorization will be for 5 doses to cover the entire RSV season (November through April, last dose to be dispensed in March).
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Synvisc/Synvisc One
Generic Name: Hylan G-F 20

Synvisc (Intra-articular Hyaluronan Injection) PA Criteria:

- Coverage is provided for patients with symptomatic osteoarthritis of the knee, that interferes with activities of daily living, who have had an inadequate response to convention therapy listed below:
 - Analgesics (acetaminophen) or NSAIDs. If the patient has a contraindication to these medications it will be viewed as a treatment failure, and
 - Failure to respond to a physical therapy or physician directed exercise program. The patient's inability to tolerate an exercise program and their other medical conditions will be taken into account, and
 - Failure to respond or an inadequate response to an intra-articular corticosteroid injection.
- Coverage is provided for one knee treatment course at a time and treatment for the other knee will be considered after response to the first knee is assessed.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must over ride criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Victrelis
Generic Name: Boceprevir

Victrelis (boceprevir) Prior Authorization Criteria

- Benefit is approved when the following criteria is met:
 - The patient has Hepatitis C Virus, genotype 1 with compensated liver disease.
 - They do not have a co-infection with HIV and have not used Incivek or Victrelis in the past.
 - The patient's HCV RNA levels prior to treatment, their treatment status (naive, partial responder, relapser, or null responder), and the start date of triple therapy with ribavirin and peginterferon alfa will be documented
- Benefit is approved for a minimum of 12 weeks and a maximum of 44 weeks total
 - Initial: 12 weeks in duration at a dose of 800mg three times a day.
 - First reauthorization: an additional 12 weeks if HCV RNA is not > 100IU/mL
 - Second reauthorization: an additional 20 weeks if HCV RNA is not detectable at 24 weeks.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Voltaren Gel
Generic Name: Diclofenac Sodium

- Coverage provided when the following criteria has been met:
 - A diagnosis of osteoarthritis for utilization in joints amenable to topical treatment like knees and hands (not the spine, hip, or shoulder), AND
 - No utilization of oral NSAIDs in addition to the topical treatment to avoid the increased risk of adverse NSAID side effects.
 - A trial of at least two formulary oral NSAIDs like naproxen, diclofenac, ibuprofen, sulindac, piroxicam, meloxicam, ketoprofen, nabumetone, indomethacin, flurbiprofen, Celebrex, OR
 - The member is unable to take oral NSAIDs due to an underlying condition like gastrointestinal bleeding, a coagulation defect, chronic oral corticosteroid therapy, and concurrent therapy with an anticoagulant.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Brand Name: Zyprexa
Generic Name: Olanzapine

Zyprexa (olanzapine) PA Criteria:

- Zyprexa 2.5mg and 5mg Low Dose Prior Authorization Criteria:
 - Zyprexa 2.5mg and 5mg in members 18 to 60 years of age will be approved via prior authorization for Food and Drug Administration (FDA) approved indications, which include:
 - Bipolar Disorder
 - Schizophrenia
- Zyprexa in Children Less than 6 years of age Prior Authorization Criteria:
 - Coverage is provided for the following diagnoses when the medication is being prescribed by an appropriate specialist (including a Pediatric Neurologist, a Child and Adolescent Psychiatrist, or a Child Development Pediatrician) and chart documented evidence is provided of a comprehensive evaluation by the prescriber or in conjunction with a specialist listed above.
 - Autism, OR
 - Mental retardation, OR
 - Oppositional Defiant Disorder (ODD) with aggression, OR
 - Bipolar Disease, OR
 - Tourette's Syndrome, OR
 - Transient Encephalopathy
- Benefit is approved for 12 months.
- When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary