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## **ACAMPROSATE**

### **Affected Drugs**

CAMPRAL®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ADALIMUMAB**

### **Affected Drugs**

HUMIRA®

### **Covered Uses**

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

### **Exclusion Criteria**

A 50-75% reduction in PASI score after 6 months when compared to baseline. At least 50-70% improvement from existing immunosuppressant therapy ie MTX [methotrexate]: Swollen joint counts, tender joint count, and all of the following 5 variables: Patient assessed global disease activity (eg by VAS), Evaluator assessed global disease activity (eg by VAS), Patient pain assessment (eg by VAS), Functional disability (eg by HAQ), Acute phase response (ESR or CRP).

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ADEFOVIR**

### **Affected Drugs**

HEPSERA®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **AFINITOR**

### **Affected Drugs**

AFINITOR®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **AGALSIDASE BETA**

### **Affected Drugs**

FABRAZYME®

### **Covered Uses**

Prescriptions for agalsidase beta (Fabrazyme®) may be approved for coverage for use in the treatment of documented Fabry disease when under the care of a contracted provider.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ALDESLEUKIN**

### **Affected Drugs**

PROLEUKIN®

### **Covered Uses**

Prescriptions for aldesleukin (Interleukin®, Proleukin®) may be approved for coverage if written by an oncologist for the treatment of metastatic renal cell cancer or metastatic melanoma.

### **Exclusion Criteria**

It is considered investigational when used for the treatment of multiple melanoma, HIV or AIDS, metastatic colon cancer or non-Hodkins lymphoma.

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ALEMTUZUMAB**

### **Affected Drugs**

CAMPATH®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ALGLUCOSIDASE ALFA**

### **Affected Drugs**

MYOZYME®

### **Covered Uses**

Prescriptions for alglucosidase alfa (Myozyme®) may be approved for coverage for infantile-onset patients diagnosed with Pompe's disease. The use of Myozyme in other forms of Pompe disease has not been adequately studied to assure safety and efficacy. Positive laboratory confirmation documentation is required for authorization.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ALITRETINOIN**

### **Affected Drugs**

PANRETIN®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ALOSETRON**

### **Affected Drugs**

LOTRONEX®

### **Covered Uses**

Prescriptions for alosetron (Lotronex®) may be approved for coverage for members who are: Female gender, AND A documented diagnosis of irritable bowel syndrome (IBS) with severe diarrhea in treatment with a gastroenterologist, AND Documentation of failure of 6 months of conventional treatment.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ALPHA 1 PROTEINASE INHIBITOR**

### **Affected Drugs**

ARALAST®  
PROLASTIN®

### **Covered Uses**

Prescriptions for alpha 1 proteinase inhibitor (Prolastin®) may be approved for coverage for members who are Alpha-1-antitrypsin deficient.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **AMBRISENTAN**

### **Affected Drugs**

LETAIRIS®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ANAKINRA**

### **Affected Drugs**

KINERET®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **APREPITANT**

### **Affected Drugs**

EMEND®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 6 months.

### **Other Criteria**

Amounts 48 to 72 hours post highly emetogenic chemotherapy (Part B) or radiation (Part D) induced nausea and vomiting. Amounts over 48 hours prescriptions will process as Part D. In addition, if the antiemetic therapy is a combination of the injectable and oral, then the oral tablets are covered under Part D.

# **ARIPIRAZOLE**

## **Affected Drugs**

ABILIFY DISCMELT®  
ABILIFY®

## **Covered Uses**

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

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

N/A

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

## **ARSENIC TRIOXIDE**

### **Affected Drugs**

TRISENOX®

### **Covered Uses**

Prescriptions for arsenic trioxide (Trisenox®) may be approved for coverage for remission-induction and consolidation of the acute promyelocytic (M3) subtype of acute myeloid (myelogenous, nonlymphocytic) leukemia (AML, ANLL) that is refractory to retinoid and anthracycline therapy or has relapsed despite such therapy.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **B VS D - PART B VERSUS PART D COVERAGE PA**

### **Affected Drugs**

AZASAN®  
AZATHIOPRINE  
CARIMUNE NF NANOFILTERED®  
CELLCEPT®  
CYCLOPHOSPHAMIDE  
CYCLOSPORINE  
FLEBOGAMMA®  
GAMASTAN S-D®  
GAMMAGARD LIQUID®  
GAMUNEX®  
GENGRAF  
IVEEGAM EN®  
METHOTREXATE  
MYCOPHENOLATE MOFETIL  
MYFORTIC®  
ONDANSETRON HCL  
ONDANSETRON ODT  
PANGLOBULIN NF®  
POLYGAM S-D®  
PROGRAF®  
RAPAMUNE®

### **Covered Uses**

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.

## **BECAPLERMIN**

### **Affected Drugs**

REGRANEX®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

10 week, and 2nd 10 week with 30% decrease in ulcer size. Renew for 10wk courses if still improving.

### **Other Criteria**

N/A

## **BETAINE**

### **Affected Drugs**

CYSTADANE®

### **Covered Uses**

Prescriptions for betaine (Cystadane®) may be approved for coverage for members with: high levels of homocysteine in the plasma and urine , homocystinuria with concomittant methionine dietary restriction and B6, B12 and folate administration.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **BORTEZOMIB**

### **Affected Drugs**

VELCADE®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

# **BOSENTAN**

## **Affected Drugs**

TRACLEER®

## **Covered Uses**

Prescriptions for bosentan (Tracleer) may be approved for: Member has a documented diagnosis\* of pulmonary arterial hypertension with WHO Class III or IV symptoms AND member is NOT concurrently on glyburide or cyclosporine AND Member has had baseline liver function tests (ALT, AST) performed prior to initiation of therapy AND If member is a woman of childbearing potential, she has had a baseline negative pregnancy test prior to initiation of therapy. Manufacturer recommends obtaining results from a urine or serum pregnancy test performed during the first 5 days of a normal menstrual period and at least 11 days after the last unprotected act of sexual intercourse. \*NOTE: Documented diagnoses can include primary pulmonary hypertension, or pulmonary hypertension secondary to any of the following conditions: Congenital heart disease with shunting, or Congenital diaphragmatic hernia, or Connective tissue diseases, or Anorectic agents (diet drugs), or Portopulmonary hypertension, or Chronic thromboembolic pulmonary hypertension, or HIV infection, or Sarcoidosis, or Familial pulmonary hypertension.

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

N/A

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

## **CELECOXIB**

### **Affected Drugs**

CELEBREX®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **CINACALCET**

### **Affected Drugs**

SENSIPAR®

### **Covered Uses**

Prescriptions for cinacalcet (Sensipar®) may be approved for coverage for members with documented secondary hyperparathyroidism, (indicated by elevated levels of PTH) following documented trials and failures of formulary agents, ie calcitriol, generic Rocaltrol®.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **CYCLOSPORINE, OPHTHALMIC**

### **Affected Drugs**

RESTASIS®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **DARBOEPOETIN**

### **Affected Drugs**

ARANESP®

### **Covered Uses**

Prescriptions for darboepoetin (Aranesp®) may be approved for coverage for members with the following diagnosis: Anemia induced by Chronic Renal Failure, Anemia induced by chemotherapy for nonmyeloid malignancies, Specifically, Amgen's Aranesp and Johnson and Johnson's Procrit should be labeled to state ESAs are not indicated for patients undergoing curative treatment, those with metastatic breast cancer, or those with metastatic head and neck cancer. AND A documented contraindication, allergy or intolerance to epoetin alfa with Current iron therapy, adequate serum iron (greater than 40), transferrin saturation (greater than 20%) and less than 10mg/dl Hgb\*, OR Those requiring extended therapy with epoetin alfa.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **DASATINIB ORAL**

### **Affected Drugs**

SPRYCEL®

### **Covered Uses**

Prescriptions for dasatinib, oral (Sprycel®) may be approved for coverage, is a multiple tyrosine kinase inhibitor used for Chronic Myeloid Leukemia (CML): Blastic Phase, Chronic phase, Accelerated Phase, OR Philadelphia Chromosome Positive (Ph+) Acute Lymphoid Leukemia. WHEN Resistant or intolerant to prior therapy including imatinib (ALL indications).

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

Must be prescribed by a hematologist/oncologist.

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **DEFERASIROX**

### **Affected Drugs**

EXJADE®

### **Covered Uses**

Prescriptions for deferasirox (Exjade®) may be approved for coverage for patients with: Chronic iron overload AND No sensitivities known to deferasirox AND Liver and kidney evaluations documented by current liver and renal function tests.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **DENILEUKIN DIFTITOX**

### **Affected Drugs**

ONTAK®

### **Covered Uses**

Cutaneous T-cell Lymphoma. Prescriptions for denileukin diftitox (Ontak®) may be approved for coverage and is used for the treatment of persistent or recurrent cutaneous T-cell lymphoma (CTCL, e. g. , mycosis fungoides, Sézary syndrome) in patients whose malignant cells express the CD25 component of the IL-2 receptor.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **DESMOPRESSIN**

### **Affected Drugs**

DESMOPRESSIN ACETATE

### **Covered Uses**

Prescriptions for desmopressin (DDAVP®) may be approved for coverage for patients with Diabetes insipidus.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **DICLOFENAC TOPICAL**

### **Affected Drugs**

SOLARAZE®

### **Covered Uses**

Prescriptions for diclofenac topical (Solaraze®) may be approved for coverage for members with documented actinic keratosis.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **DOFETILIDE**

### **Affected Drugs**

TIKOSYN®

### **Covered Uses**

Prescriptions for dofetilide (Tikosyn®) may be approved for coverage for members undergoing cardioversion or treatment for atrial fibrillation/flutter and prescribed by a cardiologist.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **DORNASE ALFA**

### **Affected Drugs**

PULMOZYME®

### **Covered Uses**

Prescriptions for dornase alpha (Pulmozyme®) may be approved for coverage as an adjunctive mucolytic for compliant respiratory cystic fibrosis patients.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **DOXERCALCIFEROL**

### **Affected Drugs**

HECTOROL®

### **Covered Uses**

Prescriptions for doxercalciferol (Hectorol®) may be approved for coverage for patients with hyperparathyroidism secondary to chronic renal failure with or without dialysis.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **DULOXETINE**

### **Affected Drugs**

CYMBALTA®

### **Covered Uses**

Prescriptions for duloxetine (Cymbalta®) may be approved for coverage for members requiring antidepressant therapy failing SSRIs [Selective Serotonin Reuptake Inhibitors] or needing SSRI [Selective Serotonin Reuptake Inhibitor] and SNRI [Selective Norepineprine reuptake inhibitor] dual activity. Psychiatrists are exempt from prior authorization.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

# **ELTROMBOPAG**

## **Affected Drugs**

PROMACTA®

## **Covered Uses**

All FDA-approved indications not otherwise excluded from Part D. Prescriptions for eltrombopag (Promacta) may be initially approved for coverage for patients with moderate or severe thrombocytopenia due to chronic immune (idiopathic) thrombocytopenic purpura (ITP) who have had documented trials and failures of corticosteroids, immunoglobulins OR splenectomy AND are bleeding or whose clinical condition increases the risk of bleeding (e. g. , patient will start myelosuppressive or immunosuppressive agents or surgery. ) Repeat courses may be covered with demonstrated maintenance of platelet count = 50 x 10<sup>9</sup>/L and current liver function tests.

## **Exclusion Criteria**

N/A

## **Required Medical Information**

Documentation of trials and failures of corticosteroids, immunoglobulins OR splenectomy AND are bleeding or whose clinical condition increases the risk of bleeding (e. g. , patient will start myelosuppressive or immunosuppressive agents. ), platelet counts and liver function tests.

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

Hematologist and/or oncologist registered with Promacta Cares Program.

## **Coverage Duration**

6 months.

## **Other Criteria**

N/A

## **ENOXAPARIN**

### **Affected Drugs**

LOVENOX®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

7 days.

### **Other Criteria**

N/A

## **ENTECAVIR**

### **Affected Drugs**

BARACLUDE®

### **Covered Uses**

Prescriptions for entecavir (Baraclude®) may be approved for coverage for members with: Nucleoside naïve Chronic Type B Viral Hepatitis OR Lamivudine-Refractory Chronic Hepatitis B WITH evidence of active viral replication as well as evidence of histologically active disease or persistent elevations in serum aminotransferases.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **EPOETIN ALPHA**

### **Affected Drugs**

PROCRIT®

### **Covered Uses**

All FDA-approved indications not otherwise excluded from Part D worded as anemia associated with chronic renal failure (CRF) (or renal insufficiency), including patients on dialysis and not on dialysis, if hemoglobin (Hb) is less than or equal to 11.0 g/dL for therapy initiation. If the patient has previously been receiving darbepoetin or epoetin alfa, approve only if Hb is less than or equal to 12.0 g/dL. Deny darbepoetin if hemoglobin exceeds 12.0 g/dL if previously receiving the product for this indication and in any situation (continuation or initiation). Anemic patients with HIV who are receiving zidovudine therapy if Hb is less than or equal to 10.0 g/dL or endogenous erythropoietin levels are less than or equal to 500 munits/mL and deny epoetin alfa if Hb is greater than 12.0 g/dL if previously receiving the product for this indication and in any situation (continuation or initiation). Anemia in cancer due to chemotherapy approve for 4 months if the patient has Hb less than or equal to 10.0 g/dL or Hb is greater than 10.0 g/dL but less than or equal to 12.0 g/dL and the physician anticipates a Hb decrease or the patient has comorbidities that require higher Hb levels. Also, deny epoetin alfa if Hb is greater than 12.0 g/dL if previously receiving the product for this indication and in any situation (continuation or initiation). Anemic patients with Hb less than or equal to 13.0 g/dL at high risk for perioperative transfusions secondary to significant, anticipated blood loss and are scheduled to undergo elective noncardiac, nonvascular surgery to reduce the need for allogeneic blood transfusions approve for 21 days. Anemia due to myelodysplastic syndrome (MDS) but do not approve if Hb is greater than 12.0 g/dL if previously receiving the product for this indication and in any situation (continuation or initiation). Anemia in HIV-infected patients if Hb is less than or equal to 10.0 g/dL or endogenous erythropoietin levels are less than or equal to 500 mUnits/mL but deny if Hb is greater than 12.0 g/dL if previously receiving the product for this indication and in any situation (continuation or initiation). Preoperative use in patients undergoing major surgery utilizing hemodilution intraoperatively for one month. Treatment of aplastic anemia if prescribed by a hematologist and to deny if Hb exceeds 12.0 g/dL if previously receiving the product for this indication and in any situation (continuation or initiation).

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Authorization will be for 12 months.

**Other Criteria**

N/A

## **ERTAPENUM**

### **Affected Drugs**

INVANZ®

### **Covered Uses**

Prescriptions for ertapenum (Invanz®) may be approved for coverage based on culture and sensitivities OR Prescription written by an Infectious Disease Specialist.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ETANERCEPT**

### **Affected Drugs**

ENBREL®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **EXENATIDE**

### **Affected Drugs**

BYETTA®

### **Covered Uses**

Prescriptions for exenatide (Byetta®) may be approved for coverage as an adjunct to therapy with metformin and/or a sulfonylurea for the management of type 2 (noninsulin-dependent) diabetes mellitus in patients who have not achieved adequate glycemic control with these antidiabetic agents alone or in combination. AND Have documented compliance with trials and failures of formulary alternatives that are first-line ie sulfonureas, biguanides, thiazolidinediones, basal and short acting insulin therapies.

### **Exclusion Criteria**

Byetta is not covered as a weight loss product.

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **EZETIMIBE**

### **Affected Drugs**

ZETIA®

### **Covered Uses**

Prescriptions for ezetimibe (Zetia®) may be approved for coverage for members with a documented diagnosis of hypercholesterolemia with the following criteria: Intolerance to HMG CoA Reductase Inhibitors OR Contraindication to HMG CoA Reductase Inhibitors.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **FENTANYL PATCHES**

### **Affected Drugs**

FENTANYL

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **FILGRASTIM**

### **Affected Drugs**

NEUPOGEN®

### **Covered Uses**

Prescriptions for filgrastim (Neupogen®) may be approved for coverage for members with the following documented diagnosis and an ANC less than 1,000/mm<sup>3</sup>: Chemotherapy-induced neutropenia or febrile neutropenia, bone marrow transplantation, peripheral blood stem cell mobilization, chronic congenital neutropenia, chronic cyclic neutropenia or idiopathic neutropenia.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

# **FONDAPARINUX**

## **Affected Drugs**

ARIXTRA®

## **Covered Uses**

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

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

N/A

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

# **GALSULFASE**

## **Affected Drugs**

NAGLAZYME®

## **Covered Uses**

Prescriptions for galsulfase (Naglazyme®) may be approved for coverage for: the treatment of Mucopolysaccharidosis type VI (MPS VI or Maroteaux-Lamy syndrome). Clinical studies demonstrated that galsulfase improved walking and stair-climbing capacity (Prod Info Naglazyme(TM), 2005). Other than ameliorative care to alleviate some of the symptoms, galsulfase provides the only safe and effective treatment for MPS VI. MPS VI, an autosomal recessive disease, is a deficiency in of an enzyme, N-acetylgalactosamine 4-sulfatase, resulting in an accumulation of glycosaminoglycans (GAG) in lysosomes of various tissues throughout the body. Accumulation of GAG results in widespread cellular, tissue, and organ dysfunction. The widespread organ involvement leads to a variety of clinical symptoms including skeletal deformities, and organ and soft tissue involvement. Individuals may experience short stature, abnormal bone formation, degenerative joint disease, hydrocephalus, impaired vision and hearing, sleep disorders, reduced endurance, coarse facial features, carpal tunnel syndrome, spinal cord compression, spastic quadriplegia, hepatomegaly, splenomegaly, cardiac valve dysfunction, respiratory dysfunction, and shortened life span (Yogalingam , 2004).

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

N/A

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

## **GEFITINIB**

### **Affected Drugs**

IRESSA®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **GLATIRAMER ACETATE**

### **Affected Drugs**

COPAXONE®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

# **GRANISETRON**

## **Affected Drugs**

GRANISETRON HCL  
GRANISOL

## **Covered Uses**

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

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

N/A

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

## **IDURSULFATASE**

### **Affected Drugs**

ELAPRASE®

### **Covered Uses**

Prescriptions for idursulfatase (Elaprase®) may be approved for coverage for Hunters syndrome.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **IMATINIB**

### **Affected Drugs**

GLEEVEC®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **IMI GLUCERASE**

### **Affected Drugs**

CEREZYME®

### **Covered Uses**

Prescriptions for imiglucerase (Cerezyme®) may be approved for coverage for long term enzyme replacement therapy for pediatric and adult patients with a documented diagnosis of Type 1 Gaucher's disease under the supervision of a contracted provider AND Anemia, OR Thrombocytopenia, OR Bone disease, OR Hepatomegaly OR Splenomegaly are present.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **INFLIXIMAB**

### **Affected Drugs**

REMICADE®

### **Covered Uses**

Prescriptions for infliximab (Remicade®) may be approved following determination of Part B v. Part D coverage in the following conditions: Active Crohn's Disease, as manifested by any one of the following signs/symptoms: Diarrhea, Abdominal pain, Bleeding, Weight loss, Perianal disease, Internal fistulae, Intestinal obstruction, Megacolon, or Extra-intestinal manifestations: arthritis or spondylitis, and Crohn's disease has remained active despite treatment with one of the following: Corticosteroids or 6-mercaptopurine/azathioprine, or Member has fistulizing Crohn's disease for at least 3 months, or Member has rheumatoid arthritis and has had an inadequate response to a 3 or more month trial of methotrexate or is unable to tolerate methotrexate monotherapy, or Member is 18 years of age or older, has moderate to severe chronic plaque psoriasis, and meets the following selection criteria: Plaque psoriasis has been present for more than 1 year, and Ten percent or more body surface area is affected by plaque psoriasis, and Palms and soles of the feet are affected, and Member has failed to adequately respond to or is intolerant to a three or more month trial of one of the following phototherapies (unless contraindicated): Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA) or UVB with coal tar or dithranol. To continue treatment for plaque psoriasis, the following condition must be met for approval: Improvement in PASI score of 50-75% after 6 months from baseline. Psoriatic Arthritis: Member has active psoriatic arthritis, as indicated by both of the following: At least 3 swollen joints and At least 3 tender joints. Member has had an inadequate response to any one of the non-steroidal anti-inflammatory drugs (NSAIDs) (unless contraindicated) and to any one of the following disease-modifying anti-rheumatic drugs (DMARDs) (methotrexate, cyclosporine, sulfasalazine, mercaptopurine, gold compounds, or corticosteroids). Members with active ankylosing spondylitis or other active spondyloarthropathy with evidence of inflammatory disease who have an inadequate response to NSAIDs [Non-steroidal anti-inflammatory drugs] and to any one of the DMARDs [Disease-modifying antirheumatic drugs] (sulfasalazine, methotrexate, corticosteroids, azathioprine, cyclosporine, cyclophosphamide). Members who have failed or are intolerant to non-steroidal anti-inflammatory drugs, sulfasalazine, steroids and methotrexate.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Authorization will be for 12 months.

**Other Criteria**

N/A

## **INTERFERON ALPHA**

### **Affected Drugs**

INFERGEN®  
INTRON A®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **INTERFERON BETA**

### **Affected Drugs**

AVONEX ADMINISTRATION PACK®  
AVONEX®  
BETASERON®  
REBIF®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ISOTRETINOIN, ORAL**

### **Affected Drugs**

AMNESTEEM  
CLARAVIS  
SOTRET

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

# **ITRACONAZOLE**

## **Affected Drugs**

ITRACONAZOLE

## **Covered Uses**

Prescriptions for itraconazole (Sporanox®) may be approved for coverage for members with: the diagnosis of onychomycosis, AND immunocompromised or diabetic or has peripheral vascular disease, AND symptomatic defined as toenail or fingernail involvement prevents the patient from performing normal daily tasks such as walking, standing, typing due to pain, OR secondary involvement of tissues surrounding the nail and the nail bed. May be approved for all other diagnosis if written by an ID specialist.

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

Prior authorization not required if prescribed by a contracted infectious disease specialist or pulmonologist.

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

# **IXABEPILONE**

## **Affected Drugs**

IXEMPRA®

## **Covered Uses**

Prescriptions for ixabepilone (Ixemptra®) may be approved for coverage for members with breast cancer: as monotherapy for the treatment of locally advanced or metastatic breast cancer in patients whose tumors are refractory or resistant to anthracyclines, taxanes, and capecitabine. OR in combination with capecitabine for the treatment of locally advanced or metastatic breast cancer that is anthracycline- and taxane-resistant. Anthracycline resistance is defined as progression while receiving therapy, within 6 months of adjuvant therapy, or within 3 months of metastatic treatment, taxane resistance is defined as progression while receiving therapy, within 12 months of adjuvant therapy, or within 4 months of metastatic treatment.

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

N/A

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

# LANSOPRAZOLE

## Affected Drugs

PREVACID®

## Covered Uses

Prescriptions for lansoprazole (Prevacid®) may be approved for coverage for members with a documented diagnosis listed below: Duodenal ulcer - active ulcer, maintenance of healed ulcer, Gastric ulcer - active benign, maintenance, Gastrojejunal ulcer - active, maintenance, NSAID-induced gastric ulcer - healing, risk reduction for recurrence, Peptic ulcer disease, Stress ulcer/surgical prophylaxis, Barrett's esophagus, Crohn's disease, Erosive esophagitis - active, maintenance, healed, Gastric residual reduction, Gastrointestinal bleed, GERD [Gastroesophageal Reflux Disease] - moderate to severe with symptoms (treatment, maintenance, screening), H. pylori, treatment, Hypersecretory conditions, including Zollinger-Ellison Syndrome, Laryngopharyngeal reflux, AND A document intolerance to the nonprescription Prilosec OTC, OR Failure of an adequate trial of at least eight (8) weeks of the nonprescription Prilosec OTC 40mg (2-20mg) up to 80mg TID for hypersecretory conditions with generic Zantac BID or QHS AND A documented intolerance to the formulary alternative in this class, OR Failure of an adequate trial of at least eight (8) weeks of the formulary alternative in this class.

## Exclusion Criteria

N/A

## Required Medical Information

N/A

## Age Restrictions

N/A

## Prescriber Restrictions

N/A

## Coverage Duration

Authorization will be for 12 months.

## Other Criteria

N/A

## **LAPATINIB**

### **Affected Drugs**

TYKERB®

### **Covered Uses**

Prescriptions for Lapatinib ditosylate (Tykerb®) may be covered for patients when written by oncology: as combination therapy with capecitabine for the treatment of patients with human epidermal receptor-2 (HER2)-overexpressing advanced or metastatic breast cancer who have progressed after receiving prior therapies including an anthracycline, a taxane, and trastuzumab. Its clinical efficacy has been demonstrated in combination with capecitabine in a phase III, open-label, randomized trial, resulting in statistically significant improvements in the overall response and prolongation of the median time to disease progression compared to capecitabine alone (Prod Info TYKERB(R) oral tablets, 2007). as a theoretical advantage over monoclonal antibodies that target extracellular HER2 only (eg, trastuzumab) by recognizing truncated forms of HER1 and HER2 that lack an extracellular domain. The small molecular size also makes lapatinib more penetrable through the blood-brain barrier than larger molecules, such as trastuzumab, allowing lapatinib to reach adequate pharmacologic concentrations.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

Must be prescribed by oncology.

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **LARONIDASE**

### **Affected Drugs**

ALDURAZYME®

### **Covered Uses**

MUCOPOLYSACCHARIDOSIS I: 1) Enzyme replacement therapy with intravenous laronidase is indicated for patients with Hurler and Hurler-Scheie forms of mucopolysaccharidosis I and for patients with the Scheie forms who have moderate to severe symptoms. Laronidase has been shown to improve pulmonary function and walking capacity, however, it has not been evaluated for its effects on the central nervous system manifestations of the disease. Long-term effects on morbidity and mortality are unknown. 2) Bone marrow transplantation (BMT) remains the best hope for patients with Hurler's syndrome. BMT [Bone Marrow Transplant] may achieve life-long normalization of enzyme activity, it prolongs survival and enables continued cognitive development in children with a baseline Mental Development Index of greater than 70. The 5-year actuarial probability of survival of children with Hurler's syndrome following related-donor BMT [Bone Marrow Transplant] is about 65%, and this serves as a benchmark for long-term studies with laronidase in Hurler children. Some problems with BMT [Bone Marrow Transplant] in this setting are graft-versus-host disease and poorer developmental outcome in children engrafted after 2 years of age. Use of laronidase in the context of BMT [Bone Marrow Transplant] requires investigation. Potential roles include administration after BMT [Bone Marrow Transplant] in older Hurler children to improve outcome, and use in patients unable to undergo BMT [Bone Marrow Transplant] or those unable to achieve stable engraftment or near-normal enzyme activity post-BMT.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

**Other Criteria**

N/A

## **LENALIDOMIDE**

### **Affected Drugs**

REVLIMID®

### **Covered Uses**

All FDA - approved indications not otherwise excluded from Part D. Prescriptions for lenalidomide (Revlimid®) may be approved for coverage for members for the treatment of transfusion-dependent patients with 5q- myelodysplastic syndrome. It has shown efficacy in an open-label single arm clinical trial and has not been evaluated in randomized clinical trials. The benefits of lenalidomide must be weighed against the risks, as it is highly myelosuppressive.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **LEUPROLIDE**

### **Affected Drugs**

ELIGARD®  
LEUPROLIDE ACETATE  
LUPRON DEPOT®  
LUPRON DEPOT-PED®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **LIDOCAINE PATCH**

### **Affected Drugs**

LIDODERM®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **LINEZOLID**

### **Affected Drugs**

ZYVOX®

### **Covered Uses**

Prescriptions for linezolid (Zyvox®) may be approved for coverage for members with: A documented diagnosis of vancomycin-resistant *Enterococcus faecium* infection, OR A documented diagnosis of methicillin-resistant *Staphylococcus aureus* infection, OR A documented diagnosis of penicillin-resistant *Streptococcus pneumoniae* infection, OR A documented diagnosis of nosocomial pneumonia, community-acquired pneumonia, or skin or skin structure infections, including diabetic foot infections without concomitant osteomyelitis, caused by susceptible organisms (*Staphylococcus aureus*, *Streptococcus pneumoniae*, *Streptococcus pyogenes*, or *Streptococcus agalactiae*) that have documented failure or non-susceptibility to all formulary and all more cost effective non-formulary antibiotics.

### **Exclusion Criteria**

Linezolid will not be approved for catheter-related bloodstream or catheter-site infections due to increased risk of death with gram negative infections.

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **MECASERMIN**

### **Affected Drugs**

INCRELEX®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **MEMANTINE**

### **Affected Drugs**

NAMENDA®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **MICAFUNGIN**

### **Affected Drugs**

MYCAMINE®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **MIGULSTAT**

### **Affected Drugs**

ZAVESCA®

### **Covered Uses**

A) Miglustat should be considered an alternative to enzyme replacement therapy with beta-glucocerebrosidase (ie, alglucerase or imiglucerase) in patients with confirmed nonneuronopathic Gaucher's disease. Patients unwilling to continue intravenous infusions of enzyme or those unable to receive infusions due to non-insured costs (rising to \$150, 000 annually in some cases) or other factors (eg, poor intravenous access) would be likely candidates. Cost of enzyme therapy is a major consideration in some countries. However, miglustat appears less effective than enzyme infusions (particularly with respect to hematologic response), and may not be associated with clinically-relevant benefit in some patients, the main goal of miglustat therapy, a significant reduction in stores of glucocerebroside (glucosylceramide), has not been addressed in available published clinical studies. As the primary studies in these patients were uncontrolled, some benefits reported may have occurred in the absence of therapy. Although controlled studies in type 1 Gaucher's disease are difficult to perform, an additional study at least investigating effects of the drug on tissue or plasma glucocerebroside appears warranted. B) Combination therapy with oral miglustat and enzyme replacement has been studied. In a small active-controlled study, miglustat appeared to increase the clearance of imiglucerase (Cerezyme(R)) by 70%, therefore, combination therapy with imiglucerase is not indicated. C) Data are too limited in HIV infection to recommend use of miglustat.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

**Other Criteria**

N/A

## **MODAFINIL**

### **Affected Drugs**

PROVIGIL®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **MONTELUKAST SODIUM**

### **Affected Drugs**

SINGULAIR®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **NAFARELIN**

### **Affected Drugs**

SYNAREL®

### **Covered Uses**

Prescriptions for nafarelin (Synarel®) may be approved for coverage for patients: For the treatment and management of endometriosis who have contraindications or intolerance to Leuprolide injections or danazol therapy and who are not candidates for surgery.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **NILOTINIB**

### **Affected Drugs**

TASIGNA®

### **Covered Uses**

Prescriptions for nilotinib (Tasigna®) may be approved for coverage for patients with: chronic phase or accelerated phase chronic myeloid leukemia (CML), who are refractory or intolerant to imatinib.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **NITISINONE**

### **Affected Drugs**

ORFADIN®

### **Covered Uses**

Prescriptions for nitisinone (Orfadin®) may be approved for coverage: Nitisinone (combined with dietary restriction) should be considered the treatment of choice for hereditary tyrosinemia type 1. Treatment should be initiated early. Data suggest that beginning treatment before 2 years may reduce the risk of hepatocellular carcinoma, this benefit may be lost if therapy is started later in life. About 10% of children will, however, not respond to nitisinone therapy, and liver transplantation is indicated in these patients. Transplantation is also indicated in patients with suspected hepatocellular carcinoma.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **OCTREOTIDE**

### **Affected Drugs**

OCTREOTIDE ACETATE  
SANDOSTATIN LAR®

### **Covered Uses**

Prescriptions for octreotide (Sandostatin®) may be approved for coverage for members with the following conditions only: Metastatic carcinoid tumors, Vasoactive intestinal peptide secreting tumors (VIPomas), Pancreatic tumors, Gastrinomas, Documented secretory diarrhea Acromegaly. GH [growth hormone], IGF levels are needed.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Efficacy, safety and reassessment documentation must be submitted every 3 months.

### **Other Criteria**

N/A

# **OLANZAPINE**

## **Affected Drugs**

ZYPREXA ZYDIS®  
ZYPREXA®

## **Covered Uses**

Prescriptions for olanzapine (Zyprexa®) may be approved for coverage: This PA edit will only apply to new start beneficiaries. The edit will not apply to beneficiaries stabilized on the medication or transitioning beneficiaries stabilized on the medication. Does not require prior auth when prescribed by a contracted psychiatrist. May be approved for members with a documented diagnosis of schizophrenia or acute manic or mixed episode associated with bipolar disease when under the care of a psychiatrist.

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

N/A

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

## **OMALIZUMAB**

### **Affected Drugs**

XOLAIR®

### **Covered Uses**

Prescriptions for omalizumab (Xolair®) may be approved for coverage for members 12 and over with documented compliance with current inhaled and/or nasal corticosteroids first line AND Leukotriene inhibitors (LT4s such as montelukast (Singulair®) and zafirlukast (Accolate®) added to compliant corticosteroid use. Immunotherapy treatments must be considered as well. AND Pretreatment IgE levels are required between 30 and 700 IU/mL. Documented positive skin testing (or invitro testing) sensitization to perennial aeroallergen (ie. , dust mites, animal danders, cockroach, molds). Baseline FEV1, peak flow, or other pulmonary function testing is recommended. AND Diagnosis is Asthma prevention.

### **Exclusion Criteria**

Xolair is not covered for food allergy.

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

Prescriber must be pulmonary or allergist.

### **Coverage Duration**

Approval is for 6 month period.

### **Other Criteria**

N/A

## **ONDANSETRON**

### **Affected Drugs**

ONDANSETRON HCL

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

Oncologists are exempt.

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **OPRELVEKIN**

### **Affected Drugs**

NEUMEGA®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **OSELTAMIVIR PHOSPHATE**

### **Affected Drugs**

TAMIFLU®

### **Covered Uses**

Prescriptions for oseltamivir phosphate (Tamiflu®) may be approved for coverage: A documented: Onset of influenza symptoms within 48 hours or less AND Presence of a fever (over 100 degrees Fahrenheit) AND Presence of two or more specific influenza symptoms OR A documented need for prophylactic therapy due to presence of influenza in a family member. OR A documented need for prophylactic therapy in high risk patient due to community influenza outbreak. High risk patients as defined in Notes below: persons aged greater than 65 years, residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions, adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including asthma, adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus [HIV]), children and adolescents (aged 6 months--18 years) who are receiving long-term aspirin therapy and, therefore, might be at risk for experiencing Reye syndrome after influenza infection, women who will be pregnant during the influenza season, AND Contraindication to the formulary alternatives (amantadine and rimantadine), OR Intolerance to one (1) formulary alternative indicated for the member's condition, OR Allergy to one (1) formulary alternative agent indicated for the member's condition.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

**Other Criteria**

N/A

# **OXANDROLONE**

## **Affected Drugs**

OXANDROLONE

## **Covered Uses**

A) Oxandrolone is indicated as adjunctive therapy to promote weight gain in patients who have undergone extensive surgery, chronic infection, long-term corticosteroid therapy, or severe trauma, or who by some unknown pathogenic process have failed to gain weight. Oxandrolone also is indicated in the treatment of bone pain associated with osteoporosis. B) Oxandrolone has a place in the treatment of constitutional delay of growth and puberty in boys and Turner's syndrome in girls. Although studies have not involved large numbers of patients, definite increases in growth rate and improvements in psychological disturbances have been reported. Sustained growth rates have occurred following withdrawal of therapy, and final height has not been compromised. The growth acceleration induced by oxandrolone even in uncontrolled studies appears to be real, as the boys evaluated had not achieved a level of sexual maturation sufficient enough to be associated with spontaneous growth spurts. Oxandrolone has been more effective than growth hormone in accelerating growth rate. In girls with Turner's syndrome, oxandrolone plus human growth hormone appears to be the most successful regimen available with respect to predicted adult height (Nilsson et al, 1996, Nilsson, 1989). C) A high-dose, short-term regimen of oxandrolone in combination with parenteral nutrition has produced clinical benefits in patients with alcoholic hepatitis. Long-term survival may also be improved. As there are no other reliable modalities available for these patients, except possibly high-dose corticosteroids (Bonkovsky et al, 1991), oxandrolone should also be on hospital formularies for this indication. D) Oxandrolone may also be considered as adjunctive therapy in patients with severe conditions associated with loss of tissue protein, especially in terminal patients, and in male patients with severe symptomatic hypertriglyceridemia who are unresponsive to conventional therapy. For the latter indication, the drug should be given only as a last resort because of its deleterious effects on high- and low-density lipoprotein levels.

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Authorization will be for 12 months.

**Other Criteria**

N/A

## **OXYCODONE, EXTENDED RELEASE**

### **Affected Drugs**

OXYCODONE HCL  
OXYCONTIN®

### **Covered Uses**

Prescriptions for generic oxycodone, extended release (Oxycontin®) may be approved for coverage for members on Doses greater than 80 BID AND Evidence of adverse drug reaction\* on Kadian and MS [Multiple Sclerosis] Contin. The brand will be covered if the generic is not being manufactured. Pain management specialists are exempt from prior authorization.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **PALIPERIDONE**

### **Affected Drugs**

INVEGA®

### **Covered Uses**

Prescriptions for paliperidone (Invega®) may be approved for coverage for members who have: positive and negative symptoms, disorganized thoughts, uncontrolled hostility/excitement, and anxiety/depression symptoms associated with a diagnosis of schizophrenia AND documented compliant trials and failures with risperidone first line.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

# **PAMIDRONATE**

## **Affected Drugs**

PAMIDRONATE DISODIUM

## **Covered Uses**

Prescriptions for pamidronate (Aredia®) may be approved for coverage for members who have: hypercalcemia of malignancy, Paget's disease, and osteolytic bone lesions of multiple myeloma and breast cancer. The drug offers potential advantages over etidronate in that it inhibits bone resorption at doses that do not impair bone mineralization, and is less likely than etidronate to produce osteomalacia. AND pain due to osteolytic disease and as an adjunctive treatment for patients receiving radiation therapy, analgesics, or surgical intervention to stabilize fractures of impending fractures AND metastatic bone pain, prevention of complications due to bone metastases, and prevention of bone metastases and in the palliative treatment of pain from bone metastases associated with advanced-case breast cancer, multiple myeloma, and other primary and secondary neoplasms. AND Etidronate failure, tumor-induced hypercalcemia (TIH) and a serum calcium of 3 mmol/L or greater (corrected for protein concentration) and for symptomatic patients with a serum calcium less than 3 mmol/L. in conjunction with calcitonin during the first 2 days of treatment. OR PAGET'S DISEASE with symptoms ie, bone pain, head pain due to involvement of the skull (neural compression) or in patients who will be undergoing orthopedic surgery of a bone affected by Paget's disease as evidenced by serum or bone-specific alkaline phosphatase or to induce a remission.

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

N/A

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

## **PANTOPRAZOLE SODIUM**

### **Affected Drugs**

PROTONIX IV®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **PAPILLOMAVIRUS VACCINE, HUMAN**

### **Affected Drugs**

GARDASIL®

### **Covered Uses**

For Abrazo Advantage Health Plan (AAHP) female members, this quadrivalent, recombinant human papillomavirus vaccine types 6, 11, 16, 18 is covered for prevention with Ages 9 through 26 years old, regardless of whether the series has been completed.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **PEG - INTERFERON ALFA-2B +/- RIBAVIRIN**

### **Affected Drugs**

PEGASYS®

### **Covered Uses**

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

### **Exclusion Criteria**

Treatment will not be approved for members with decompensated liver disease as manifested by bilirubin greater than 2 mg/dL, patient greater than 3 seconds prolonged or INR greater than 2, WBC less than 3000/mm<sup>3</sup>, platelets less than greater than 70,000/mm<sup>3</sup>, history of hepatic encephalopathy, variceal bleeding, ascites, or other clinical signs of decompensation.

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

# PEGADEMASE

## Affected Drugs

ADAGEN®

## Covered Uses

A) In limited case reports, pegademase bovine has been effective and safe for the treatment of adenosine deaminase deficiency and severe combined immunodeficiency disease in children. The place in therapy of pegademase bovine at present would appear to be as an alternative when bone marrow transplantation is not feasible or has been unsuccessful. It may also be considered in lieu of transplantation in milder cases of adenosine deaminase deficiency (Levy et al, 1988). Pegademase bovine is preferable to red cell transfusions in these patients. B) Although the relatively small number of cases of adenosine deaminase deficiency precludes large studies, more investigations are required to determine optimal doses and whether sustained benefit can be achieved with pegademase bovine. Further evaluation of the adverse immunologic effects of pegademase bovine during long-term treatment is also required.

## Exclusion Criteria

N/A

## Required Medical Information

N/A

## Age Restrictions

N/A

## Prescriber Restrictions

N/A

## Coverage Duration

Authorization will be for 12 months.

## Other Criteria

N/A

## **PEGFILGRASTIM**

### **Affected Drugs**

NEULASTA®

### **Covered Uses**

Prescriptions for pegfilgrastim (Neulasta®) may be approved for coverage will be approved for members with the following documented diagnosis and an ANC less than 1, 000/mm<sup>3</sup> in patients with non-myeloid malignancies receiving myelosuppressive anticancer drugs associated with a clinically significant incidence of febrile neutropenia.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **PEGVISOMANT**

### **Affected Drugs**

SOMAVERT®

### **Covered Uses**

Prescriptions for pegvisomant (Somavert®) may be approved for coverage for members with documented acromegaly AND The member has had an inadequate response to surgery and/or radiation therapy OR The member has a contraindication to these therapies AND The member has failed optimum medical.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **PENTOSAN POLYSULFATE SODIUM**

### **Affected Drugs**

ELMIRON®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **PIMECROLIMUS**

### **Affected Drugs**

ELIDEL®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **PRAMLINITIDE**

### **Affected Drugs**

SYMLIN®

SYMLINPEN 120®

SYMLINPEN 60®

### **Covered Uses**

Prescriptions for pramlinitide (Symlin®) may be approved for coverage for use as an adjunct to preprandial insulin therapy for the management of type 1 (insulin-dependent) diabetes mellitus in patients who have not achieved adequate glycemic control with insulin therapy. Pramlintide also is used as an adjunct to therapy with preprandial insulin with or without concomitant metformin and/or a sulfonylurea for the management of type 2 (noninsulin-dependent) diabetes mellitus in patients who have not achieved adequate glycemic control with insulin given alone or in combination with metformin and/or a sulfonylurea.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

# **PREGABALIN**

## **Affected Drugs**

LYRICA®

## **Covered Uses**

Prescriptions for pregabalin (Lyrica®) may be approved for coverage for members needing adjunctive therapy for documented complex partial or simple partial seizures. Patients with epilepsy who are stabilized on this medication do not require prior authorization. OR Diabetic, peripheral neuropathy\* and fibromyalgia\*\* upon documented, compliant trials and failures of gabapentin, tramadol, tricyclics, SSRIs [Selective Serotonin Reuptake Inhibitors], antiepileptics, such as phenytoin and carbamazepine and lidocaine and capsaicin topical OR Post herpetic neuralgia upon documented, compliant trials and failures of tricyclics such as nortriptyline or amitriptyline, gabapentin, tramadol, opioids and topical capsaicin and lidocaine.

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

N/A

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

## **RAMELTEON**

### **Affected Drugs**

ROZEREM®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **RANOLAZINE**

### **Affected Drugs**

RANEXA®

### **Covered Uses**

Prescriptions for ranolazine (Ranexa®) may be approved for coverage for chronic angina in patients with documented compliant therapy with beta blockers, calcium channel blockers, long and short acting nitrate therapy.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

# **RASBURICASE**

## **Affected Drugs**

ELITEK®

## **Covered Uses**

Prescriptions for rasburicase (Elitek®) may be approved for coverage: Rasburicase, a biosynthetic (recombinant DNA origin) form of urate oxidase, is an enzyme that catalyzes oxidation of uric acid into an inactive and soluble metabolite, allantoin. Chemotherapy-induced hyperuricemia: Rasburicase is used for the initial management of plasma uric acid concentrations in pediatric patients with leukemia, lymphoma, or solid tumors who are receiving chemotherapy expected to result in tumor lysis and subsequent elevation of plasma uric acid concentrations, when allopurinol cannot be tolerated.

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

N/A

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

## **RIBAVIRIN**

### **Affected Drugs**

RIBAVIRIN

### **Covered Uses**

Prescriptions for ribavirin (Rebetol®) may be approved for coverage: In conjunction with PEG interferon may be approved for the treatment of chronic hepatitis C, Initial treatment – May be approved for 12 weeks for members with a documented diagnosis of chronic hepatitis C AND All of the following: Elevated HCV RNA titer, Elevated ALT level, Liver biopsy or “Fibersure Test” showing fibrosis plus moderate inflammation, Identification of genotype as 1 – 6, No history of liver transplantation, Documentation or discussion regarding abstinence from ETOH/IV drug use and patient/physician contract agreeing to random urine drug screens, Currently not being treated for depression or clearance from behavioral health for treatment. For Continued treatment: Members with Genotype 1 May be approved for additional 36 weeks for members with Genotype 1 who have a documented decrease in their HCV titer. (Lack of response is indicated by failure to achieve at least a 2 log<sub>10</sub> decrease in serum HCV RNA from pretreatment baseline. ) Members with Genotype 2 – 6 May be approved for additional 12 weeks for members with Genotype 2-6 who have a documented decrease in their HCV titer. (Lack of response is indicated by failure to achieve at least a 2 log<sub>10</sub> decrease in serum HCV RNA from pretreatment baseline. ).

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **RILONACEPT**

### **Affected Drugs**

ARCALYST®

### **Covered Uses**

Prescriptions for rilonacept (Arcalyst) may be approved for coverage in patients with Familial cold urticaria - Muckle-Wells (Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children 12 years and older), or Rilonacept improved symptoms (joint pain, rash, feeling of fever/chills, eye redness/pain, and fatigue) significantly more than placebo in a randomized, double-blind, placebo-controlled study (n = 47) (Prod Info ARCALYST(TM) subcutaneous injection, 2008). Rilonacept has not been studied in patients with Neonatal-Onset Multisystem Inflammatory Disease (NOMID), a related disease and together with FCAS and MWS that make up the CAPS, or Rilonacept is a targeted inhibitor of interleukin-1 (IL-1), the key driver of inflammation in cryopyrin-associated periodic syndromes (CAPS). Rilonacept acts as a decoy receptor that binds IL-1 beta and blocks IL-1 beta signaling, thereby preventing its interaction with cell surface receptors. It also binds IL-1 alpha and IL-1 receptor antagonist with reduced affinity (Prod Info ARCALYST(TM) subcutaneous injection, 2008), or Inflammation in CAPS is associated with mutations in the NLRP-3 gene (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3), also known as Cold-induced Autoinflammatory Syndrome-1 [CIAS1], which encodes the protein cryopyrin, an important component of the inflammasome. Cryopyrin regulates the protease caspase-1 and controls the activation of interleukin-1 beta. NLRP-3 mutations lead to an overactive inflammasome, resulting in an excessive release of activated IL-1 beta that drives inflammation (Prod Info ARCALYST(TM) subcutaneous injection, 2008).

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

**Coverage Duration**

Authorization will be for 12 months, unless otherwise specified.

**Other Criteria**

N/A

## **RISPERIDONE**

### **Affected Drugs**

RISPERDAL CONSTA®

### **Covered Uses**

Prescriptions for risperidone (Risperdal®) may be approved for coverage: This PA edit will only apply to new start beneficiaries. The edit will not apply to beneficiaries stabilized on the medication or transitioning beneficiaries stabilized on the medication. Does not require prior auth when prescribed by a contracted psychiatrist. May be approved for members with a documented diagnosis of schizophrenia or acute manic episode associated with bipolar disease when under the care of a psychiatrist.

### **Exclusion Criteria**

As per the FDA black box warning this drug will not be approved for use by PCPs in the treatment of behavioral symptoms in elderly patients with dementia unless prescribed in conjunction with ongoing psychiatric consultation.

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **RITUXIMAB**

### **Affected Drugs**

RITUXAN®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **RIVASTIGMINE TARTRATE**

### **Affected Drugs**

EXELON®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **SACROSIDASE**

### **Affected Drugs**

SUCRAID®

### **Covered Uses**

Prescriptions for sacrosidase (Sucraid®) may be approved for coverage: A) Recommended in congenital sucrase-isomaltase deficiency: may allow consumption of more normal diet with reduced symptoms, especially in infants/children. Additional studies needed: long-term efficacy, definition of optimal dose regimen. B) Role in secondary (acquired) sucrase deficiencies (eg, celiac disease, AIDS enteropathy, severe parasitic infections, short-bowel syndrome) requires further clinical evaluation.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **SAPROPTERIN**

### **Affected Drugs**

KUVAN®

### **Covered Uses**

Prescriptions for sapropterin (Kuvan®) may be approved for coverage: for the reduction of blood phenylalanine (Phe) levels in patients with hyperphenylalaninemia (HPA) due to BH4-responsive phenylketonuria (PKU). Prolonged elevation in blood Phe levels can result in severe neurologic damage. In conjunction, ongoing Phe-restricted diet management is necessary to optimize blood Phe control.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **SELEGILINE PATCH**

### **Affected Drugs**

EMSAM®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **SILDENAFIL**

### **Affected Drugs**

REVATIO®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **SITAGLIPTIN**

### **Affected Drugs**

JANUMET®

JANUVIA®

### **Covered Uses**

Prescriptions for sitagliptin (Januvia®, Janumet®) may be approved for coverage for use in the treatment of type 2 diabetes in patients that have documented compliant trials with formulary agents such as biguanides, sulfonureas, TZD, and all formulary insulin products OR when documented adherence with diet and exercise regimens plus a thiazolidinedione alone do not provide adequate control.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **SODIUM OXYBATE**

### **Affected Drugs**

XYREM®

### **Covered Uses**

Prescriptions for sodium oxybate (Xyrem®) may be approved for coverage for cataplexy associated narcolepsy patients under the care of a contracted neurologist.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

Prescriptions for sodium oxybate (Xyrem®) may be approved for coverage for cataplexy associated narcolepsy patients under the care of a contracted neurologist.

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **SODIUM PHENYLBUTYRATE**

### **Affected Drugs**

BUPHENYL®

### **Covered Uses**

Prescriptions for sodium phenylbutyrate (Buphenyl®) may be approved for coverage with urea cycle disorders who have tried and failed or cannot tolerate phenylacetate.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **SOMATROPIN RECOMBINANT**

### **Affected Drugs**

NORDITROPIN NORDIFLEX®

NORDITROPIN®

OMNITROPE®

### **Covered Uses**

Prescriptions for sodium, recombinant somatropin (Nutropin®, Genotropin®, Humatrope®, Saizen®, Serostim®, and others) may be approved for coverage: For members with Idiopathic growth hormone (GH) deficiency (NOT approved for short stature due to small gestational age, steroid therapy or nutritional deficiencies). Growth velocities submitted and documented must indicate abnormality) who have failed to respond to at least two standard GH [growth hormone] stimulation tests, defined as a serum GH [growth hormone] level (peak level) of less than 10 nanograms per milliliter (ng/ml), after stimulation with insulin, levodopa, arginine, propranolol, clonidine, or glucagon. \*, insulin-like growth factor I (IGF-I) and MRI or CT of the brain with particular attention to the hypothalamic-pituitary region has been carried out to exclude the possibility of a tumor, and at least one of the following criteria is met: Child has severe growth retardation with height standard deviation score (SDS) less than 3 SDS below the mean for chronological age and sex, or Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (growth velocity (GV)\*\* measured over one year below 25th percentile for age and sex), or Child exhibits severe deceleration in growth rate (GV\*\* measured over 1 year -2 SDS below the mean for age and sex), or Child has decreasing growth rate combined with a predisposing condition such as previous cranial irradiation or tumor, or Child exhibits evidence of other pituitary hormone deficiencies or signs of congenital GHD (hypoglycemia, microphallus). For children with chronic renal insufficiency after renal transplantation, consistent with established guidelines health plan does not consider resumption of growth hormone therapy medically necessary until at least 1 year after the transplant to allow time to ascertain whether catch-up growth will occur. For children with Turner's syndrome and growth retardation who meet all of the following criteria: The diagnosis of Turner's syndrome is confirmed by chromosome analysis, At least one of the following criteria under Idiopathic GH [growth hormone] deficiency is met: For children with Prader Willi syndrome (confirmed by genetic testing) and growth retardation who meet all of the following criteria and the child has GH [growth hormone] deficiency, and at least one of the above criteria listed under Idiopathic GH [growth hormone] deficiency is met: For HIV-infected persons with AIDS-related wasting and with involuntary weight loss of greater than 10% of pre-illness baseline body weight or body mass index (BMI) less than 20 kg/m<sup>2</sup>, in the absence of a concurrent illness or medical condition other than HIV infection that would explain these

findings, and who have failed to adequately respond or are intolerant to anabolic steroids (e. g. , Megace).

**Exclusion Criteria**

N/A

**Required Medical Information**

N/A

**Age Restrictions**

N/A

**Prescriber Restrictions**

N/A

**Coverage Duration**

Authorization will be for 12 months.

**Other Criteria**

N/A

# **SORAFENIB**

## **Affected Drugs**

NEXAVAR®

## **Covered Uses**

Prescriptions for sorafenib (Nexavar®) may be approved for coverage for members: for active, dual-action inhibitor of tumor cell proliferation and angiogenesis through the blockade of Raf kinase and vascular endothelial growth factor receptor (Strumberg et al, 2005). Sorafenib is indicated in treating patients with advanced renal cell carcinoma who have progressed after one prior systemic therapy (Prod Info NEXAVAR(R) oral tablets, 2005). Sorafenib has significantly increased median progression-free survival (PFS) in patients with advanced renal cell carcinoma, and response to sorafenib has been observed in patients with advanced hepatocellular carcinoma (Ratain et al, 2005, Anon, 2005). In addition, it has been proposed that sorafenib may be an effective treatment for melanoma and papillary thyroid cancers because of its inhibitory effect on B-Raf (Robert et al, 2005). Sorafenib has generally been well tolerated, preliminary studies have identified gastrointestinal symptoms, fatigue, hand-foot reaction, and rash as the most common drug-related toxicities. Since sorafenib has not been shown to cause significant neutropenia, thrombocytopenia, or anemia, it may be reasonable to combine sorafenib with other anticancer agents.

## **Exclusion Criteria**

N/A

## **Required Medical Information**

N/A

## **Age Restrictions**

N/A

## **Prescriber Restrictions**

N/A

## **Coverage Duration**

Authorization will be for 12 months.

## **Other Criteria**

N/A

## **SUMATRIPTAN**

### **Affected Drugs**

IMITREX®  
SUMATRIPTAN SUCCINATE

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **SUNITINIB**

### **Affected Drugs**

SUTENT®

### **Covered Uses**

Prescriptions for sunitinib (Sutent®) may be approved for coverage for patients with Gastrointestinal Stromal Tumors and Renal Cell Carcinoma AND Under the care of an oncologist.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **TELBIVUDINE**

### **Affected Drugs**

TYZEKA®

### **Covered Uses**

This exception criterion applies to PHP members only. Prescriptions for telbivudine (Tyzeka®) may be approved for coverage for members who have: A documented diagnosis of chronic hepatitis B infection and compensated liver disease AND Documented active viral replication, HBV DNA viral load, HBeAg positive or negative status, liver enzyme elevation information, or histologically active disease AND Lamivudine or other hepatitis B antiviral drug failures or contraindications AND Assessment and laboratory information of HIV co-infection, hepatitis C virus, hepatitis delta virus, history or signs of hepatic decompensation or history of alcohol or illicit substance abuse within the preceding 2 years. AND Prescribed by a gastroenterologist.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

Must be prescribed by a gastroenterologist, hematologist or a infectious disease specialist.

### **Coverage Duration**

Approve 4 week initially. Upon an HBV DNA viral load less than 4log10 copies/ml after 24 weeks of treatment.

### **Other Criteria**

N/A

## **TELITHROMYCIN**

### **Affected Drugs**

KETEK®

### **Covered Uses**

Prescriptions for telithromycin (Ketek®) may be approved for coverage for a member with a diagnosis and culture and sensitivity indicating mild to moderate community-acquired pneumonia. (Bacterial sinusitis and acute bacterial exacerbations of chronic bronchitis are no longer approved indications). AND Contraindication to at least two formulary alternatives indicated for the member's condition, one of which was a macrolide. (Myasthenia gravis is a contraindication to Ketek). OR Documented allergy, intolerance or failure to at least two (2) formulary alternatives indicated for the member's condition, one of which was a macrolide AND Monitoring of liver function\* and vision disturbances.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

# TERBINAFINE HYDROCHLORIDE

## Affected Drugs

TERBINAFINE HCL

## Covered Uses

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

## Exclusion Criteria

N/A

## Required Medical Information

N/A

## Age Restrictions

N/A

## Prescriber Restrictions

N/A

## Coverage Duration

Approve 30 tabs X 4 months only.

## Other Criteria

N/A

## **TERIPARATIDE**

### **Affected Drugs**

FORTEO®

### **Covered Uses**

Prescriptions for teriparatide (Forteo®) may be approved for coverage for patients diagnosed with osteoporosis and that have documented compliance and concomitant therapy with: Bisphosphonate (ie Actonel or Fosamax daily or weekly administration) AND Calcium regulating agent (ie Calcitonin nasal inhalation) AND Estrogen therapy (unless contraindicated) AND Oral Calcium and Vitamin D therapy.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Therapy is only approved for 6 months in quarterly intervals.

### **Other Criteria**

N/A

## **TIGECYCLINE**

### **Affected Drugs**

TYGACIL®

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **TOPIRAMATE**

### **Affected Drugs**

TOPAMAX®  
TOPIRAMATE

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **TRETINOIN TOPICAL**

### **Affected Drugs**

TRETINOIN

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

Dermatologists are exempt.

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## VORINOSTAT

### **Affected Drugs**

ZOLINZA®

### **Covered Uses**

Prescriptions for vorinostat (Zolinza®) may be approved for coverage in patients for the treatment cutaneous manifestations associated with cutaneous T-cell lymphoma that is progressive, persistent or recurrent on two systemic therapies. Vorinostat, a histone deacetylase(HDAC) inhibitor, is FDA-approved based on results from 2 single-arm, open-label trials (Prod Info ZOLINZA(TM) oral capsules, 2006, Duvic et al, 2006). The use of vorinostat in combination with 5-fluorouracil, leucovorin and oxaliplatin (FOLFOX) in patients with advanced colorectal cancer has been studied in a phase I trial. Vorinostat has also been investigated in combination with carboplatin and paclitaxel for the treatment of advanced solid malignancies.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

Must be written by oncology.

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ZAFIRLUKAST**

### **Affected Drugs**

ACCOLATE®

### **Covered Uses**

Prescriptions for zafirlukast (Accolate®) may be approved for coverage for use in a member with documented moderate to severe asthma AND documented, compliant and adequate trial and failures of inhaled steroids, including a long acting beta agonist (LABA) i. e. , salmeterol (Serevent®) AND the medication is being added as a third component.

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

## **ZONISAMIDE**

### **Affected Drugs**

ZONISAMIDE

### **Covered Uses**

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

### **Exclusion Criteria**

N/A

### **Required Medical Information**

N/A

### **Age Restrictions**

N/A

### **Prescriber Restrictions**

N/A

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

N/A

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