



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

#### Actimmune (interferon gamma-1b) Prior Authorization Criteria

- Coverage is provided for the treatment of the following:
  - Chronic granulomatous disease
  - Osteopetrosis.
- Coverage is provided for 12 months.

Brand Name: Actiq  
Generic Name: Fentanyl Citrate

#### Actiq (fentanyl citrate) Prior Authorization Criteria

Benefit is approved for the treatment of the following:

- Management of breakthrough cancer pain in patients 16 and older with malignancies who are already receiving and who are tolerant to around-the-clock opioid therapy.
- Coverage is provided for 12 months.

Brand Name: Adagen  
Generic Name: Pegademase Bovine

#### Adagen (pegademase bovine injection) Prior Authorization Criteria

- Coverage is provided for the treatment of severe combined immunodeficiency disease due to adenosine deaminase (ADA) deficiency in members who are not suitable candidates for or who have failed bone marrow transplantation.
- Adagen 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, and if warranted, HLA identical bone marrow transplantation).
- Coverage is provided for 12 months.

Brand Name: Adcirca  
Generic Name: Tadalafil

#### Adcirca (tadalafil) 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 is provided 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 the treatment of the following:

- Progressive neuroendocrine tumors of pancreatic origin (PNET) that is unresectable, locally advanced or metastatic.
- Advanced renal cell carcinoma (RCC) after failure of treatment with Sutent (sunitinib) or Nexavar (sorafenib).
- Subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS) who require therapeutic intervention but are not candidates for curative surgical resection.
- Coverage is provided for 12 months.

Brand Name: Aldurazyme  
Generic Name: Laronidase

#### Aldurazyme (Iaronidase) Injection Prior Authorization Criteria

- Coverage is provided for members with Hurler and Hurler-Scheie forms of mucopolysaccharidosis I (MPS I) and for members with the Scheie form of MPS I 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 is provided for 12 months.

Brand Name: Alimta  
Generic Name: Premetrexed Sodium

#### Alimta (pemetrexed) Prior Authorization Criteria

- Coverage is provided for Alimta for the treatment of:
  - Malignant pleural mesothelioma that is either unresectable or is unable to be removed surgically due to member factors
  - Locally advanced or metastatic nonsquamous non-small cell lung cancer (NSCLC) for second line treatment as monotherapy, for first line treatment in combination with cisplatin, or for maintenance treatment of members whose disease has not progressed after 4 cycles of platinum based first line chemotherapy.
- Coverage is provided for 12 months.

Brand Name: Amevive  
Generic Name: Alefacept

#### Amevive (alefacept) Prior Authorization Criteria

- Coverage is provided for the treatment of adult members with moderate to severe chronic plaque psoriasis, with documentation of a PASI score or the percent of the member'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 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 is 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 B<sub>12</sub>, or pyridoxine deficiency; antibacterial therapy; and the appropriate use of corticosteroids.
- Coverage will be provided for 12 months.

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: Arcalyst  
Generic Name: Riloncept

#### Arcalyst (riloncept) Prior Authorization Criteria

- Coverage is provided for the treatment of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children 12 and older.
- Coverage is provided for 12 months.

Brand Name: Aredia  
Generic Name: Pamidronate

#### Aredia (pamidronate) Prior Authorization Criteria

- Coverage is provided for the following conditions:
  - Hypercalcemia of malignancy
  - Osteolytic bone metastasis associated with breast cancer
  - Osteolytic lesions of multiple myeloma
  - Paget's disease
- Coverage is provided for 12 months.

Brand Name: Aricept 23  
Generic Name: Donepezil HCl

#### Aricept 23 (donepezil) Prior Authorization Criteria

- Coverage is provided for the treatment of mild, moderate, or severe Alzheimer's disease
- Coverage is not provided for members with purely stroke or vascular related dementia.
- Coverage is not provided for combination with other cholinesterase inhibitors (except for donepezil and memantine).
- Coverage is provided 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: Avastin  
Generic Name: Bevacizumab

#### Avastin (bevacizumab) Prior Authorization Criteria

- Coverage is provided for:
  - First line or second line treatment of metastatic colorectal cancer in combination with 5-fluorouracil based chemotherapy
  - First line treatment of locally advanced, recurrent, or metastatic non-squamous, non-small cell lung cancer (NSCLC) in combination with carboplatin and paclitaxel
  - For the treatment of metastatic renal cell cancer in combination with interferon alfa
  - For the treatment of metastatic breast cancer for members who have not previously received chemotherapy for metastatic HER2-negative breast cancer, in combination with paclitaxel
  - For the treatment of malignant glioma that has progressed on prior therapy
- Coverage is provided for 12 months.

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

#### Avonex (interferon beta-1a) Prior Authorization Criteria

- Coverage is 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 is 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

- Coverage is provided for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome in children 4 years and older and adults.
- Coverage is provided for 12 months.

Brand Name: Baraclude  
Generic Name: Entecavir

#### Baraclude (entecavir) Prior Authorization Criteria

- Coverage is provided for the 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 member previously attempted therapy with lamivudine and been resistant to, or failed such therapy
- If approved, the prescribing physician must be monitoring the member for lactic acidosis and hepatomegaly steatosis while receiving therapy.
- Coverage is provided for 12 months.

Brand Name: Bentyl  
Generic Name: Dicyclomine HCl

#### Bentyl (dicyclomine ) Prior Authorization Criteria

- Coverage is provided for patients less than 65 years of age.
- Coverage is provided for patients 65 years of age and greater for the treatment of irritable bowel syndrome with documentation of intolerance to or clinical failure with safer alternatives such as prescription strength polyethylene glycol, loperamide, scopolamine, Amitiza.
- Coverage is provided for 12 months.

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: OnabotulinumtoxinA

**Botox (onabotulinumtoxinA) Injection Prior Authorization Criteria:**

Coverage for Botulinum toxin will be considered for members 12 years of age and older with the following diagnoses:

- Incontinence due to detrusor instability, associated with neurologic condition:
  - For the treatment of urinary incontinence due to detrusor overactivity related to a neurologic condition (eg, spinal cord injury, multiple sclerosis) in adults who have had an inadequate response to or are intolerant of at least one anticholinergic medication
- Migraine Prophylaxis:
  - For the prophylaxis of headaches in adult patients with chronic migraine (at least 15 days per month with headache lasting 4 hours a day or longer).
- 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 (16 years and older) 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.
- Spasticity:
  - To decrease the severity of upper limb spasticity in elbow flexors, wrist flexors, and finger flexors (patients should still receive usual standard of care rehabilitation regimens)
- Coverage is provided 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 members with urea cycle disorders involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamoylase (OTC) or argininosuccinic acid synthetase (AAS).
  - Members with neonatal-onset deficiency (complete enzymatic deficiency, presenting within the first 28 days of life).
  - Members with late-onset disease (partial enzymatic deficiency, presenting after the first month of life) who have a history of hyperammonemic encephalopathy.
- Coverage is provided 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 members with type 2 diabetes mellitus that have not achieved adequate glycemic control while on optimal doses of metformin, a sulfonylurea, a combination of metformin and a sulfonylurea, or Lantus as evidenced by a HA1C  $\geq$  7%.
- Coverage is provided for 12 months.

Brand Name: Calcitriol  
Generic Name: Calcitriol

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: Campath  
Generic Name: Alemtuzumab

Campath (alemtuzumab) Injection Prior Authorization Criteria

- Coverage is provided for the treatment of B-cell chronic lymphocytic leukemia (B-CLL) as monotherapy.
- Coverage is approved for three times a week infusions for up to 12 weeks total.
- Members should be monitored for cytopenias, infections, and infusion reactions while on Campath.

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: Carnitor  
Generic Name: Levocarnitine

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 provided 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.
- Coverage is provided for 12 months.

Brand Name: Cerezyme  
Generic Name: Imiglucerase

Cerezyme (imiglucerase) Prior Authorization Criteria

- Coverage is provided for members with the diagnosis of Type I Gaucher Disease with documentation of complications such as anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.
- Coverage is provided for 12 months.

Brand Name: Cervarix  
Generic Name: Human Papillomav Vacc Bival/PF

Cervarix (human papillomavirus vaccine) Prior Authorization Criteria

- Coverage is provided for females 9 to 25 years of age for the prevention of diseases caused by the human papillomavirus (HPV) types 6, 11, 16 and 18.
- Coverage is provided for 6 months.

Brand Name: Chantix  
Generic Name: Varenicline Tartrate

Chantix (varenicline) Prior Authorization Criteria

- Coverage is provided for smoking cessation purposes in members with nicotine withdrawal who had an adequate trial and failure of nicotine replacement therapy and bupropion (generic Zyban).
- Coverage is provided 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 is provided for 12 months.

Brand Name: Cimzia  
Generic Name: Certolizumab

Cimzia (Certolizumab) Prior Authorization Criteria

- Coverage is provided for adult patients:
  - For maintaining clinical response and reductions of signs/symptoms of moderate to severe Crohn's disease who had an inadequate response to conventional therapy
    - Documentation of trial and failure of at least 2 of the following: sulfasalazine, Pentasa, asacol, colazal, metronidazole, ciprofloxacin, prednisone, entocort, azothioprine, 6-mercaptopurine, methotrexate
  - For treatment of moderate to severe active rheumatoid arthritis alone or with non-biologic DMARDs
    - Patient must have documentation of trial and failure to methotrexate
- Product must be prescribed by Rheumatologist, Gastroenterologist, or Dermatologist
- Coverage is not provided for use of Cimzia in combination with Kineret, Enbrel, Humira or 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
- Coverage is provided for 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: Concerta  
Generic Name: Methylphenidate Tab SA

Concerta ( Methylphenidate ER ) Prior Authorization Criteria

- Coverage is provided for:
  - Attention deficit hyperactivity disorder for adults up to age 65 years
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives, like Strattera
- Coverage is provided for 12 months

Brand Name: Copaxone  
Generic Name: Glatiramer Acetate

Copaxone (glatiramer acetate) Prior Authorization Criteria

- Coverage is 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 is provided for situations in which there is functional status that can be preserved. Member 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: Cubicin  
Generic Name: Daptomycin

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

- Coverage is provided for the management of nephropathic cystinosis in children and adults.
- Coverage is provided for 12 months.

Brand Name: Dacogen  
Generic Name: Decitabine

Dacogen (Decitabine) Prior Authorization Criteria

- Coverage is provided for the treatment of members 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 is provided 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: Demerol  
Generic Name: Meperidine HCl

Demerol (Meperidine) Prior Authorization Criteria

- Coverage is provided for patients less than 65 years of age.
- Coverage is provided for patients 65 years of age and greater for the treatment of moderate to severe pain with documentation of intolerance to or clinical failure with safer alternatives.
- Coverage is provided for 12 months.

Brand Name: Demerol  
Generic Name: Meperidine HCl Inj

Demerol (Meperidine) Prior Authorization Criteria

- Coverage is provided for patients less than 65 years of age.
- Coverage is provided for patients 65 years of age and greater for the treatment of moderate to severe pain with documentation of intolerance to or clinical failure with safer alternatives.
- Coverage is provided for 12 months.

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: Egrifta  
Generic Name: Tesamorelin Acetate

Egrifta (tesamorelin acetate) Prior Authorization Criteria

- Coverage is provided for lipodystrophy associated with HIV infection
- Coverage is NOT provided for weight loss management
- Coverage is provided for 12 months

Brand Name: Elaprase  
Generic Name: Idursulfase

Elaprase (idursulfase) Injection Prior Authorization Criteria

- Coverage is provided for members 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 members.
- Coverage is provided for 12 months.



Brand Name: Elidel  
Generic Name: Pimecrolimus

#### Elidel (pimecrolimus) 1% Cream Prior Authorization Criteria

- Coverage is provided for the treatment of mild to moderate atopic dermatitis in members 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 is provided for 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 members 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: Emend  
Generic Name: Aprepitant

#### Emend (aprepitant) Prior Authorization Criteria

- Coverage is provided for adults:
  - In combination with other anti-emetics for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately to highly emetogenic chemotherapy, including high-dose cisplatin
  - For prophylaxis of postoperative nausea and vomiting
- Must be prescribed by oncologist
- Coverage is provided for 6 months

Brand Name: Emla  
Generic Name: Lidocaine-Prilocaine

#### 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: 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: Exjade  
Generic Name: Deferasirox

Exjade (deferasirox) Prior Authorization Criteria

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

Brand Name: Fabrazyme  
Generic Name: Agalsidase Beta

Fabrazyme (agalsidase beta) Prior Authorization Criteria

- Coverage is provided for members diagnosed with Fabry disease.
- Coverage is provided for 12 months.

Brand Name: Fanapt  
Generic Name: Iloperidone

Fanapt (iloperidone) Prior Authorization Criteria

- Coverage is provided for the acute treatment of schizophrenia when the member has tried at least two of the following atypical antipsychotics: Abilify, clozapine, risperidone, Seroquel, and Zyprexa.
- Coverage is provided for 12 months.

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.
- Must be prescribed by Oncologist
- Coverage is provided 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: Furadantin  
Generic Name: Nitrofurantoin

Furadantin ( Nitrofuratoin ) Prior Authorization Criteria

- Coverage is provided for:
  - Treatment of urinary tract infection due to susceptible strains of E. coli, enterococci, Staphylococcus aureus and some strains of Klebsiella and Enterobacter.
  - UTI Prophylaxis
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives
- Coverage is provided for 12 months

Brand Name: Gamunex  
Generic Name: Immune Glob, Gam Caprylate

#### Intravenous Immunoglobulin (IVIg) Prior Authorization Criteria

- Coverage is provided under Part B for Primary immunodeficiencies.
- 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 is provided for 12 months

Brand Name: Gleevec  
Generic Name: Imatinib Mesylate

#### Gleevec (Imatinib) Prior Authorization Criteria

- 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)
    - Members 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.
- Coverage is provided in situations where the treatment is initiated by a hematologist-oncologist.
- Coverage is provided for 12 months.

Brand Name: Halaven  
Generic Name: Eribulin Mesylate

#### Halaven (Eribulin) Prior Authorization Criteria

- Coverage is provided for treatment of metastatic breast cancer in patients who previously received at least 2 chemotherapeutic regimens for metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting.
- Coverage is provided for 12 months.

Brand Name: Heparin Sodium  
Generic Name: Heparin Sodium, Porcine IV

#### 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: Heparin Sodium  
Generic Name: Heparin Sodium, Porcine SQ

#### 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: Humira  
Generic Name: Adalimumab

#### Humira (adalimumab) Prior Authorization Criteria

- Coverage is provided for rapidly advancing, progressive disease Rheumatoid or Psoriatic Arthritis in members 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<sup>®</sup>, Asacol<sup>®</sup>, Colazal<sup>®</sup>).
    - Antibiotics (*i.e.*, Metronidazole, Ciprofloxacin).
    - Steroids (*i.e.*, prednisone, Entocort<sup>®</sup>).
    - Immunomodulators (*i.e.*, Azothioprine<sup>®</sup>, 6-Mercaptopurine, Methotrexate<sup>®</sup>)
- 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 members who have experienced a failure, an inadequate response, or are unable to receive methotrexate. The member may continue on methotrexate with Humira.
- Coverage is provided for Ankylosing Spondylitis if it is prescribed by a rheumatologist and the member 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 member 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.
- Coverage is provided for 12 months.

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: Increlex  
Generic Name: Mecasermin

Increlex (mecasermin, recombinant, rh-IGF-1) Prior Authorization Criteria

- Coverage is provided for the treatment of growth failure in children with severe primary insulin-like growth factor (IGF-1) deficiency or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH in the presence of the following:
  - Member's height must be below the third percentile for their age and gender related height documented on a growth chart
  - Growth velocity subnormal (*i.e.*,  $\geq 2$  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)  $\geq 2$  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
- Coverage is not provided when the member has closed epiphyses or active/suspected neoplasia.
- Coverage is provided for 12 months.
- Medication must be prescribed by an endocrinologist.

Brand Name: Infergen  
Generic Name: Interferon Alfacon-1

Infergen (interferon alfacon-1) Prior Authorization Criteria

- Coverage is provided for the treatment of 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 member's condition)
- Coverage is not provided for concurrent use of more than one interferon product.
- Coverage is provided for 6 months.
- Daily dosing of Infergen (interferon alfacon-1) will be provided for those with Hepatitis C who are non-responders to prior pegylated interferon treatment.

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  
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 member'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

- Coverage is provided for the treatment of schizophrenia or schizoaffective disorder in members 18 years of age or older with an inadequate response or intolerance to two or more atypical antipsychotics, one of which is risperidone.
- Coverage is provided for 12 months.

Brand Name: Invega Sustenna  
Generic Name: Paliperidone Palmitate

#### Invega Sustenna (paliperidone injection) Prior Authorization Criteria

- Coverage is provided for the diagnosis of schizophrenia when the member has previously been on oral Invega.
- Coverage is provided for the diagnosis of schizoaffective disorder as monotherapy or as an adjunct to mood stabilizers and/or antidepressants when the member has previously been on oral Invega.
- Coverage is provided for 12 months.

Brand Name: Jevtana  
Generic Name: Cabazitaxel

#### 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: Kepivance  
Generic Name: Palifermin

#### Kepivance (palifermin) Prior Authorization Criteria

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



Brand Name: Kineret  
Generic Name: Anakinra

Kineret (anakinra) Prior Authorization Criteria

- Coverage is provided for members 18 years of age and older for the treatment of moderate to severe rheumatoid arthritis after the member has tried and failed treatment with 1 or more disease modifying antirheumatic drugs (DMARDs).
  - Examples of DMARDs include methotrexate, azothiaprine, Plaquenil
- Coverage is not provided if Kineret will 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 member has not been evaluated and where warranted, screened for the presence of latent TB infection.
- Coverage is provided for 12 months.

Brand Name: Kuvan  
Generic Name: Sapropterin Dihydrochloride

Kuvan (sapropterin dihydrochloride) Prior Authorization Criteria

- Coverage is provided for members with a diagnosis of hyperphenylalaninemia.
- Coverage is provided for 3 months initially.
- Coverage may be renewed for up to 12 months upon documentation the member is responding to treatment with Kuvan as evidenced by lowering of their Phe levels.
- Members 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 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 member has previously experienced neutropenia from antineoplastic agents).
- Coverage is provided for primary prevention of antineoplastic chemotherapy related neutropenia (i.e. member has not previously developed neutropenia from antineoplastic agents) in situations where the member 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: Lidocaine Oint  
Generic Name: Lidocaine 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: Lidoderm  
Generic Name: Lidocaine

#### Lidoderm (lidocaine) Prior Authorization Criteria

- Coverage is provided for members with a diagnosis of post-herpetic neuralgia.
- Coverage is provided for 12 months.

Brand Name: Lomotil  
Generic Name: Diphenoxylate HCl/Atrop Sulf

#### Lomotil (Atropine/Diphenoxylate) Prior Authorization Criteria

- Coverage is provided for symptomatic treatment of diarrhea as an adjunct to fluid and electrolyte therapy
- Coverage is provided for patients less than 65 years of age.
- Enrollees greater than 65 years of age must document intolerance to or clinical failure to safer alternatives.
- Coverage is provided for 12 months.

Brand Name: Lotronex  
Generic Name: Alosetron HCl

Lotronex (alosetron) Prior Authorization Criteria

- Coverage is provided for treatment of severe diarrhea predominant irritable bowel syndrome (IBS) in female members 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 members 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, members diagnosed with Crohn's disease, ulcerative colitis, diverticulitis, or severe hepatic impairment.
- Coverage is provided for 12 months.

Brand Name: Lovaza  
Generic Name: Omega-3 Acid Ethyl Esters

Lovaza (Omega-3-Acid Ethyl Esters) Prior Authorization Criteria

- Coverage is provided as an adjunct to diet to reduce very high triglyceride levels (documented as greater than or equal to 500 mg/dL) in adults.
- Coverage is provided for 12 months.

Brand Name: Lupron  
Generic Name: Leuprolide Acetate

Lupron (leuprolide acetate) Prior Authorization Criteria

- Coverage is provided for:
  - The treatment of advanced prostatic cancer
  - Endometriosis confirmed by laparoscopy in members who have failed member 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 member 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 member's quality of life
    - The member 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 member's psychologic and psychosexual status been evaluated to rule out nonsomatic causes of the pelvic pain.
- Coverage is provided for 12 months.

Brand Name: Lupron Depot  
Generic Name: Leuprolide Acetate

Lupron (leuprolide acetate) Prior Authorization Criteria

- Coverage is provided for:
  - The treatment of advanced prostatic cancer
  - Endometriosis confirmed by laparoscopy in members who have failed member 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 member 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 member's quality of life
    - The member 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 member's psychologic and psychosexual status been evaluated to rule out nonsomatic causes of the pelvic pain.
- Coverage is provided for 12 months.

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

#### Lupron (leuprolide acetate) Prior Authorization Criteria

- Coverage is provided for:
  - The treatment of advanced prostatic cancer
  - Endometriosis confirmed by laparoscopy in members who have failed member 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 member 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 member's quality of life
    - The member 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 member's psychologic and psychosexual status been evaluated to rule out nonsomatic causes of the pelvic pain.
- Coverage is provided for 12 months.

Brand Name: Macrobid  
Generic Name: Nitrofurantoin/Nitrofurantoin Mac

#### Macrobid (Nitrofurantoin) Prior Authorization Criteria

- Coverage is provided for:
  - Treatment of urinary tract infection due to susceptible strains of E. coli, enterococci, Staphylococcus aureus and some strains of Klebsiella and Enterobacter.
  - UTI Prophylaxis
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives.
- Coverage is provided for 12 months.

Brand Name: Macrochantin  
Generic Name: Nitrofurantoin Macrocrystal

#### Macrochantin ( Nitrofurantoin ) Prior Authorization Criteria

- Coverage is provided for:
  - Treatment of urinary tract infection due to susceptible strains of E. coli, enterococci, Staphylococcus aureus and some strains of Klebsiella and Enterobacter.
  - UTI Prophylaxis
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives.

Coverage is provided for 12 months.



Brand Name: Marinol  
Generic Name: Dronabinol

Marinol (dronabinol) Prior Authorization Criteria

- Coverage is provided for the treatment of chemotherapy-induced nausea/vomiting (CINV) that is refractory to conventional antiemetic agents when members have had an inadequate response or intolerance to conventional antiemetic therapy.
- Coverage is provided for use as an appetite stimulant in patients with anorexia due to AIDs when:
  - The member has had an involuntary weight loss of greater than 10% of pre-illness baseline body weight or body mass index (BMI) less than 20kg/m<sup>2</sup> in the absence of a concurrent illness or medical condition other than HIV infection that may cause weight loss, AND
  - The member has had an inadequate response or intolerance to a 30 day drug regimen of megestrol (generic Megace)
- Coverage is provided for 6 months.

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: Metadate ER  
Generic Name: Methylphenidate HCl SA

Metadate ER (methylphenidate er) Prior Authorization Criteria

- Coverage is provided for:
  - Attention deficit hyperactivity disorder for children ages 6 and up
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives, such as Strattera.
- Coverage is provided for 12 months.

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: 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: 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: Mozobil  
Generic Name: Plerixafor

Mozobil (plerixafor) Prior Authorization Criteria

- Coverage is provided for peripheral blood stem cell (PBSC) mobilization for collection and subsequent autologous transplantation in patients with non-Hodgkin's lymphoma and multiple myeloma
- Mozobil should be given in combination with a granulocyte colony stimulating factor (G-CSF).
- Coverage is provided 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

- Coverage is provided for the treatment of moderate to severe Alzheimer's type dementia.
- Coverage is provided for 12 months.
- Renewal coverage is provided in situations where therapy continues to provide clinical benefit.

Brand Name: Neulasta  
Generic Name: Pegfilgrastim

Neulasta (pegfilgrastim) Prior Authorization Criteria

- Coverage is provided for:
  - Neutropenia in members with non-myeloid malignancies receiving myelosuppressive chemotherapy agents.
  - Secondary prevention of antineoplastic chemotherapy related neutropenia (situation where the member has previously experienced neutropenia from antineoplastic agents).
  - Primary prevention of antineoplastic chemotherapy related neutropenia (i.e. member has not previously developed neutropenia from antineoplastic agents) in situations where the member may be at high risk for developing antineoplastic chemotherapy induced neutropenia.
- Documentation that the member 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),
  - Member at risk for serious infection,
  - Expected incidence of myelosuppressive chemotherapy-induced neutropenia is greater than 40%.
- Chemotherapy cycle length is required
- Coverage is provided for 6 months.

Brand Name: Neumega  
Generic Name: Oprelvekin

Neumega (oprelvekin) Prior Authorization Criteria

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

Brand Name: Neupogen  
Generic Name: Filgrastim

#### Neupogen (filgrastim) Prior Authorization Criteria

- Coverage 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 member has previously experienced neutropenia from antineoplastic agents).
- Coverage is provided for primary prevention of antineoplastic chemotherapy related neutropenia (i.e. member has not previously developed neutropenia from antineoplastic agents) in situations where the member 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

- Coverage is provided for the treatment of advanced renal cell carcinoma.
- Coverage is provided for the treatment of unresectable hepatocellular carcinoma.
- Coverage is provided for 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:
  - Member's height must be below the third percentile for their age and gender related height
  - Growth velocity subnormal (*i.e.*,  $\geq 2$  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)  $\geq 2$  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 provided for:
  - Pediatric growth failure due to chronic renal failure (in situations where the member 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 3<sup>rd</sup> 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 is provided for 6 months.

Brand Name: Norflex  
Generic Name: Orphenadrine citrate

#### Norflex (Orphenadrine) Prior Authorization Criteria

- Coverage is provided for adults for the relief of pain associated with acute musculoskeletal conditions.
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives such as baclofen, tizanidine.
- Coverage is provided for 12 months.

Brand Name: Ontak  
Generic Name: Denileukin Diftitox

#### Ontak (denileukin diftitox) Prior Authorization Criteria

- Coverage is provided for members 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 member can be closely monitored for an appropriate period based on his or her health.
- Coverage is provided for 12 months.

Brand Name: Orfadin  
Generic Name: Nitisinone

Orfadin (nitisinone) Injection Prior Authorization Criteria

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

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.
- Patient 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.
- Coverage is provided for 12 months

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: Parafon Forte DSC  
Generic Name: Chlorzoxazone

Parafon Forte (Chlorzoxazone) Prior Authorization Criteria

- Coverage is provided for use as muscle relaxant for the treatment of painful musculoskeletal disorders
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives such as baclofen and tizanidine
- Coverage is provided for 12 months

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

Peg-Intron (peginterferon alfa-2b) Prior Authorization Criteria

- Coverage is provided for the treatment of the following:
  - 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 member's condition)
- Coverage is not provided for concurrent use of more than one interferon product.
- Coverage is provided for 6 months.

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:
    - Member 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 member's condition)
- Coverage is not provided for concurrent use of more than one interferon product.
- Coverage is provided for 6 months.

Brand Name: Procrit  
Generic Name: Epoetin Alfa

Procrit (recombinant epoetin alfa) Prior Authorization Criteria

- Coverage 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
    - Member is symptomatic or has required transfusion
    - Renewal coverage provided for hematocrit  $\leq 36\%$  or hemoglobin  $\leq 12$  g/dL
    - If hematocrit  $> 36\%$  or hemoglobin  $> 12$  g/dL, the physician must indicate that the dose of erythropoietin is being held or titrated downward
    - Coverage is provided for 6 months and is renewable
  - Anemia 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
    - Member is symptomatic or has required transfusion AND erythropoietin level is  $< 500$  units/L
    - Renewal coverage provided for hematocrit  $\leq 36\%$  or hemoglobin  $\leq 12$  g/dL
    - If hematocrit  $> 36\%$  or hemoglobin  $> 12$  g/dL, the physician must indicate that the dose of erythropoietin is being held or titrated downward
    - Coverage is provided for 4 months and is renewable
  - Chemotherapy induced anemia in accord with the following:
    - Hematocrit  $\leq 30\%$  or hemoglobin  $\leq 10$  gm/dL
    - If hematocrit  $> 36\%$  or hemoglobin  $> 12$  gm/dL, the physician must indicate that the dose of erythropoietin is being held or titrated downward.
    - Coverage is provided for 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 is provided for 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 members in accord with the following:
    - Therapy must be for elective non-vascular or non-cardiac surgery
    - Member refuses or cannot undergo autologous blood donation prior to surgery
    - Hemoglobin must be  $\leq 13$  gm/dL
    - Coverage is provided for 1 month

Brand Name: Prolastin  
Generic Name: Alpha-1 Proteinase Inhibitor

Prolastin (alpha-1 proteinase inhibitor) Prior Authorization Criteria

- Coverage is provided for the treatment of panacinar emphysema due to congenital alpha<sub>1</sub>-antitrypsin.
- Coverage is provided for 12 months.

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 members with normal cardiac and pulmonary functions as defined by thallium stress testing and formal pulmonary function testing AND a head CT or MRI negative for brain metastases within past 8 weeks.
- Coverage is provided for 12 months.

Brand Name: Promacta  
Generic Name: Eltrombopag Olamine

Promacta (eltrombopag) Prior Authorization Criteria

- Coverage is provided for the treatment of thrombocytopenia in members with chronic idiopathic thrombocytopenic purpura (ITP) who had an insufficient response to corticosteroids, immunoglobulins, or splenectomy.
- Documentation of platelet count is necessary.
- Coverage is provided for 12 months.

Brand Name: Proventil  
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: Provigil  
Generic Name: Modafinil

Provigil (modafinil) Prior Authorization Criteria

- Coverage is provided for:
  - Members 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.
- Coverage is provided 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

- Coverage is provided for:
  - The management of cystic fibrosis.
  - Situations in which Pulmozyme (recombinant dornase alfa) is used in conjunction with standard therapies such as mechanical drainage or chest physiotherapy.
- Coverage is provided for 12 months.

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

Razadyne / ER (galantamine) Prior Authorization Criteria

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

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

Rebif (Interferon beta-1a) Prior Authorization Criteria

- Coverage provided for relapsing forms of MS
- Coverage is not provided for primary progressive MS.
- Coverage provided for situations in which there is functional status that can be preserved. Member 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 interferon beta-1a and Copaxone (glatiramer acetate) is not covered.

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

- Coverage is provided for use in members 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 is not provided with known neoplasm at the site of application or with exposed joint, ligament, tendon or bone at the site of application.
- Coverage is provided 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: Methylalntrexone Br

Relistor (methylalntrexone) Prior Authorization Criteria

- Coverage is provided for the treatment of opiate agonist-induced constipation in patients with advanced illness who are receiving palliative care when response to laxative therapy has been insufficient.
- Coverage is provided for 12 months.

Brand Name: Remicade  
Generic Name: Infliximab

Remicade (infliximab) Prior Authorization Criteria

- Prior to treatment, the member must have been evaluated and where warranted, screened for the presence of latent TB infection (dates and results required)
- Coverage is provided for the treatment of members with:
  - Moderate to severe active Rheumatoid arthritis
    - If the member has tried methotrexate with an inadequate response
    - If the member has a contraindication to methotrexate
    - If the member has tried/failed a DMARD other than methotrexate (eg: sulfasalazine, Plaquenil)
    - Coverage is provided for 6 months.
  - Psoriatic Arthritis
    - If the member has tried and failed methotrexate or another DMARD.
    - Coverage is provided for 6 months.
  - Moderate to severe Crohn's Disease, Fistulizing Crohn's Disease, or Ulcerative Colitis
    - If the member has tried/failed two or more of the following medications:
      - Aminosalicylates, 5-ASAs (*i.e.*, Sulfasalazine, Pentasa®, Asacol®, Colazal®).
      - Antibiotics (*i.e.*, Metronidazole, Ciprofloxacin).
      - Steroids (*i.e.*, prednisone, Entocort®).
      - Immunomodulators (*i.e.*, Azathioprine®, 6-Mercaptopurine, Methotrexate®)
    - Coverage is provided for 6 months.
  - Ankylosing Spondylitis
    - If the member has 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 member 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 is provided for 8 weeks
  - Moderate to Severe Plaque Psoriasis
    - Coverage is provided if:
      - At least 10 to 100% of the member's body is affected by the psoriasis, AND
      - The member 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 provided for 12 months.

Brand Name: Revlimid  
Generic Name: Lenalidomide

Revlimid (lenalidomide) Prior Authorization Criteria

- Coverage is provided for the following:
  - Treatment of members 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 members who have failed thalidomide (defined as disease progression or intolerance).
- Coverage is not provided for members with severe neutropenia, severe thrombocytopenia, or those with treatment-related myelodysplastic syndromes.
- Coverage is provided for 12 months.

Brand Name: Risperdal Consta  
Generic Name: Risperidone microspheres

Risperdal Consta (risperidone injection) Prior Authorization Criteria

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

Brand Name: Ritalin  
Generic Name: Methylphenidate HCl

Ritalin (methylphenidate) Prior Authorization Criteria

- Coverage is provided for:
  - Attention deficit hyperactivity disorder
  - narcolepsy
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives, like Strattera
- Coverage is provided for 12 months.

Brand Name: Ritalin SR  
Generic Name: Methylphenidate HCl SR

Ritalin LA (methylphenidate) Prior Authorization Criteria

- Coverage is provided for:
  - Attention deficit hyperactivity disorder
  - narcolepsy
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives, like Strattera
- Coverage is provided for 12 months.

Brand Name: Rituxan  
Generic Name: Rituximab

Rituxan (rituximab) Injection Prior Authorization Criteria

- Coverage for rituximab is provided for the following conditions:
  - Adults with Microscopic polyarteritis nodosa in combination with glucocorticoids
  - Wegener's granulomatosis in combination with glucocorticoids
  - Non-Hodgkin's Lymphoma (NHL):
    - For members who have tried and failed first line chemotherapies, if applicable.
  - Rheumatoid Arthritis (RA):
    - In members with moderately to severely active RA who have had an inadequate response to 1 or more tumor necrosis factor (TNF) antagonist therapies.
  - Chronic Lymphocytic Leukemia (CLL):
    - For the treatment of patients with previously untreated or previously treated CD20-positive CLL in combination with cyclophosphamide and fludarabine
- Coverage provided for 12 months.

Brand Name: Robaxin  
Generic Name: Methocarbamol

Robaxin (Methocarbamol) Prior Authorization Criteria

- Coverage is provided for musculoskeletal pain and as adjunct therapy for the control of neuromuscular manifestations of tetanus in adults
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives, such as baclofen or tizanidine
- Coverage is provided for 12 months

Brand Name: Sabril  
Generic Name: Vigabatrin

Sabril (vigabatrin) Prior Authorization Criteria

- Coverage is provided for the treatment of:
  - 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
  - Adjunct therapy for refractory complex partial seizures in adults who have inadequately responded to several alternative treatments for whom the potential benefits outweigh risk of vision loss
- Coverage is provided for 12 months

Brand Name: Saphris  
Generic Name: Asenapine

Saphris (asenapine) Prior Authorization Criteria

- Coverage is provided for adult members for the acute treatment of schizophrenia or bipolar I disorder who have failed at least 2 atypical antipsychotics.
- Coverage is provided for 12 months.

Brand Name: Serostim  
Generic Name: Somatropin

Serostim (somatropin) Prior Authorization Criteria

- Coverage is provided for the treatment of AIDS related cachexia.
- Coverage is provided for 6 months.

Brand Name: Solaraze  
Generic Name: Diclofenac Sodium

Solaraze (diclofenac gel) Prior Authorization Criteria

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

Brand Name: Somavert  
Generic Name: Pegvisomant

Somavert (pegvisomant) Prior Authorization Criteria

- Coverage is provided for the treatment of acromegaly after inadequate response to surgery and/or radiation and or other medical therapies or when such therapies are inappropriate, and when prescribed by an endocrinologist.
- Coverage is provided for 12 months.

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 members with elevated/abnormal liver function tests or active liver disease.
- Coverage is provided for up to 3 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 members with elevated/abnormal liver function tests or active liver disease.
- Coverage is provided for up to 3 months.

Brand Name: Sprycel  
Generic Name: Dasatinib

**Sprycel (dasatinib) Prior Authorization Criteria**

- Coverage is provided for the treatment of adults with:
  - Newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia in chronic phase.
  - Chronic, accelerated, or myeloid or lymphoid blast phase CML with resistance or intolerance to prior therapy, including imatinib.
  - Treatment of adults with Philadelphia chromosome-positive(Ph+) ALL with resistance or intolerance to prior therapy.
- Coverage is provided for 12 months.

Brand Name: Sutent  
 Generic Name: Sunitinib malate

Sutent (sunitinib) Prior Authorization Criteria

- Coverage is provided for:
  - Treatment of gastrointestinal stromal tumor after disease progression on, or intolerance to, imatinib mesylate.
  - Treatment of advanced renal cell carcinoma
  - Treatment of progressive, well-differentiated advanced pancreatic neuroendocrine tumors with unresectable locally advanced or metastatic disease
- Coverage is provided for 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 members who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy as evidenced by a HbA1C  $\geq 7\%$ , 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 members 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 HbA1C  $\geq 7\%$ , pre-prandial blood glucose between  $> 90\text{mg/dL}$  and post-prandial blood glucose  $\geq 180\text{mg/dL}$ .
- Coverage is not provided for members with a diagnosis of gastroparesis, for members that have not attempted prior insulin therapy or when HbA1C  $< 7$ .
- Coverage is provided for 12 months.

Brand Name: Synagis  
 Generic Name: Palivizumab

Synagis (palivizumab) Prior Authorization Criteria

- Coverage is provided for the prevention of RSV infections in high-risk pediatric members for:
  - A 5 months maximum (but auth should not exceed through March 31<sup>st</sup>):
    - Infants = 28 weeks, 6 days gestational at birth and  $< 12$  months of age on November 1<sup>st</sup>
    - Infants between 29 weeks, 0 days and 31 weeks, 6 days gestational age at birth and  $< 6$  months of age on November 1<sup>st</sup>
    - Infants  $\leq 34$  weeks, 6 days gestational age at birth and  $< 12$  months of age on November 1<sup>st</sup> with a congenital abnormality of the airway or neuromuscular condition that compromises respiratory secretions
    - Infants 2 years of age or younger with Chronic Lung Disease (CLD) and has required medical therapy (supplemental oxygen, bronchodilator, diuretic or corticosteroid therapy) for CLD within the past 6 months
    - Infants 2 years of age or younger and is diagnosed with hemodynamically significant Congenital Heart Disease (i.e. receiving medications to control CHF, moderate to severe pulmonary hypertension, cyanotic heart disease)
  - A 3 month maximum (but auth should not exceed through March 31<sup>st</sup>). 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  $\leq 3$  months of age on November 1<sup>st</sup>) 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).

Brand Name: Talwin NX  
Generic Name: Pentazocine/Naloxone

Talwin NX (pentazocine and naloxone) Prior Authorization Criteria

- Coverage is approved for the relief of moderate to severe pain.
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives.
- Coverage is provided for 12 months.

Brand Name: Tarceva  
Generic Name: Erlotinib

Tarceva (erlotinib) Prior Authorization Criteria

- Coverage is provided for the treatment of members 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.
- Coverage is provided in combination with Gemzar (gemcitabine) for first-line treatment of members with locally advanced, unresectable, or metastatic pancreatic cancer and is requested by oncology.
- Coverage is provided for 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 members 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.
- Coverage is provided for 12 months for one 60gm tube per month. Coverage 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: Tasisna  
Generic Name: Nilotinib HCl

Tasisna (nilotinib) Prior Authorization Criteria

- Coverage is provided for the following indications:
  - Treatment of chronic- and accelerated-phase Philadelphia chromosome–positive CML in adult members resistant or intolerant to prior therapy that included imatinib.
  - Treatment of chronic Philadelphia chromosome positive CML in adult patients newly diagnosed
- Coverage is not provided if the member has hypokalemia, hypomagnesemia, or a prolonged QT interval.
- Coverage is provided for 12 months.

Brand Name: Thioridazine HCl  
Generic Name: Thioridazine HCl

Mellaril (Thioridazine) Prior Authorization Criteria

- Coverage is approved for the following indications:
  - Management of schizophrenic patients who fail to respond adequately with other antipsychotic drugs.
- Approved for patients 65 years and younger; requests for patients greater than 65 years must document intolerance to or clinical failure of safer alternatives.
- Coverage is approved for 12 months.

Brand Name: Tobri  
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: Trelstar  
Generic Name: Triptorelin

Trelstar (triptorelin) Prior Authorization Criteria:

- Coverage is provided for the palliative treatment of advanced prostate cancer.
- Coverage is provided for 12 months.

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 members 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.
- Following documentation is required:
  - prior therapy with retinoid and anthracycline chemotherapy
  - APL characterized by presence of the t(15;17) translocation or PML/RAR-alpha gene expression.
- Coverage is provided for 12 months.

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 members with advanced or metastatic breast cancer whose tumors overexpress HER2 and who have received prior therapy including an anthracycline, a taxane, and trastuzumab.
- Coverage is provided for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor and for whom hormonal therapy is indicated.
- Coverage is provided for 12 months.



Brand Name: Tyzeka  
Generic Name: Telbivudine

#### Tyzeka (telbivudine) Prior Authorization Criteria

- Coverage is provided for treatment of chronic hepatitis B in adult members with evidence of viral replication and either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease.
- Documentation of date and results of serum aminotransferases or evidence of histologically active disease.
- Coverage approved for 12 months.

Brand Name: Vancomycin HCL  
Generic Name: Vancomycin 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: Vandetanib  
Generic Name: Vandetanib

#### Vandetanib Prior Authorization Criteria:

- Coverage is provided for the treatment of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease.
- Coverage is provided for 12 months.

Brand Name: Velcade  
Generic Name: Bortezomib

#### Velcade (bortezomib) Injection Prior Authorization Criteria

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

Brand Name: Ventavis  
Generic Name: Iloprost

#### Ventavis ( iloprost ) Inhalation Solution Prior Authorization Criteria

- Coverage is provided for the treatment of members with pulmonary arterial hypertension (PAH) .
- Coverage is approved for 12 months.

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 members 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 is provided for 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 the relief of the pain of osteoarthritis of knee or hand joints in the following situations:
  - When a member has tried and failed at least two of the following: ibuprofen, sulindac, naproxen, piroxicam, diclofenac, meloxicam, ketoprofen, nabumetone, indomethacin, flurbiprofen, or Celebrex
  - When the member is unable to take oral NSAIDs due to an underlying condition such as: peptic ulcer disease, gastrointestinal bleeding, a coagulation defect, chronic oral corticosteroid therapy, or concurrent therapy with an anticoagulant like warfarin, heparin, Lovenox, Arixtra, or Fragmin.
- Coverage is provided for 12 months.



Brand Name: Xenazine  
Generic Name: Tetrabenazine

Xenazine (tetrabenazine) Prior Authorization Criteria

- Coverage is provided for the treatment of chorea associated with Huntington's Disease.
- Coverage is provided for 12 months.

Brand Name: Xolair  
Generic Name: Omalizumab

Xolair (omalizumab) Prior Authorization Criteria

- Coverage is provided as maintenance therapy for prophylaxis of asthma exacerbations in members with moderate to severe allergic asthma in the following circumstances:
  - the member is  $\geq$  12 years of age
  - the member's baseline serum IgE level is  $\geq$  30IU/mL or  $>$  700IU/mL .
  - the member has tested positive to perennial allergens by skin testing or in vitro testing
- AND
- the member's symptoms are inadequately controlled with inhaled corticosteroids
- the member's current weight and IgE level fall within the normal dosing guidelines
- Coverage is provided for 6 months.
- Coverage may be renewed 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 members 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 members 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 members with cutaneous T-cell lymphoma (CTCL) who have progressive, persistent, or recurrent disease on or following 2 systemic therapies.
- Documentation of trial and failure of two systemic therapies is required.
- Coverage duration is 12 months.

Brand Name: Zometa  
Generic Name: Zoledronic acid

Zometa (zoledronic acid) Prior Authorization Criteria

- Coverage is provided for the treatment of:
  - Hypercalcemia of malignancy (albumin-corrected serum calcium  $\geq 12\text{mg/dL}$ )
  - Members with multiple myeloma and members with documented osteolytic metastases from solid tumors, in conjunction with standard antineoplastic therapy
- Documented albumin-corrected serum calcium level must be reported.
- Coverage is provided for 12 months.

Brand Name: Zytiga  
Generic Name: Abiraterone acetate

Zytiga (Abiraterone acetate) Prior Authorization Criteria

- Coverage is provided for the following indications:
  - In combination with prednisone for metastatic castration-resistant prostate cancer (CRPC)
- Additional information required with request:
  - Documented prior chemotherapy containing docetaxel
- Coverage is provided for 12 months

Brand Name: Zyvox  
Generic Name: Linezolid

Zyvox (linezolid) Prior Authorization Criteria

- Coverage is provided for the following indications:
  - Vancomycin-resistant enterococci (VRE...i.e.: *Enterococcus faecium*) infection with or without 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 member is unable to receive alternative oral or intravenous antibiotics (due to member allergies or lack of alternative antibiotics)
- Coverage is provided for 28 days.
- 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) Prior Authorization Criteria

- Coverage is provided for the following indications:
  - Vancomycin-resistant enterococci (VRE...i.e.: *Enterococcus faecium*) infection with or without 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
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  - Culture and sensitivity results
  - Documentaion that member is unable to receive alternative oral or intravenous antibiotics (due to member allergies or lack of alternative antibiotics)
- Coverage is provided for 28 days.
- 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.