

Brand Name: **Accutane**
Generic Name: **Isotretinoin**

Accutane (isotretinoin) Prior Authorization Criteria

- Coverage provided for the treatment of the following:
 - Acne vulgaris and cystic acne unresponsive to a systemic antibiotic
 - Acne rosacea
 - Darier-White disease (Keratosis follicularis)
 - Hidradenitis suppurativa (acne inversa)
- Benefit is approved for 12 months.
- Both the patient, physician, and pharmacy must be registered with the iPledge program.

Brand Name: **Actimmune**
Generic Name: **Interferon Gamma-1B,Recomb.**

Actimmune (interferon gamma-1b) Prior Authorization Criteria

- Benefit is approved for the treatment of the following:
 - Chronic granulomatous disease
 - Osteopetrosis.
- Benefit is approved for 12 months.

Brand Name: **Adagen**
Generic Name: **Pegademase Bovine**

Adagen (pegademase bovine injection) Prior Authorization Criteria

- Coverage will be provided for enzyme replacement therapy for adenosine deaminase (ADA) deficiency in patients with severe combined immunodeficiency disease who are not suitable candidates for or who have failed bone marrow transplantation.
- Pegademase bovine is recommended for use in infants from birth or in children of any age at the time of diagnosis. It is not intended as a replacement for HLA identical bone marrow transplant therapy, and it is also not intended to replace continued close medical supervision and the initiation of appropriate diagnostic tests and therapy (eg, antibiotics, nutrition, oxygen, gammaglobulin) as indicated for intercurrent illnesses.
- Benefit is approved for 12 months.

Brand Name: **Adriamycin**
Generic Name: **Doxorubicin HCl**

Part B versus Part D

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

Brand Name: **Afinitor**
Generic Name: **Everolimus**

Afinitor (everolimus) Prior Authorization Criteria

- Coverage is provided for patients with advanced renal cell cancer who have failed treatment with Sutent (sunitinib) or Nexavar (sorafenib).
- Benefit is approved for 12 months.

Brand Name: **Aldurazyme**
Generic Name: **Laronidase**

Aldurazyme (laronidase) Injection Prior Authorization Criteria

- Coverage is provided for patients with Hurler and Hurler-Scheie forms of mucopolysaccharidosis I (MPS I) and for patients with the Scheie form who have moderate to severe symptoms as evidenced by a baseline forced vital capacity (FVC) less than or equal to 77% of predicted in order to improve pulmonary function and walking capacity.
- Coverage will be provided for quantities necessary to prepare a once weekly IV infusion of 0.58mg/kg.

- Benefit is approved for 12 months.

Brand Name: **Amevive**

Generic Name: **Alefacept**

Amevive (alefacept) Prior Authorization Criteria

- Coverage for Amevive (alefacept) is considered for the treatment of adult patients with moderate to severe chronic plaque psoriasis, with documentation of a PASI score or the percent of the patient's body affected, who have failed treatment with two or more of the following classes of medications: topical corticosteroids, phototherapy, oral retinoids, DMARDs, or cyclosporine.
- Coverage for Amevive (alefacept) is provided for 12 weeks and may be considered for an additional 12 weeks provided CD4+ T-cell counts are within the normal range, psoriasis is less than clear based on the Physician Global Assessment, and 12 weeks has elapsed from the end of the first treatment.

Brand Name: **Aminosyn**

Generic Name: **Amino Acids**

Part B versus Part D

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

Brand Name: **Anadrol-50**

Generic Name: **Oxymetholone**

Anadrol-50 (oxymetholone) Prior Authorization Criteria

- Coverage for Oxymetholone will be provided for the treatment of anemias caused by deficient red cell production. Acquired or congenital aplastic anemias, myelofibrosis, and/or hypoplastic anemias caused by the administration of myelotoxic drugs or hereditary angioedema.
- Oxymetholone should not replace other supportive measures, such as transfusion; correction of iron, folic acid, vitamin B₁₂, or pyridoxine deficiency; antibacterial therapy; and the appropriate use of corticosteroids.
- Coverage will be provided for 12 months duration.

Patients should be monitored for risks and side effects of anabolic steroid use including the following: Changes in blood lipids, decrease in HDL and increase in LDL, liver cell tumors and peliosis hepatic.

Brand Name: **Aranesp (25, 40 mcg)**

Generic Name: **Darbepoetin Alfa**

Aranesp (darbepoetin alfa) Prior Authorization Criteria

- Benefit is approved for the following indications:
 - Anemia due to chronic renal failure or chronic renal insufficiency, including patients on and not on dialysis with the following:
 - Hematocrit \leq 36% or hemoglobin \leq 12gm/dL OR
 - Patient is symptomatic or has required transfusion
 - Benefit renewal coverage provided for hematocrit \leq 36% or hemoglobin \leq 12gm/dL
 - For hematocrit $>$ 36% or hemoglobin $>$ 12 gm/dL, the physician must indicate that dose of erythropoietin is being held or titrated downward.
 - The patient's iron status should be evaluated and oral iron supplementation be initiated when transferrin saturation is less than 20% and/or ferritin less than 100 mcg/L.
 - Coverage duration is 4 months and is renewable.
 - Anemia due to chemotherapy in patients with nonmyeloid malignancies:
 - Hematocrit \leq 30% or hemoglobin \leq 10gm/dL
 - For hematocrit $>$ 36% or hemoglobin $>$ 12gm/dL, the physician must indicate that dose of darbepoetin alfa is being held or titrated downward.
 - Documentation of the patient's chemotherapy regimen if available.
 - The patient's iron status should be evaluated and oral iron supplementation be initiated when transferrin saturation is less than 20% and/or ferritin less than 100 mcg/L.
 - Coverage duration is 4 months and is renewable.

Brand Name: **Aranesp (60, 100, 150, 200, 300, 500-mcg)**

Generic Name: **Darbepoetin Alfa**

Aranesp (darbepoetin alfa) Prior Authorization Criteria

- Benefit is approved for the following indications:
 - Anemia due to chronic renal failure or chronic renal insufficiency, including patients on and not on dialysis with the following:
 - Hematocrit \leq 36% or hemoglobin \leq 12gm/dL OR
 - Patient is symptomatic or has required transfusion
 - Benefit renewal coverage provided for hematocrit \leq 36% or hemoglobin \leq 12gm/dL
 - For hematocrit $>$ 36% or hemoglobin $>$ 12 gm/dL, the physician must indicate that dose of erythropoietin is being held or titrated downward.
 - The patient's iron status should be evaluated and oral iron supplementation be initiated when transferrin saturation is less than 20% and/or ferritin less than 100 mcg/L.
 - Coverage duration is 4 months and is renewable.
 - Anemia due to chemotherapy in patients with nonmyeloid malignancies:
 - Hematocrit \leq 30% or hemoglobin \leq 10gm/dL
 - For hematocrit $>$ 36% or hemoglobin $>$ 12gm/dL, the physician must indicate that dose of darbepoetin alfa is being held or titrated downward.
 - Documentation of the patient's chemotherapy regimen if available.
 - The patient's iron status should be evaluated and oral iron supplementation be initiated when transferrin saturation is less than 20% and/or ferritin less than 100 mcg/L.
 - Coverage duration is 4 months and is renewable.

Brand Name: **Aredia**

Generic Name: **Pamidronate**

Aredia (pamidronate) Prior Authorization Criteria

- Benefit coverage is provided for the following conditions/dose ranges:
 - Hypercalcemia of malignancy
 - Osteolytic bone metastasis associated with breast cancer
 - Osteolytic lesions of multiple myeloma
 - Paget's disease
- Benefit is covered for 12 months duration.

Brand Name: **Aricept**

Generic Name: **Donepezil HCl**

Aricept (donepezil) Prior Authorization Criteria

- Benefit coverage is provided for palliative treatment of Alzheimer's type dementia.
- Benefit coverage is not provided for patients with purely stroke or vascular related dementia.
- Benefit coverage is not provided for combination with other cholinesterase inhibitors (except for donepezil and memantine).
- Benefit coverage is for 12 months.
- Renewal coverage is provided in situations where therapy continues to provide clinical benefit.

Brand Name: **Atrovent Inhalant Solution**

Generic Name: **Ipratropium Bromide**

Part B versus Part D

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

Brand Name: **Avonex**

Generic Name: **Interferon Beta-1A**

Avonex (interferon beta-1a) Prior Authorization 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.

Brand Name: **Banzel**
Generic Name: **Rufinamide**

Banzel (rufinamide) Prior Authorization Criteria

- Benefit is approved for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome in children 4 years and older and adults.
- When approved, benefit provided for 12 months in duration.
- 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: **Baraclude**
Generic Name: **Entecavir oral solution**

Baraclude (entecavir) Prior Authorization Criteria

- Benefit coverage is provided for treatment of chronic hepatitis B virus (HBV) infection in adults with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease.
- Coverage is provided if the patient previously attempted therapy with lamivudine and been resistant to, or failed such therapy
- If approved, the prescribing physician must be monitoring the patient for lactic acidosis and hepatomegaly steatosis while receiving therapy.
- Benefit coverage duration is 12 months.

Brand Name: **Baraclude**
Generic Name: **Entecavir tablets**

Baraclude (entecavir) Prior Authorization Criteria

- Benefit coverage is provided for treatment of chronic hepatitis B virus (HBV) infection in adults with evidence of active viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease.
- Coverage is provided if the patient previously attempted therapy with lamivudine and been resistant to, or failed such therapy
- If approved, the prescribing physician must be monitoring the patient for lactic acidosis and hepatomegaly steatosis while receiving therapy.
- Benefit coverage duration is 12 months.

Brand Name: **Betaseron**
Generic Name: **Interferon Beta-1B**

Betaseron (interferon beta-1b) Prior Authorization Criteria

- Coverage is provided for patients with a diagnosis of relapsing-remitting multiple sclerosis or secondary-progressive multiple sclerosis.
- 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 Betaseron or Avonex (interferon beta-1a) and Copaxone (glatiramer acetate) is not covered.

Brand Name: **Bleomycin Sulfate**
Generic Name: **Bleomycin Sulfate**

Part B versus Part D

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

Brand Name: **Botox**
Generic Name: **Botulinum Toxin Type A**

Botox (botulinum) Injection Prior Authorization Criteria

- Coverage for Botulinum toxin will be considered for patients with the following diagnoses:
 - Axillary hyperhidrosis:
 - For the treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents.
 - Cervical dystonia (CD):
 - For the treatment of CD in adults to decrease the severity of abnormal head position and neck pain associated with CD.
 - Strabismus and blepharospasm associated with dystonia:
 - For the treatment of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders.
- Benefit is approved for 12 months.

Brand Name: **Buphenyl**
Generic Name: **Sodium Phenylbutyrate**

Buphenyl (sodium phenylbutyrate) Prior Authorization Criteria

- Coverage is provided for:
 - 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).
 - Patients with neonatal-onset deficiency (complete enzymatic deficiency, presenting within the first 28 days of life).
 - Patients with late-onset disease (partial enzymatic deficiency, presenting after the first month of life) who have a history of hyperammonemic encephalopathy.

Benefit is approved for 12 months.

Brand Name: **Busulfex**
Generic Name: **Busulfan Inj**

Part B versus Part D

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

Brand Name: **Byetta**
Generic Name: **Exenatide**

Byetta (exenatide) Prior Authorization Criteria

- Coverage is provided for patients with type 2 diabetes mellitus that have not achieved adequate glycemic control while on metformin, a sulfonylurea, or a combination of metformin and a sulfonylurea as evidenced by a HA1C $\geq 7\%$.

Benefit is approved for 12 months.

Brand Name: **Campath**
Generic Name: **Alemtuzumab**

Campath (alemtuzumab) Injection Prior Authorization Criteria

- Coverage is approved for the treatment of B-cell chronic lymphocytic leukemia (B-CLL)
- Benefit will be approved for three times a week infusions for up to 12 weeks total.

Brand Name: **Camptosar**
Generic Name: **Irinotecan HCl**

Part B versus Part D

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

Brand Name: **Carboplatin**
Generic Name: **Carboplatin**

Part B versus Part D

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

Brand Name: **Ceredase**
Generic Name: **Alglucerase**

Ceredase (alglucerase) Injection Prior Authorization Criteria

- Coverage is approved for use as long-term enzyme replacement therapy for children, adolescents, and adults with a confirmed diagnosis of type 1 Gaucher disease who exhibit signs and symptoms that are severe enough to result in 1 or more of the following conditions: moderate to severe anemia, thrombocytopenia with bleeding tendency, bone disease, significant hepatomegaly, or splenomegaly.
- Benefit is approved for 12 months.

Brand Name: **Cerezyme**
Generic Name: **Imiglucerase**

Cerezyme (imiglucerase) Prior Authorization Criteria

- Benefit is approved for patients with the diagnosis of Type I Gaucher Disease with documentation of complications such as anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.
- Benefit is approved for 12 months duration.

Brand Name: **Chantix**

Generic Name: **Varenicline Tartrate**

Chantix (varenicline) Prior Authorization Criteria

- Benefit is approved for smoking cessation purposes in patients with nicotine withdrawal who had an adequate trial and failure of nicotine replacement therapy and bupropion (generic Zyban).
- Benefit duration is for 24 weeks.

Brand Name: **Chorionic Gonadotropin**

Generic Name: **Gonadotropin, Chorionic, Human**

Human Chorionic Gonadotropin (hCG) Prior Authorization Criteria

- Coverage is provided for:
 - Prepubertal cryptorchidism not caused by anatomic obstruction
 - Hypogonadism in males secondary to a pituitary deficiency.
- Coverage duration is 12 months.

Brand Name: **Cisplatin**

Generic Name: **Cisplatin**

Part B versus Part D

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

Brand Name: **Cladribine**

Generic Name: **Cladribine**

Part B versus Part D

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

Brand Name: **Copaxone**

Generic Name: **Glatiramer Acetate**

Copaxone (glatiramer acetate) Prior Authorization 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.

Brand Name: **Cromolyn Sodium**

Generic Name: **Cromolyn Sodium Inh Soln**

Part B versus Part D

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

Brand Name: **Cystagon**
Generic Name: **Cysteamine Bitartrate**

Cystagon (cysteamine) Prior Authorization Criteria

- Benefit is approved for the management of nephropathic cystinosis in children and adults.
- Benefit is approved for 12 months.

Brand Name: **Daunorubicin HCl**
Generic Name: **Daunorubicin HCl**

Part B versus Part D

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

Brand Name: **Dilaudid**
Generic Name: **Hydromorphone HCl Inj**

Part B versus Part D

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

Brand Name: **DuoNeb**
Generic Name: **Ipratropium/Albuterol Sulfate**

Part B versus Part D

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

Brand Name: **Duramorph**
Generic Name: **Morphine Sulfate/PF Inj**

Part B versus Part D

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

Brand Name: **Elaprase**
Generic Name: **Idursulfase**

Elaprase (idursulfase) Injection Prior Authorization Criteria

- Coverage is provided for patients with Hunter syndrome (mucopolysaccharidosis type II) with documented deficiency in iduronate-2-sulfatase enzyme activity that have a percent predicted forced vital capacity (%-predicted FVC) of less than 80% in order to improve walking capacity in these patients.
- Benefit is approved for 12 months.

Brand Name: **Elidel**
Generic Name: **Pimecrolimus**

Elidel (pimecrolimus) 1% Cream Prior Authorization Criteria

- Coverage is provided for Elidel (pimecrolimus) 1% Cream for the treatment of mild to moderate atopic dermatitis in those 2 years of age and older with documentation of trial and failure of one topical corticosteroid if between the ages of 2 and 17 or two topical corticosteroids if 18 years or older.
- Coverage duration is 12 months.

Brand Name: **Elitek**
Generic Name: **Rasburicase**

Elitek (rasburicase) Injection Prior Authorization Criteria

- Coverage is provided for the initial management of plasma uric acid levels in patients with leukemia, lymphoma, and solid tumor malignancies who are receiving anti-cancer therapy expected to result in tumor lysis and subsequent elevation of plasma uric acid.
- Coverage is provided for one five-day course of treatment only.

Brand Name: **Eloxatin**
 Generic Name: **Oxaliplatin**

Part B versus Part D

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

Brand Name: **Elspar**
 Generic Name: **Asparaginase**

Part B versus Part D

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

Brand Name: **Enbrel**
 Generic Name: **Etanercept**

Enbrel (etanercept) Prior Authorization 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 not provided in situations where the patient has not been evaluated and where warranted, screened for the presence of latent TB infection.
- Coverage is provided for the treatment of moderately- to severely-active polyarticular juvenile idiopathic arthritis (JIA) for children aged 2-17 who have tried and failed therapy with at least two non-steroidal anti-inflammatory drugs (NSAIDs).
- 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 ≥ 4 cm and a Physician Global Assessment score of > 2 on the Likert scale.
 - Inadequate response or intolerance to previous therapies tried and failed: NSAIDs and/or DMARDs
- Coverage is provided for the treatment of plaque psoriasis when patients have a PASI score ≥ 10 and have failed to respond to two or more of the following therapies:
 - Topical therapy
 - Phototherapy
 - Oral retinoids
 - DMARD
 - Cyclosporine
- Benefit approved for 12 months.

Brand Name: **Engerix-B**
 Generic Name: **Hep B Vir Vacc Recomb**

Part B versus Part D

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

Brand Name: **Epogen**
 Generic Name: **Epoetin Alfa**

Epogen (recombinant epoetin alfa) Prior Authorization 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 \leq 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 \leq 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 \leq 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 \leq 10gm/dL
 - For hematocrit $>$ 36% or hemoglobin $>$ 12gm/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 \leq 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 \leq 13 gm/dL
 - Coverage duration is 1 month

Brand Name: **Epogen (20,000 u)**

Generic Name: **Epoetin Alfa**

Epogen (recombinant epoetin alfa) Prior Authorization 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 \leq 11 g/dL OR
 - Patient is symptomatic or has required transfusion
 - Benefit renewal coverage provided for hematocrit \leq 36% or hemoglobin \leq 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 \leq 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 \leq 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 \leq 10gm/dL
 - For hematocrit $>$ 36% or hemoglobin $>$ 12gm/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 \leq 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 \leq 13 gm/dL
 - Coverage duration is 1 month

Brand Name: **Exelon**

Generic Name: **Rivastigmine Tartrate**

Exelon (rivastigmine) Prior Authorization Criteria

- Benefit coverage is provided for palliative treatment of Alzheimer's type dementia.
- Benefit coverage is not provided for patients with purely stroke or vascular related dementia.
- Renewal coverage is provided in situations where therapy continues to provide clinical benefit.
- Benefit coverage is for 12 months.

Brand Name: **Exjade**

Generic Name: **Deferasirox**

Exjade (deferasirox) Prior Authorization Criteria

- Benefit is approved for treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis) with a documented serum ferritin level.
- Benefit is approved for 12 months.

Brand Name: **Fabrazyme**

Generic Name: **Agalsidase Beta**

Fabrazyme (agalsidase beta) Prior Authorization Criteria

- Benefit coverage is provided for patients diagnosed with Fabry disease.
- Benefit is approved for 12 months.

Brand Name: **Fanapt**

Generic Name: **Iloperidone**

Fanapt (iloperidone) Prior Authorization Criteria

- Benefit coverage is provided for patients 18 years or older who are diagnosed with schizophrenia
 - Patients must have tried and failed or were intolerant to two or more atypical antipsychotics.
- Coverage will be provided for 12 months duration.

Brand Name: **Faslodex**

Generic Name: **Fulvestrant**

Faslodex (fulvestrant) Prior Authorization Criteria

- Coverage is provided for the treatment of hormone receptor positive metastatic breast cancer in postmenopausal women with disease progression following antiestrogen therapy.
- Benefit is approved for 12 months.

Brand Name: **Fentanyl Citrate**

Generic Name: **Fentanyl Citrate/PF Inj**

Part B versus Part D

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

Brand Name: **Fludarabine Phosphate**

Generic Name: **Fludarabine Phosphate**

Part B versus Part D

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

Brand Name: **Fluorouracil**

Generic Name: **Fluorouracil Inj**

Part B versus Part D

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

Brand Name: **Fungizone IV**

Generic Name: **Amphotericin B**

Part B versus Part D

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

Brand Name: **Gamunex**

Generic Name: **Immune Glob, Gam Caprylate**

Intravenous Immunoglobulin (IVIG) Prior Authorization Criteria

- Coverage is provided for Primary immunodeficiencies under Part B.
- Coverage is provided under Part D for:
 - Idiopathic thrombocytopenia purpura in adults with a platelet count <30,000 and rationale for use.
 - Kawasaki disease when the following are met:
 - Fever present for at least five days; and
 - Must be on concurrent aspirin therapy; and
 - At least four of the following conditions are met:
 - Mucous membrane changes such as strawberry tongue and dry fissured lips without discrete lesions
 - Changes in the extremities such as edema of the hands and feet
 - Enlarged lymph nodes in the neck
 - Diffuse red rash covering most of the body
 - Redness of the eyes
- Hematopoietic stem cell transplantation (HSCT) when the following conditions are met:
 - Not Autologous HSCT
 - Meet one of the following criteria
 - IVIG is medically necessary for treatment of severe GVHD in persons receiving matched HLA allogeneic Bone marrow transplant
 - IVIG is medically necessary for prophylaxis treatment against infection in persons with hypogammaglobulinemia (IgG level < 400mg/dL)
- Chronic Lymphocytic Leukemia (CLL) when the following conditions are met:
 - Anemia and/or low platelet count.
 - Disease-related symptoms such as weakness, night sweats, weight loss, painful lymph node swelling, or fever.
 - Progressive disease, as demonstrated by rapidly increasing white cells in the blood, and/or rapidly enlarging lymph nodes, spleen, or liver.
 - Repeated infections.
- Pediatric HIV Type 1 infection when the following are met:
 - CD-4 lymphocyte count $\geq 200/\text{mm}^3$
 - IgG level < 400mg/dL
- Coverage Duration is one year.

Brand Name: **Gardasil**

Generic Name: **Human Papillomavirus Vaccine**

Gardasil (recombinant human papillomavirus) Vaccine Prior Authorization Criteria

- Coverage will be provided automatically without requiring coverage review for females 9 to 26 years of age for the prevention of diseases caused by the human papillomavirus (HPV) types 6, 11, 16 and 18.
- Benefit is approved for 6 months.

Brand Name: **Gleevec**

Generic Name: **Imatinib Mesylate**

Gleevec (imatinib) Prior Authorization Criteria

- Benefit coverage is provided for treatment of:
 - Acute lymphoblastic leukemia (ALL)
 - Adults with relapsed or refractory Philadelphia chromosome-positive ALL
 - Aggressive systemic mastocytosis (ASM)
 - Adults with ASM without the D816V c-Kit mutation or with c-Kit mutational status unknown.
 - Chronic myeloid leukemia (CML)
 - Newly diagnosed adults and children with Ph+CML in chronic phase, blast crisis, accelerated phase, or in chronic phase after failure of interferon alpha therapy
 - Treatment of children with Ph+ chronic phase CML whose disease has recurred after stem-cell transplant or who are resistant to interferon alpha therapy.
 - Dermatofibrosarcoma protuberans (DFSP)
 - Adults with unresectable, recurrent, and/or metastatic DFSP
 - GI stromal tumors (GIST)

- Kit (CD117) positive, unresectable and/or metastatic malignant GIST
 - Hypereosinophilic syndrome (HES) and/or Chronic eosinophilic leukemia (CEL)
 - Adults with HES and/or CEL who have the FIP1L1-PDGFR alpha fusion kinase (mutational analysis or FISH demonstration of CHIC2 allele deletion)
 - Patients with HES and/or CEL who are FIP1L1-PDGFR alpha fusion kinase negative or unknown
 - Myelodysplastic / myeloproliferative diseases (MDS/MPD)
 - Adults with MDS/MPD associated with platelet-derived growth factor receptor gene rearrangements.
- Benefit coverage is provided in situations where the treatment is initiated by a hematologist-oncologist.
- Benefit coverage duration is 12 months.

Brand Name: **Humira**

Generic Name: **Adalimumab**

Humira (adalimumab) Prior Authorization 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 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.*, Azothioprine[®], 6-Mercaptopurine, Methotrexate[®])
- Coverage is provided for a diagnosis of moderate to severe plaque psoriasis
 - Must have tried/failed 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 it is prescribed by a rheumatologist and the patient has tried and failed methotrexate for 40mg every other week
- 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.

Brand Name: **Hycamtin**

Generic Name: **Topotecan HCl**

Part B versus Part D

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

Brand Name: **Idarubicin HCl**

Generic Name: **Idarubicin HCl**

Part B versus Part D

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

Brand Name: **Infergen**

Generic Name: **Interferon Alfacon-1**

Infergen (interferon alfacon-1) Prior Authorization Criteria

- Covered uses for Infergen (interferon alfacon-1) include:
 - 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)

- Coverage is not provided for concurrent use of more than one interferon product.
- Coverage is provided for 6 months for the treatment of chronic hepatitis C.

Brand Name: **Infumorph**

Generic Name: **Morphine Sulfate/PF**

Part B versus Part D

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

Brand Name: **Intron A (3mmu pen)**

Generic Name: **Interferon Alfa-2B, Recomb.**

Intron-A (recombinant interferon alfa-2b) Prior Authorization Criteria

- Coverage is provided for treatment of the following conditions:
 - Chronic hepatitis B
 - 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)
 - Chronic myelogenous leukemia (CML)
 - Essential thrombocythemia
 - Hairy cell leukemia
 - Kaposi's sarcoma
 - Sarcoma in the presence of a T-cell count $\geq 400/\text{mm}^3$ and in the absence of opportunistic infections.
 - Multiple myeloma
 - Non-Hodgkin's Lymphoma
 - Condyloma acuminata (genital warts)
 - In situations where conventional therapy (e.g., podophyllin or cryotherapy) has not been effective.
 - Renal cell carcinoma
- Coverage is not provided for concurrent use of more than one interferon product.
Coverage is provided for 6 months.

Brand Name: **Intron A (vials; 5, 10 mmu pens)**

Generic Name: **Interferon Alfa-2B, Recomb.**

Intron-A (recombinant interferon alfa-2b) Prior Authorization Criteria

- Coverage is provided for treatment of the following conditions:
 - Chronic hepatitis B
 - 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)
 - Chronic myelogenous leukemia (CML)
 - Essential thrombocythemia
 - Hairy cell leukemia
 - Kaposi's sarcoma
 - Sarcoma in the presence of a T-cell count $\geq 400/\text{mm}^3$ and in the absence of opportunistic infections.
 - Multiple myeloma
 - Non-Hodgkin's Lymphoma
 - Condyloma acuminata (genital warts)
 - In situations where conventional therapy (e.g., podophyllin or cryotherapy) has not been effective.
 - Renal cell carcinoma
- Coverage is not provided for concurrent use of more than one interferon product.
Coverage is provided for 6 months.

Brand Name: **Invega**

Generic Name: **Paliperidone**

Invega (paliperidone) Prior Authorization Criteria

- Benefit coverage is provided for patients 18 years or older who are diagnosed with schizophrenia or schizoaffective disorder
 - Patients must have tried and failed or were intolerant to two or more atypical antipsychotics, one of which is risperidone.

- Coverage will be provided for 12 months duration.

Brand Name: **Invega Sustenna (117mg, 156mg, 234mg)**

Generic Name: **Paliperidone palmitate**

Invega Sustenna (paliperidone injection) Prior Authorization Criteria

- Coverage will be provided for the maintenance treatment of schizoaffective disorder as monotherapy or as an adjunct to mood stabilizers and/or antidepressants in patients unable to be maintained on oral paliperidone.
- Coverage will be provided for the treatment of schizophrenia in patients unable to be maintained on oral paliperidone.
- Coverage duration is 12 months.

Brand Name: **Invega Sustenna (39mg, 78mg)**

Generic Name: **Paliperidone palmitate**

Invega Sustenna (paliperidone injection) Prior Authorization Criteria

- Coverage will be provided for the maintenance treatment of schizoaffective disorder as monotherapy or as an adjunct to mood stabilizers and/or antidepressants in patients unable to be maintained on oral paliperidone.
- Coverage will be provided for the treatment of schizophrenia in patients unable to be maintained on oral paliperidone.
- Coverage duration is 12 months.

Brand Name: **Kepivance**

Generic Name: **Palifermin**

Kepivance (palifermin) Prior Authorization Criteria

- Coverage is provided to decrease the incidence and duration of severe oral mucositis in patients with hematologic malignancies who are receiving myelotoxic therapy requiring hematopoietic stem cell support.
 - Coverage will not be provided for the treatment of patients with non-hematologic malignancies.
 - Coverage will be provided only when prescribed by a hematologist/oncologist.
- Coverage duration is 12 months.

Brand Name: **Kineret**

Generic Name: **Anakinra**

Kineret (anakinra) Prior Authorization Criteria

- Benefit is approved for patients 18 years of age and older for the treatment of moderate to severe rheumatoid arthritis after the patient has tried and failed treatment with 1 or more disease modifying antirheumatic drugs (DMARDs).
 - Examples of DMARDs include methotrexate, azothiaprime, Plaquenil
- Benefit will not be approved if Kineret is to be used in combination with another Tumor Necrosis Factor (TNF) Blocking Agents. (*i.e.*, Humira, Enbrel, Remicade)
- Coverage is not provided in situations where the patient has not been evaluated and where warranted, screened for the presence of latent TB infection.
- Benefit coverage is 12 months in duration.

Brand Name: **Kuvan**

Generic Name: **Sapropterin Dihydrochloride**

Kuvan (sapropterin dihydrochloride) Prior Authorization Criteria

- Coverage is provided for patients with a diagnosis of hyperphenylalaninemia for three months initially.
- Authorization may be renewed for up to 12 months duration upon documentation the patient is responding to treatment with Kuvan as evidenced by lowering of their Phe levels.
- Patients taking Kuvan must continue to follow a Phe restricted diet and have their blood Phe levels monitored.

Brand Name: **Leucovorin Calcium (inj)**

Generic Name: **Leucovorin Calcium**

Part B versus Part D

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

Brand Name: **Leukine**

Generic Name: **Sargramostim**

Leukine (sargramostim) Prior Authorization Criteria

- Coverage for sargramostim 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)
- 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 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

Brand Name: **Lidoderm**
 Generic Name: **Lidocaine**

Lidoderm (lidocaine) Prior Authorization Criteria

- Coverage is provided for patients with a diagnosis of post-herpetic neuralgia.
- Coverage will be provided for 12 months duration.

Brand Name: **Lotronex**
 Generic Name: **Alosetron HCl**

Lotronex (alosetron) Prior Authorization Criteria

- Benefit is approved for treatment of severe diarrhea predominant irritable bowel syndrome (IBS) in female patients 18 or older that have failed to respond to conventional therapy.
- IBS symptoms should be chronic in nature (generally lasting 6 months or longer).
- The prescribing physician must be enrolled in the Prescribing Program for Lotronex.
- Coverage is not provided as a first line treatment.
- Coverage is not provided for patients with chronic or severe constipation or sequelae from constipation, intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation and/or adhesions, ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state, patients diagnosed with Crohn's disease, ulcerative colitis, diverticulitis, or severe hepatic impairment.
- Coverage duration is 12 months.

Brand Name: **Lupron**
 Generic Name: **Leuprolide Acetate**

Lupron (leuprolide acetate) Prior Authorization Criteria

- Benefit coverage is provided for:
 - The treatment of advanced prostatic cancer
 - Endometriosis confirmed by laparoscopy in patients who have failed patient failed or has a contraindication to conventional medical treatment such as oral contraceptives, non steroidal anti-inflammatory agents, progestins or danazol.
 - Uterine leiomyomata resistant to conventional treatment
 - Must provide documentation that the presence of anemia due to a fibroid is delaying a hysterectomy and the patient has failed a one month trial of iron therapy or that therapy is intended to be used preoperatively to shrink the fibroid(s) to allow a less invasive surgical approach other than abdominal hysterectomy.
 - Central precocious puberty
 - Documentation of onset of sexual characteristics, documentation that the diagnosis of CPP was confirmed by a pubertal response to a GnRH / Lupron stimulations test performed by a pediatric endocrinologist and documentation of the following tests:
 - Baseline evaluation including height, weight, sex steroid levels, adrenal steroid level to exclude congenital adrenal hyperplasia, Neuro-imaging (CT or MRI) of the head to rule out intracranial tumor, and If a male child, Beta human chorionic gonadotropin level to rule out a chorionic gonadotropin secreting tumor.
 - Premenopausal women with advanced breast cancer
 - Pelvic pain without a diagnosis of endometriosis resistant to conventional treatment
 - Documentation that the pelvic pain occurred for more than 6 months with a negative impact of the patient's quality of life

- The patient failed conventional medical treatment such as oral contraceptives, non steroidal anti-inflammatory agents, progestins or danazol,
 - STDs were excluded, abnormalities of the urinary, gastrointestinal and musculoskeletal systems ruled out as sources of pelvic pain
 - The patient's psychologic and psychosexual status been evaluated to rule out nonsomatic causes of the pelvic pain.
- Benefit is covered for 12 months duration.

Brand Name: **Lupron Depot**
 Generic Name: **Leuprolide Acetate**

Lupron (leuprolide acetate) Prior Authorization Criteria

- Benefit coverage is provided for:
 - The treatment of advanced prostatic cancer
 - Endometriosis confirmed by laparoscopy in patients who have failed patient failed or has a contraindication to conventional medical treatment such as oral contraceptives, non steroidal anti-inflammatory agents, progestins or danazol.
 - Uterine leiomyomata resistant to conventional treatment
 - Must provide documentation that the presence of anemia due to a fibroid is delaying a hysterectomy and the patient has failed a one month trial of iron therapy or that therapy is intended to be used preoperatively to shrink the fibroid(s) to allow a less invasive surgical approach other than abdominal hysterectomy.
 - Central precocious puberty
 - Documentation of onset of sexual characteristics, documentation that the diagnosis of CPP was confirmed by a pubertal response to a GnRH / Lupron stimulations test performed by a pediatric endocrinologist and documentation of the following tests:
 - Baseline evaluation including height, weight, sex steroid levels, adrenal steroid level to exclude congenital adrenal hyperplasia, Neuro-imaging (CT or MRI) of the head to rule out intracranial tumor, and If a male child, Beta human chorionic gonadotropin level to rule out a chorionic gonadotropin secreting tumor.
 - Premenopausal women with advanced breast cancer
 - Pelvic pain without a diagnosis of endometriosis resistant to conventional treatment
 - Documentation that the pelvic pain occurred for more than 6 months with a negative impact of the patient's quality of life
 - The patient failed conventional medical treatment such as oral contraceptives, non steroidal anti-inflammatory agents, progestins or danazol,
 - STDs were excluded, abnormalities of the urinary, gastrointestinal and musculoskeletal systems ruled out as sources of pelvic pain
 - The patient's psychologic and psychosexual status been evaluated to rule out nonsomatic causes of the pelvic pain.
- Benefit is covered for 12 months duration.

Brand Name: **Lupron Depot-Ped**
 Generic Name: **Leuprolide Acetate**

Lupron (leuprolide acetate) Prior Authorization Criteria

- Benefit coverage is provided for:
 - The treatment of advanced prostatic cancer
 - Endometriosis confirmed by laparoscopy in patients who have failed patient failed or has a contraindication to conventional medical treatment such as oral contraceptives, non steroidal anti-inflammatory agents, progestins or danazol.
 - Uterine leiomyomata resistant to conventional treatment
 - Must provide documentation that the presence of anemia due to a fibroid is delaying a hysterectomy and the patient has failed a one month trial of iron therapy or that therapy is intended to be used preoperatively to shrink the fibroid(s) to allow a less invasive surgical approach other than abdominal hysterectomy.
 - Central precocious puberty
 - Documentation of onset of sexual characteristics, documentation that the diagnosis of CPP was confirmed by a pubertal response to a GnRH / Lupron stimulations test performed by a pediatric endocrinologist and documentation of the following tests:
 - Baseline evaluation including height, weight, sex steroid levels, adrenal steroid level to exclude congenital adrenal hyperplasia, Neuro-imaging (CT or MRI) of the head to rule out intracranial tumor, and If a male child, Beta human chorionic gonadotropin level to rule out a chorionic gonadotropin secreting tumor.
 - Premenopausal women with advanced breast cancer
 - Pelvic pain without a diagnosis of endometriosis resistant to conventional treatment
 - Documentation that the pelvic pain occurred for more than 6 months with a negative impact of the patient's quality of life
 - The patient failed conventional medical treatment such as oral contraceptives, non steroidal anti-inflammatory agents, progestins or danazol,
 - STDs were excluded, abnormalities of the urinary, gastrointestinal and musculoskeletal systems ruled out as sources of pelvic pain
 - The patient's psychologic and psychosexual status been evaluated to rule out nonsomatic causes of the pelvic pain.

- Benefit is covered for 12 months duration.

Brand Name: **Mesna**
Generic Name: **Mesna Inj**

Part B versus Part D

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

Brand Name: **Methotrexate**
Generic Name: **Methotrexate Sodium**

Part B versus Part D

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

Brand Name: **Methotrexate**
Generic Name: **Methotrexate Sodium Inj**

Part B versus Part D

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

Brand Name: **Morphine Sulfate**
Generic Name: **Morphine Sulfate Inj**

Part B versus Part D

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

Brand Name: **Myobloc**
Generic Name: **Botulinum Toxin Type B**

Botox (botulinum) Injection Prior Authorization Criteria

- Coverage for Botulinum toxin will be considered for patients with the following diagnoses:
 - Axillary hyperhidrosis:
 - For the treatment of severe primary axillary hyperhidrosis that is inadequately managed with topical agents
 - Cervical dystonia (CD):
 - For the treatment of CD in adults to decrease the severity of abnormal head position and neck pain associated with CD.
 - Strabismus and blepharospasm associated with dystonia:
 - For the treatment of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders.
- Benefit is approved for 12 months.

Brand Name: **Naglazyme**
Generic Name: **Galsulfase**

Naglazyme (galsulfase) Injection Prior Authorization Criteria

- Coverage is provided for patients with mucopolysaccharidosis VI (MPS VI; Maroteaux-Lamy syndrome) in order to improve walking and stair-climbing capacity.
- Patient's weight must be documented for the appropriate dose.
- Coverage is provided for 12 months.

Brand Name: **Namenda**
Generic Name: **Memantine HCl**

Namenda (memantine) Prior Authorization Criteria

- Benefit is approved for treatment of moderate to severe Alzheimer's type dementia.
- Benefit is approved for 12 months.

Brand Name: **Neulasta**

Generic Name: **Pegfilgrastim**

Neulasta (pegfilgrastim) Prior Authorization Criteria

- Coverage is provided for
 - Neutropenia in patients with non-myeloid malignancies receiving myelosuppressive chemotherapy agents.
 - Secondary prevention of antineoplastic chemotherapy related neutropenia (situation where the patient has previously experienced neutropenia from antineoplastic agents).
 - 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.
- Documentation that the patient previously experienced febrile neutropenia (low white cell count) or a severe drop in absolute neutrophil count from antineoplastic chemotherapy agents or is at risk for developing antineoplastic chemotherapy related neutropenia as indicated by the presence of any of the following:
 - Pre-existing neutropenia due to disease, history of febrile neutropenia related to chemotherapy drugs,
 - Previous radiation therapy to areas containing large amounts of bone marrow (such as the pelvis),
 - Patient at risk for serious infection,
 - Expected incidence of myelosuppressive chemotherapy-induced neutropenia is greater than 40%.
- Chemotherapy cycle length is required
- Coverage duration is 6 months duration.

Brand Name: **Neumega**

Generic Name: **Oprelvekin**

Neumega (oprelvekin) Prior Authorization Criteria

- Coverage is provided for the prevention of severe thrombocytopenia in patients with non-myeloid malignancy who have experienced severe thrombocytopenia (e.g., platelet count $\leq 20,000/\mu\text{L}$). Previous or current platelet count is required.
- Benefit is not covered for the prevention of thrombocytopenia due to other medical conditions.
- Coverage duration is 6 months.

Brand Name: **Neupogen**

Generic Name: **Filgrastim**

Neupogen (filgrastim) Prior Authorization Criteria

- Coverage for 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)
- 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 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

Brand Name: **Nexavar**

Generic Name: **Sorafenib Tosylate**

Nexavar (sorafenib) Prior Authorization Criteria

- Benefit coverage is provided for the treatment of advanced renal cell carcinoma.
- Benefit coverage is provided for the treatment of unresectable hepatocellular carcinoma.
- Coverage duration is 12 months.

Brand Name: **Norditropin**
 Generic Name: **Somatropin**

Norditropin Nordiflex (somatropin) Prior Authorization 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 through wrist film evaluation
 - 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 $\geq 4.5\text{ cm/yr}$ (pre-pubertal growth phase) or $\geq 2.5\text{ cm/yr}$ (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 $< 2500\text{ g}$ 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 (provocative tests not required)
 - Treatment of Prader-Willi syndrome (provocative tests not required)
 - Noonan's Syndrome
- Coverage is provided for adult growth hormone deficiency, in the presence of a growth hormone stimulation test with a negative response to a growth stimulation test:
 - Childhood onset growth hormone deficiency
 - Pituitary or hypothalamic disease
 - Surgery or radiation therapy
 - Trauma
- Coverage is not provided for idiopathic or familial short stature or constitutional delayed growth.
- Coverage Duration is 6 months.

Brand Name: **Oncaspar**
 Generic Name: **Pegaspargase**

Part B versus Part D

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

Brand Name: **Ontak**
 Generic Name: **Denileukin Diftitox**

Ontak (denileukin diftitox) Prior Authorization Criteria

- Coverage is provided for patients with cutaneous T-cell lymphoma whose malignant cells express the CD25 component of interleukin-2 receptor.
- Coverage must be requested by an oncologist in a facility that is equipped and staffed for cardiopulmonary resuscitation, and where the patient can be closely monitored for an appropriate period based on his or her health.
- Coverage duration is 12 months.

Brand Name: **Orfadin**
 Generic Name: **Nitisinone**

Orfadin (nitisinone) Injection Prior Authorization Criteria

- Coverage will be provided for nitisinone as an adjunct to dietary restriction of tyrosine and phenylalanine in the treatment of tyrosinemia type 1 (hereditary tyrosinemia).
- Coverage will be provided for 12 months duration.

Brand Name: **Oxandrin**

Generic Name: **Oxandrolone**

Oxandrin (oxandrolone) Injection Prior Authorization Criteria

- Coverage for oxandrolone will be provided for the treatment of catabolic or tissue-depleting processes due to conditions such as chronic infections, extensive surgery, burns or severe trauma which require reversal of catabolic processes or protein-sparing effects when conventional treatment fails.
- Coverage will be provided for 12 months duration.

Brand Name: **Paclitaxel**

Generic Name: **Paclitaxel, Semi-Synthetic**

Part B versus Part D

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

Brand Name: **PEG-Intron**

Generic Name: **Peginterferon Alfa-2B**

Peg-Intron (peginterferon alfa-2b) Prior Authorization 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)
- Coverage is not provided for concurrent use of more than one interferon product.
- Coverage is provided for 6 months for the treatment of chronic hepatitis C.

Brand Name: **Pegasys**

Generic Name: **Peginterferon Alfa-2A**

Pegasys (peginteron alfa-2a) Prior Authorization Criteria

- Coverage is provided for treatment of the following conditions:
 - Chronic hepatitis B
 - Chronic hepatitis C as indicated by a positive hepatitis C viral load in accord with the following:
 - Patient has tried and failed Peg-Intron
 - 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 6 months for the treatment of chronic hepatitis C and chronic hepatitis B.

Brand Name: **Polygam S-D**

Generic Name: **Immune Globulin, Gamma**

Intravenous Immunoglobulin (IVIG) Prior Authorization Criteria

- Coverage is provided for Primary immunodeficiencies under Part B.
- Coverage is provided under Part D for:
 - Idiopathic thrombocytopenia purpura in adults with a platelet count <30,000 and rationale for use.
 - Kawasaki disease when the following are met:
 - Fever present for at least five days; and
 - Must be on concurrent aspirin therapy; and
 - At least four of the following conditions are met:
 - Mucous membrane changes such as strawberry tongue and dry fissured lips without discrete lesions
 - Changes in the extremities such as edema of the hands and feet
 - Enlarged lymph nodes in the neck
 - Diffuse red rash covering most of the body
 - Redness of the eyes
- Hematopoietic stem cell transplantation (HSCT) when the following conditions are met:
 - Not Autologous HSCT
 - Meet one of the following criteria

- IVIG is medically necessary for treatment of severe GVHD in persons receiving matched HLA allogeneic Bone marrow transplant
- IVIG is medically necessary for prophylaxis treatment against infection in persons with hypogammaglobulinemia (IgG level < 400mg/dL)
- Chronic Lymphocytic Leukemia (CLL) when the following conditions are met:
 - Anemia and/or low platelet count.
 - Disease-related symptoms such as weakness, night sweats, weight loss, painful lymph node swelling, or fever.
 - Progressive disease, as demonstrated by rapidly increasing white cells in the blood, and/or rapidly enlarging lymph nodes, spleen, or liver.
 - Repeated infections.
- Pediatric HIV Type 1 infection when the following are met:
 - CD-4 lymphocyte count $\geq 200/\text{mm}^3$
 - IgG level < 400mg/dL
- Coverage Duration is one year.

Brand Name: **Procrit (10,000; 20,000; 40,000- u/ml)**

Generic Name: **Epoetin Alfa**

Procrit (recombinant epoetin alfa) Prior Authorization 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 > 12gm/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.

Brand Name: **Procrit (3,000 u/ml)**

Generic Name: **Epoetin Alfa**

Procrit (recombinant epoetin alfa) Prior Authorization 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 < 30% or hemoglobin < 10gm/dL
 - For hematocrit > 36% or hemoglobin > 12gm/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 ≤ 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.

Brand Name: **Prolastin**

Generic Name: **Alpha-1 Proteinase Inhibitor**

Prolastin (alpha-1 proteinase inhibitor) Prior Authorization Criteria

- Coverage is provided for the following:
 - Congenital alpha₁-proteinase inhibitor (alpha₁-PI;alpha₁-antitrypsin) deficiency
- Coverage is provided for 12 months duration.

Brand Name: **Proleukin**

Generic Name: **Aldesleukin**

Proleukin (aldesleukin) Prior Authorization Criteria

- Benefit is approved for treatment of adults with metastatic renal cell carcinoma (metastatic RCC) or metastatic melanoma.
 - Benefit will only be approved for patients with normal cardiac and pulmonary functions as defined by thallium stress testing and formal pulmonary function testing.
- Benefit is approved for 12 months.

Brand Name: **Provigil**

Generic Name: **Modafanil**

Provigil (modafinil) Prior Authorization Criteria

- Benefit coverage is considered for:
 - People who meet the international classification of sleep disorders (ICSD) and DSM-IV criteria for a diagnosis of narcolepsy **and** failed 2 or more of the following: methylphenidate, Adderall (short or long-acting).
 - A diagnosis of obstructive sleep apnea/hypopnea who have:
 - Excessive sleepiness or insomnia
 - Frequent episodes of impaired breathing during sleep & associated features such as loud snoring, morning headaches, & dry mouth upon awakening
 - Polysomnography demonstrating > 5 obstructive apneas or 1 or more of the following: frequent arousals from sleep associated with the apneas, brady/tachycardia, & arterial oxygen desaturation in association with the apneas;
 - Evidence that the pt has been using their CPAP machine for at least 4 hours a night on at least 70% of nights and symptoms still persist;
 - Shift-work sleep disorder
 - Complaining of excess sleepiness or insomnia temporarily associated with a work period of at least 10 nights a month that occurs during the habitual sleep phase
 - A polysomnography and multiple sleep latency test (MSLT) scores that demonstrate loss of normal sleep/wake pattern
 - A score of at least 10 on the EPWORTH sleepiness scale.
- Benefit coverage is for 12 months.

Brand Name: **Pulmicort Respules**

Generic Name: **Budesonide Inh Soln**

Part B versus Part D

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

Brand Name: **Pulmozyme**
Generic Name: **Dornase Alfa**

Pulmozyme (recombinant dornase alfa) Prior Authorization Criteria

- Benefit coverage is considered for:
 - 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.
- Benefit coverage duration is 12 months.

Brand Name: **Ranexa**
Generic Name: **Ranolazine**

Ranexa (ranolazine) Prior Authorization Criteria

- Coverage is provided for patients with chronic angina when a patient is still experiencing increased frequency of angina episodes or intolerable side effects to their current therapy.
- Ranexa is being prescribed by or recommended by a cardiologist.
- Coverage duration is 12 months.

Brand Name: **Razadyne**
Generic Name: **Galantamine HBr**

Razadyne ER (galantamine) Prior Authorization Criteria

- Benefit coverage is provided for palliative treatment of Alzheimer's type dementia.
- Benefit coverage is not provided for patients with purely stroke or vascular related dementia.
- Benefit coverage is not provided for combination with other cholinesterase inhibitors (except for donepezil and memantine).
- Benefit coverage is for 12 months.
- Renewal coverage is provided in situations where therapy continues to provide clinical benefit.

Brand Name: **Razadyne ER**
Generic Name: **Galantamine HBr**

Razadyne ER (galantamine) Prior Authorization Criteria

- Benefit coverage is provided for palliative treatment of Alzheimer's type dementia.
- Benefit coverage is not provided for patients with purely stroke or vascular related dementia.
- Benefit coverage is not provided for combination with other cholinesterase inhibitors (except for donepezil and memantine).
- Benefit coverage is for 12 months.
- Renewal coverage is provided in situations where therapy continues to provide clinical benefit.

Brand Name: **Recombivax**
Generic Name: **Hep B Vir Vacc Recomb**

Part B versus Part D

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

Brand Name: **Regranex**
Generic Name: **Becaplermin**

Regranex (becaplermin) Prior Authorization Criteria

- Benefit is approved for use in patients 16 years and older with diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond.
 - Documentation required includes:
 - Length and width of ulcer to be treated.
 - Documentation of prior ulcer care.
- Coverage not provided with known neoplasm at the site of application or exposed joint, ligament, tendon or bone at the site of application.
- Benefit is approved for use for 10 weeks and can be renewed for an additional 10 weeks if the ulcer has decreased in size by at least 30% since beginning treatment with Regranex.

Brand Name: **Relistor**
Generic Name: **Methylnaltrexone Br**

Relistor (methylnaltrexone bromide) Prior Authorization Criteria

- Coverage for Relistor is provided for the treatment of opioid-induced constipation in patients with advanced illness who are receiving palliative care, when response to laxative therapy has not been sufficient.
- Benefit is approved for 12 months.

Brand Name: **Remicade**
 Generic Name: **Infliximab**

Remicade (infliximab) Prior Authorization 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)
 - Coverage is provided for six months.
 - Psoriatic Arthritis
 - If the patient has tried and failed methotrexate or another DMARD.
 - Coverage is provided for six months.
 - Moderate to severe Crohn's Disease, Fistulizing Crohn's Disease, or Ulcerative Colitis
 - 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[®])
 - Coverage is provided for 6 months.
 - 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 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)
 - 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
 - Coverage is authorized for one year.

Brand Name: **Revatio**
 Generic Name: **Sildenafil**

Revatio (sildenafil citrate) Prior Authorization Criteria

- Coverage is provided for the treatment of pulmonary arterial hypertension (World Health Organization Group 1) to improve exercise ability.
- Coverage will not be provided for the treatment of erectile dysfunction or in instances where a patient will be on intermittent or regular use of nitrates.
- Coverage duration is 12 months.

Brand Name: **Revlimid**
 Generic Name: **Lenalidomide**

Revlimid (lenalidomide) Prior Authorization Criteria

- Coverage is provided for the following:
 - Treatment of patients with transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities.
 - The member must have documented transfusion-dependent anemia or an anemia with documented hemoglobin less than 10 g/dL.
 - The member must have no response to treatment with erythropoietin or have an endogenous serum level of more than 500 mU/ml.

- Coverage is provided for the treatment of multiple myeloma in combination with dexamethasone for the treatment of multiple myeloma patients who have failed thalidomide (defined as disease progression or intolerance).
- Coverage is not provided for patients with severe neutropenia, severe thrombocytopenia, or those with treatment-related myelodysplastic syndromes.
- Coverage duration is 12 months.

Brand Name: **Risperdal Consta (12.5mg, 25mg)**

Generic Name: **Risperidone microspheres**

Risperdal Consta (risperidone injection) Prior Authorization Criteria

- Coverage will be provided for the maintenance treatment of bipolar I disorder in patients unable to be maintained on oral risperidone.
- Coverage will be provided for the treatment of schizophrenia in patients unable to be maintained on oral risperidone.
- Coverage duration is 12 months.

Brand Name: **Risperdal Consta (37.5mg, 50mg)**

Generic Name: **Risperidone microspheres**

Risperdal Consta (risperidone injection) Prior Authorization Criteria

- Coverage will be provided for the maintenance treatment of bipolar I disorder in patients unable to be maintained on oral risperidone.
- Coverage will be provided for the treatment of schizophrenia in patients unable to be maintained on oral risperidone.
- Coverage duration is 12 months.

Brand Name: **Rituxan**

Generic Name: **Rituximab**

Rituxan (rituximab) Injection Prior Authorization Criteria

- Coverage for rituximab is provided for the following conditions:
 - **Non-Hodgkin's Lymphoma (NHL):**
 - For members who have tried and failed first line chemotherapies, if applicable.
 - **Rheumatoid Arthritis (RA):**
 - In patients with moderately to severely active RA who have had an inadequate response to 1 or more tumor necrosis factor (TNF) antagonist therapies.
- Coverage approved for a 12 month duration.

Brand Name: **Sabril**

Generic Name: **Vigabatrin**

Sabril (vigabatrin) Prior Authorization Criteria

- Coverage is provided for infantile spasms in children ages 1 month to 2 years of age with documentation of discussing the potential risks and benefits to the parent or guardian.
- Coverage is provided as adjunctive therapy for adult patients with refractory complex partial seizures who have inadequately responded to several alternative treatments.
- Coverage is provided for 12 months.

Brand Name: **Saphris**

Generic Name: **Asenapine**

Saphris (asenapine) Prior Authorization Criteria

- Coverage is provided for adult patients for the acute treatment of schizophrenia or bipolar I disorder.
- Coverage is provided for 12 months.

Brand Name: **Sensipar (30mg)**

Generic Name: **Cinacalcet HCl**

Sensipar (cinacalcet) Prior Authorization Criteria

- Coverage is provided for the following:
 - Hypercalcemia due to parathyroid cancer
 - Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis that have failed to respond to vitamin D or have a serum parathyroid hormone (PTH) level > 300 pg/ml.
- Documentation of the following is required: iPTH level, serum calcium level, serum albumin level. Documentation that the patient has tried and failed a vitamin d analog or phosphate binder or if its use is inappropriate.

- Coverage duration is 12 months.

Brand Name: **Sensipar (60mg, 90mg)**

Generic Name: **Cinacalcet HCl**

Sensipar (cinacalcet) Prior Authorization Criteria

- Coverage is provided for the following:
 - Hypercalcemia due to parathyroid cancer
 - Secondary hyperparathyroidism in patients with Chronic Kidney Disease on dialysis that have failed to respond to vitamin D or have a serum parathyroid hormone (PTH) level > 300 pg/ml.
- Documentation of the following is required: iPTH level, serum calcium level, serum albumin level. Documentation that the patient has tried and failed a vitamin d analog or phosphate binder or if its use is inappropriate.
- Coverage duration is 12 months.

Brand Name: **Serostim**

Generic Name: **Somatropin**

Serostim (somatropin) Prior Authorization Criteria

- Coverage for Serostim (somatropin) for the treatment of AIDS related cachexia is provided for 6 months duration.

Brand Name: **Solaraze**

Generic Name: **Diclofenac Sodium**

Solaraze (diclofenac gel) Prior Authorization Criteria

- Benefit is approved for the topical treatment of Actinic keratoses (AK).
- The number and size of lesions is required to calculate quantity necessary.
- Benefit is approved for 90 days.

Brand Name: **Somavert**

Generic Name: **Pegvisomant**

Somavert (pegvisomant) Prior Authorization Criteria

- Benefit coverage is provided for the treatment of acromegaly when prescribed by an endocrinologist
- Benefit coverage will be 12 months in duration.

Brand Name: **Sporanox**

Generic Name: **Itraconazole Soln**

Sporanox (itraconazole) Prior Authorization Criteria

- Coverage is provided for the following:
 - Diagnosis of Blastomycosis
 - Diagnosis of Histoplasmosis
 - Diagnosis of Aspergillosis
 - Diagnosis of Onychomycosis after failure/intolerance to terbinafine
- Coverage is not provided for patients with elevated/abnormal liver function tests or active liver disease.
- Benefit is approved for up to three months.

Brand Name: **Sporanox**

Generic Name: **Itraconazole**

Sporanox (itraconazole) Prior Authorization Criteria

- Coverage is provided for the following:
 - Diagnosis of Blastomycosis
 - Diagnosis of Histoplasmosis
 - Diagnosis of Aspergillosis
 - Diagnosis of Onychomycosis after failure/intolerance to terbinafine
- Coverage is not provided for patients with elevated/abnormal liver function tests or active liver disease.
- Benefit is approved for up to three months.

Brand Name: **Sprycel**

Generic Name: **Dasatinib**

Sprycel (dasatinib) Prior Authorization Criteria

- Benefit is approved for the treatment of adults with chronic, accelerated, or myeloid or lymphoid blast phase CML with resistance or intolerance to prior therapy, including imatinib.

- Benefit is also approved for the treatment of adults with Philadelphia chromosome–positive(Ph+) ALL with resistance or intolerance to prior therapy.
- When approved, benefit provided for a 12 month duration.

Brand Name: **Sucraid**

Generic Name: **Sacrosidase**

Sucraid (sacrosidase) Prior Authorization Criteria

- Coverage is provided as oral replacement therapy of the genetically determined sucrase deficiency, which is part of congenital sucrase-isomaltase deficiency (CSID).
- Coverage approved for a 12 month duration.

Brand Name: **Sutent**

Generic Name: **Sunitinib malate**

Sutent (sunitinib) Prior Authorization Criteria

- Benefit coverage is provided for:
 - Treatment of gastrointestinal stromal tumor after disease progression on, or intolerance to imatinib mesylate.
 - Treatment of advanced renal cell carcinoma.
- Coverage duration is 12 months.

Brand Name: **Symlin**

Generic Name: **Pramlintide acetate**

Symlin (pramlintide) Prior Authorization Criteria

- Coverage is provided in the following situations:
 - Type I Diabetes, as an adjunct treatment in patients who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy as evidenced by a HA1C $\geq 7\%$, pre-prandial blood glucose between $< 90\text{mg/dL}$ and post-prandial blood glucose $\geq 180\text{mg/dL}$.
 - Type II Diabetes as an adjunct treatment in patients who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy, with or without a concurrent sulfonylurea or metformin as evidenced by a HA1C $\geq 7\%$, pre-prandial blood glucose between $> 90\text{mg/dL}$ and post-prandial blood glucose $\geq 180\text{mg/dL}$.
- Coverage is not provided for patients with a diagnosis of gastroparesis or for patients that have not attempted prior insulin therapy.
- Coverage duration is 12 months.

Brand Name: **Synagis**

Generic Name: **Palivizumab**

Synagis (palivizumab) Prior Authorization 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 31st):
 - Infants = 28 weeks, 6 days gestational at birth and < 12 months of age on November 1st
 - Infants between 29 weeks, 0 days and 31 weeks, 6 days gestational age at birth and < 6 months of age on November 1st
 - Infants < 34 weeks, 6 days gestational age at birth and < 12 months of age on November 1st 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 31st). 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 1st) 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: **Tarceva**
Generic Name: **Erlotinib**

Tarceva (erlotinib) Prior Authorization Criteria

- Benefit coverage is provided for the treatment of patients with locally advanced or metastatic non-small cell lung cancer as monotherapy after failure of at least one chemotherapy regimen and is requested by oncology.
- Benefit coverage is provided in combination with Gamzar (gemcitabine) is indicated for the first-line treatment of patients with locally advanced, unresectable, or metastatic pancreatic cancer and is requested by oncology.
- Benefit duration is 12 months.

Brand Name: **Targretin**
Generic Name: **Bexarotene Gel**

Targretin (bexarotene) Gel Prior Authorization Criteria

- Coverage is provided for the topical treatment of stage 1A or 1B cutaneous T-cell lymphoma in situations where patients have intolerance or have refractory or persistent disease following failure of one other therapy (e.g., PUVA, UVB, EBT, interferon, topical mechlorethamine, topical carmustine, topical corticosteroids, systemic chemotherapy).
- Documentation of clinical effectiveness of bexarotene gel such as diminished skin redness, scaly patches or itching for reauthorization.
- Benefit approved for 12 months for one 60gm tube per month. Benefit is renewable for 12 months in situations where treatment is continuing to provide clinical benefit (e.g., diminished redness, scaly patches, and itching).

Brand Name: **Tasigna**
Generic Name: **Nilotinib HCl**

Tasigna (nilotinib) Prior Authorization Criteria

- Coverage is provided for the treatment of chronic- and accelerated-phase Philadelphia chromosome–positive CML in adult patients resistant or intolerant to prior therapy that included imatinib.
- Coverage is not provided if the patient has hypokalemia, hypomagnesemia, or a prolonged QT interval.
- Benefit coverage is 12 months in duration.

Brand Name: **Taxotere**
Generic Name: **Docetaxel**

Part B versus Part D

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

Brand Name: **Tobi**
Generic Name: **Tobramycin/0.25 Normal Saline**

Part B versus Part D

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

Brand Name: **TPN Electrolytes**
Generic Name: **Electrolyte Solution**

Part B versus Part D

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

Brand Name: **Travasol**
Generic Name: **Amino Acids**

Part B versus Part D

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

Brand Name: **Trexall**
Generic Name: **Methotrexate Sodium**

Part B versus Part D

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

Brand Name: **Trisenox**
Generic Name: **Arsenic Trioxide**

Trisenox (arsenic trioxide) Injection Prior Authorization Criteria

- Coverage is provided for induction of remission and consolidation in patients with acute promyelocytic leukemia (APL) who are refractory to, or have relapsed from, retinoid and anthracycline chemotherapy, and whose APL is characterized by the presence of the t (15;17) translocation or PML/RAR-alpha gene expression.
- Coverage approved for 12 month duration.

Brand Name: **Tykerb**
Generic Name: **Lapatinib Ditosylate**

Tykerb (lapatinib) Prior Authorization Criteria

- Coverage is provided for use in combination with capecitabine, for the treatment of patients with advanced or metastatic breast cancer whose tumors overexpress HER2 and who have received prior therapy including an anthracycline, a taxane, and trastuzumab.
- Benefit coverage is 12 months in duration.

Brand Name: **Tyzeka**
Generic Name: **Telbivudine**

Tyzeka (telbivudine) Prior Authorization Criteria

- Benefit coverage is provided for treatment of chronic hepatitis B in adult patients with evidence of viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease.
- Coverage approved for a 12 month duration.

Brand Name: **Velcade**
Generic Name: **Bortezomib**

Velcade (bortezomib) Injection Prior Authorization Criteria

- Coverage is provided for the treatment of patients with mantle cell lymphoma who have received at least 1 prior therapy.
- Coverage is provided for the treatment of patients with multiple myeloma who have received at least 1 prior therapy.
- Benefit approved for 12 months duration.

Brand Name: **Ventolin**
Generic Name: **Albuterol Sulfate Inh Soln**

Part B versus Part D

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

Brand Name: **Vibramycin**
Generic Name: **Doxycycline Hyclate Inj**

Part B versus Part D

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

Brand Name: **Vidaza**
Generic Name: **Azacitidine**

Vidaza (azacitidine) Injection Prior Authorization Criteria

- Coverage is provided for the treatment of patients with the following MDS subtypes: refractory anemia (RA) or refractory anemia with

ringed sideroblasts (RARS) (if accompanied by neutropenia or thrombocytopenia or requiring transfusions), refractory anemia with excess blasts (RAEB), refractory anemia with excess blasts in transformation (RAEB-T), and chronic myelomonocytic leukemia (CMML).

- Coverage duration is 12 months.

Brand Name: **Vinblastine Sulfate**
Generic Name: **Vinblastine Sulfate**

Part B versus Part D

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

Brand Name: **Vincristine Sulfate**
Generic Name: **Vincristine Sulfate**

Part B versus Part D

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

Brand Name: **Vinorelbine Tartrate**
Generic Name: **Vinorelbine Tartrate**

Part B versus Part D

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

Brand Name: **Voltaren Gel**
Generic Name: **Diclofenac sodium**

Voltaren Gel (diclofenac) Prior Authorization Criteria

- Coverage is provided for requests of Voltaren Gel (diclofenac) when the following criteria has been met:
 - A diagnosis of osteoarthritis, AND
 - A trial of at least two formulary oral NSAIDs like naproxen, diclofenac, ibuprofen, sulindac, piroxicam, meloxicam, Celebrex, ketoprofen, nabumetone, indomethacin, or **Flurbiprofen**, OR
 - The member is unable to take oral NSAIDs due to an underlying condition like peptic ulcer disease, 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: **Xolair**
Generic Name: **Omalizumab**

Xolair (omalizumab) Prior Authorization Criteria

- Coverage will be considered as maintenance therapy for prophylaxis of asthma exacerbations in patients with moderate to severe allergic asthma in the following circumstances:
 - the patient is \geq 12 years of age
 - the patient's baseline serum IgE level is \geq 30IU/mL.
 - the patient has tested positive to perennial allergens by skin testing or in vitro testing

AND

 - the patient's symptoms are inadequately controlled with inhaled corticosteroids
 - the patient's current weight and IgE level fall within the normal dosing guidelines
- Coverage is provided for six months. Coverage may be considered for renewal in situations where treatment is providing clinical benefit as evidenced by reductions in asthma exacerbations from baseline.

Brand Name: **Zavesca**
Generic Name: **Miglustat**

Zavesca (miglustat) Prior Authorization Criteria

- Coverage is provided for the treatment of adult patients with mild to moderate type 1 Gaucher disease for whom enzyme replacement

therapy is not a therapeutic option (eg, because of constraints such as allergy, hypersensitivity, or poor venous access).

- Coverage is not provided for patients able to take enzyme replacement therapies.
- Coverage is provided for 12 months.

Brand Name: **Zemplar**

Generic Name: **Paricalcitol Inj**

Part B versus Part D

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

Brand Name: **Zolinza**

Generic Name: **Vorinostat**

Zolinza (vorinostat) Prior Authorization Criteria

- Coverage is provided for the treatment of cutaneous manifestations in patients with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent, or recurrent disease on or following 2 systemic therapies.
- Coverage duration is 12 months.

Brand Name: **Zyvox**

Generic Name: **Linezolid**

Zyvox (linezolid) Prior Authorization Criteria

- Benefit is approved for the following indications:
 - Vancomycin-resistant enterococci (VRE...i.e.: *Enterococcus faecium*) infection with concurrent bacteremia or pneumonia.
 - Nosocomial pneumonia or community-acquired pneumonia infections due to susceptible organisms (*Streptococcus agalactiae* (group B streptococci), *Streptococcus pneumoniae* (penicillin-susceptible strains only), and *Streptococcus pyogenes* (group A beta-hemolytic streptococci)), including those pneumonias with concurrent bacteremia.
 - Complicated skin and skin structure infections including diabetic foot infections (e.g., diabetic foot ulcer) without concomitant osteomyelitis
 - Infections caused by methicillin-resistant *Staphylococcus aureus* (MRSA)
 - Uncomplicated skin and skin structure infections
- Additional documentation is required with the request:
 - Culture and sensitivity results
 - Documentaion that patient is unable to receive alternative oral or intravenous antibiotics (due to patient allergies or lack of alternative antibiotics)
- Benefit is approved for 28 days in duration
- Positive nasal cultures of MRSA or positive stool cultures/rectal swabs of VRE without active infection indicate colonization and should not be treated with linezolid.

Brand Name: **Zyvox**

Generic Name: **Linezolid Inj**

Zyvox (linezolid Inj) Prior Authorization Criteria

- Benefit is approved for the following indications:
 - Vancomycin-resistant enterococci (VRE...i.e.: *Enterococcus faecium*) infection with concurrent bacteremia or pneumonia.
 - Nosocomial pneumonia or community-acquired pneumonia infections due to susceptible organisms (*Streptococcus agalactiae* (group B streptococci), *Streptococcus pneumoniae* (penicillin-susceptible strains only), and *Streptococcus pyogenes* (group A beta-hemolytic streptococci)), including those pneumonias with concurrent bacteremia.
 - Complicated skin and skin structure infections including diabetic foot infections (e.g., diabetic foot ulcer) without concomitant osteomyelitis
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