

## Special Needs Plan – Prior Authorization Drugs

Certain drugs require you to get prior authorization (prior approval) which means that your doctor or health care provider will need to contact CareSource before you fill your prescription. Without the necessary information on the Prior Authorization request, we may not cover the drug. Please refer to your Evidence of Coverage for details on how to request a Prior Authorization.

To see if one or more of the drugs you are taking requires prior authorization, type the name of the drug in the Search box below.

### 5HT3 ANTI-NAUSEA AGENT BVD DETERMINATION

**Drug Name:** GRANISETRON HCL, GRANISOL, ONDANSETRON HCL, ONDANSETRON ODT

**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.

### ADALIMUMAB

**Drug Name:** HUMIRA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Exclusion Criteria:** INITIAL: RHEUMATOID ARTHRITIS/JUVENILE IDIOPATHIC ARTHRITIS: NO TRIAL/FAILURE/INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD THERAPY, FOR MODERATE TO SEVERE PLAQUE PSORIASIS COVERING 10% BSA OR LESIONS COVERING HANDS, FEET, OR GENITAL AREA: NO TRIAL/FAILURE OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE. CROHN'S DISEASE: NO TRIAL/FAILURE OF CORTICOSTEROID, AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/JUVENILE ARTHRITIS: NO LESS THAN 20% OR GREATER IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: LESS THAN 50% IMPROVEMENT OR INCREASE IN 2 UNITS FROM BASELINE IN BASDAI. PLAQUE PSORIASIS: PATIENT HAS NOT ACHIEVED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PASI OF 50% OR MORE.

**Prescriber Restrictions:** RHEUMATOLOGIST, DERMATOLOGIST, GASTROENTEROLOGIST

**Coverage Duration:** INITIAL: 3 MO, EXCEPT PLAQUE PSORIASIS AND CROHN'S DISEASE IS 2 MO., RENEWAL: ALL DIAGNOSES 12 MO.

**Other Criteria:** INITIAL: RHEUMATOID ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN). JUVENILE IDIOPATHIC ARTHRITIS: TRIAL OF AT LEAST ONE DMARD. PLAQUE PSORIASIS: TRIAL OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE. CROHN'S: TRIAL OF CORTICOSTEROIDS,

AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE. RENEWAL: RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS FOR HUMIRA DOSE OF 40 MG EVERY WEEK: TRY/FAIL AT LEAST A 3 MONTH TRIAL OF HUMIRA 40MG EVERY OTHER WEEK.

## ANTIEMETICS

**Drug Name:** SANCUSO

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** NOT TRIED AND FAILED ANOTHER FORMULARY ANTIEMETIC DRUG, NOT ON MODERATE TO HIGHLY EMETOGENIC CHEMOTHERAPY.

**Required Medical Information:** CHEMOTHERAPY EMETOGENICITY

**Coverage Duration:** UP TO 12 MONTHS

**Other Criteria:** PREVIOUS TRIAL OF ONDANSETRON ODT, ORAL GRANISETRON, OR ORAL DOLASETRON.

## APREPITANT BVD DETERMINATION

**Drug Name:** EMEND

**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.

## ATOMOXETINE

**Drug Name:** STRATTERA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** NOT TRIED AND FAILED A STIMULANT MEDICATION

**Required Medical Information:** CONTRAINDICATION TO STIMULANT MEDICATIONS

**Coverage Duration:** 12 MONTHS

## BECAPLERMIN

**Drug Name:** REGRANEX

**Covered Uses:** ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** NON-DIABETIC. KNOWN NEOPLASM AT APPLICATION SITE. PRESSURE OR VENOUS STASIS ULCERS. ULCER DOES NOT EXTEND THROUGH DERMIS.

**Prescriber Restrictions:** VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST OR PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC ONLY

**Coverage Duration:** 3 MONTHS

## BENZYL ALCOHOL

**Drug Name:** ULESFIA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Age Restrictions:** 6 MONTHS AND OLDER

**Coverage Duration:** 1 MONTH

**Other Criteria:** UP TO 2724 GRAMS

## CALCINEURIN INHIBITORS

**Drug Name:** ELIDEL, PROTOPIC

**Covered Uses:** ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Exclusion Criteria:** NOT TRIED/FAILED OR INTOLERABLE ADVERSE EFFECTS TO TOPICAL CORTICOSTEROIDS

**Age Restrictions:** PROTOPIC 0.03%: PATIENT AGE GREATER THAN OR EQUAL TO 2 YEARS. PROTOPIC 0.1%: PATIENT AGE GREATER THAN OR EQUAL TO 15 YEARS

**Coverage Duration:** 12 MONTHS

## CERTOLIZUMAB PEGOL

**Drug Name:** CIMZIA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** NO TRIAL/FAILURE OF ONE OR MORE CONVENTIONAL THERAPIES FOR CROHN'S DISEASE SUCH AS CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPYRINE, METHOTREXATE, OR MESALAMINE

**Required Medical Information:** FOR RHEUMATOID ARTHRITIS: ALLOW IF PRIOR USE OF AT LEAST ONE DMARD, SUCH AS METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, AURANOFIN.

**Prescriber Restrictions:** DRUG BEEN PRESCRIBED BY OR IS IT CURRENTLY BEING SUPERVISED BY A GASTROENTEROLOGIST OR RHEUMATOLOGIST

**Coverage Duration:** 12 MONTHS

## CHOLINESTERASE INHIBITORS FOR ALZHEIMER'S DISEASE

**Drug Name:** ARICEPT, ARICEPT ODT, EXELON

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** MINI MENTAL STATE EXAM (MMSE) SCORE GREATER THAN 26

**Required Medical Information:** MINI MENTAL STATE EXAM (MMSE) SCORE OF 26 OR LESS

**Coverage Duration:** 12 MONTHS

CYCLOSPORINE OPHTHALMIC

### Drug Name: RESTASIS

**Covered Uses:** ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Required Medical Information:** KERATOCONJUNCTIVITIS SICCA (KCS) OR DRY EYE DISEASE

**Prescriber Restrictions:** OPHTHALMOLOGIST, OPTOMETRIST, RHEUMATOLOGIST

**Coverage Duration:** 12 MONTHS

### DALFAMPRIDINE

**Drug Name:** AMPYRA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Prescriber Restrictions:** NEUROLOGIST

**Coverage Duration:** 12 MONTHS

### DARBEPOETIN

**Drug Name:** ARANESP

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Exclusion Criteria:** ANEMIA ASSOCIATED WITH CHRONIC RENAL FAILURE: HEMOGLOBIN GREATER THAN OR EQUAL TO 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN GREATER THAN OR EQUAL TO 10G/DL

**Coverage Duration:** RENAL FAILURE:12 MONTHS CANCER CHEMOTHERPY:COURSE OF TREATMENT BASED ON CHEMOTHERAPY CYCLE.

### ELTROMBOPAG

**Drug Name:** PROMACTA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Exclusion Criteria:** INITIAL: ADEQUATE RESPONSE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SUFFICIENT RESPONSE TO SPLENECTOMY, RENEWAL: NO CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO  $50 \times 10^9/L$  AT THE MAX DOSE OF 75MG PER DAY FOR 4 WEEKS

**Coverage Duration:** INITIAL:1 MONTH RENEWAL: NO RESPONSE AFTER INITIAL:1 MONTH AT MAX DOSE, IF RESPONSE: 12 MONTHS.

## EPOETIN ALFA

**Drug Name:** EPOGEN, PROCRIT

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** CHRONIC RENAL FAILURE: HEMOGLOBIN EQUAL TO OR GREATER THAN 10 G/DL IF NOT UNDERGOING DIALYSIS OR GREATER THAN OR EQUAL TO 12 IF ON DIALYSIS. PATIENTS WITH ANEMIA RELATED TO AZT THERAPY: HEMOGLOBIN EQUAL TO OR GREATER THAN 12 G/DL. ANEMIA DUE TO CONCOMITANTLY ADMINISTERED CHEMOTHERAPY: HEMOGLOBIN EQUAL TO OR GREATER THAN 10 G/DL. PATIENTS SCHEDULED FOR ELECTIVE, NONCARDIAC SURGERY, NONVASCULAR SURGERY: HEMOGLOBULIN GREATER THAN 13 G/DL

**Coverage Duration:** ANEMIA FROM CHRONIC RENAL FAILURE/AZT/CHEMOTHERAPY:12 MONTHS, ANEMIA FROM ELECTIVE SURGERY: 21 DAYS

## ETANERCEPT

**Drug Name:** ENBREL

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Exclusion Criteria:** INITIAL: FOR RHEUMATOID ARTHRITIS OR JUVENILE ARTHRITIS: NO TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD AGENT. FOR MODERATE TO SEVERE PLAQUE PSORIASIS COVERING 10% BSA OR LESIONS COVERING HANDS, FEET, OR GENITAL AREA: NO TRIAL/FAILURE/INTOLERABLE SIDE EFFECTS TO AT LEAST ONE PREFERRED THERAPY. (PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE). RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS/JUVENILE ARTHRITIS: NO LESS THAN 20% OR GREATER IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: NO LESS THAN 50% IMPROVEMENT OR INCREASE IN 2 UNITS FROM BASELINE IN BASDAI. PLAQUE PSORIASIS: PATIENT HAS NOT ACHIEVED CLEAR OR MINIMAL DISEASE OR A DECREASE IN PASI OF 50% OR MORE.

**Prescriber Restrictions:** RHEUMATOLOGIST OR DERMATOLOGIST ONLY

**Coverage Duration:** INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

**Other Criteria:** INITIAL: RHEUMATOID ARTHRITIS/JUVENILE IDOPATHIC ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN). PLAQUE PSORIASIS: TRIAL OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORINE.

## EXENATIDE

**Drug Name:** BYETTA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Required Medical Information:** TYPE II DIABETES: FAILURE TO REACH TREATMENT GOALS WITH EITHER METFORMIN, A SULFONYLUREA AGENT, OR A THIAZOLIDINEDIONE

**Coverage Duration:** 12 MONTHS

## FENTANYL TRANSDERMAL PATCH

**Drug Name:** FENTANYL

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** PATIENT ABLE TO TAKE OR HAS NOT FAILED ORAL LONG-ACTING OPIOID NARCOTIC ANALGESICS.

**Required Medical Information:** PATIENT IS RECEIVING DAILY, AROUND-THE-CLOCK PAIN MEDICATION FOR AT LEAST ONE WEEK

**Coverage Duration:** 12 MONTHS

## FENTANYL TRANSMUCOSAL AGENTS

**Drug Name:** FENTANYL CITRATE, FENTORA, ONSOLIS

**Covered Uses:** ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Required Medical Information:** CANCER: ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE PAIN MEDICATION, AND EITHER A TRIAL AND FAILURE OF 1 IMMEDIATE-RELEASE ORAL PAIN AGENT OR DIFFICULTY SWALLOWING TABLETS/CAPSULES

**Coverage Duration:** 6 MONTHS

## FONDAPARINUX

**Drug Name:** ARIXTRA

**Covered Uses:** ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** ACUTE DVT/PE TREATMENT: IS STABILIZED ON WARFARIN AND HAS ESTABLISHED AN ORAL ANTICOAGULANT EFFECT WITH A THERAPEUTIC INR BETWEEN 2 TO 3.

**Coverage Duration:** HIP REPLACEMENT/FRACTURE SURGERY UP TO 33 DAYS KNEE/ABDOMINAL SURGERY/DVT/PE TREATMENT UP TO 14 DAYS

## GLP-1 ANALOGS

**Drug Name:** VICTOZA 3-PAK

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** DIAGNOSIS: NON TYPE 2 DIABETES. NO FAILURE TO REACH TREATMENT GOAL WITH METFORMIN, SULFONYLUREA, OR THIAZOLIDINEDIONE.

**Required Medical Information:** DIAGNOSIS: TYPE 2 DIABETES

**Coverage Duration:** 12 MONTHS

## GOLIMUMAB

**Drug Name:** SIMPONI

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Exclusion Criteria:** INITIAL: FOR ALL DIAGNOSES: CONCURRENT USE WITH ORENCIA/ KINERET. ACUTE RHEUMATOID ARTHRITIS: NOT CURRENTLY ON METHOTREXATE AND NO TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE OTHER DMARD AGENT. PSORIATIC ARTHRITIS: NO TRIAL/FAILURE OR EXPERIENCE WITH INTOLERABLE SIDE EFFECTS TO AT LEAST ONE DMARD AGENT. RENEWAL: ACTIVE RHEUMATOID ARTHRITIS/PSORIATIC ARTHRITIS: NO LESS THAN 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT. ANKYLOSING SPONDYLITIS: NO LESS THAN 20% IMPROVEMENT IN ANKYLOSING SPONDYLITIS (ASAS20) CRITERIA.

**Age Restrictions:** 18 YEARS OR OLDER

**Prescriber Restrictions:** RHEUMATOLOGIST OR DERMATOLOGIST ONLY

**Coverage Duration:** INITIAL: 3 MONTHS RENEWAL: 12 MONTHS

**Other Criteria:** INITIAL: RHEUMATOID/PSORIATIC ARTHRITIS: TRIAL/FAILURE OF AT LEAST ONE DMARD (METHOTREXATE, LEFLUNOMIDE, AZATHIOPRINE, CYCLOSPORINE, HYDROXYCHLOROQUINE, PENICILLAMINE, SULFASALAZINE, GOLD SODIUM THIOMALATE, OR AURANOFIN).

## HEPATITIS A VACCINE (INACTIVATED) BVD DETERMINATION

**Drug Name:** HAVRIX, VAQTA

**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.

## HEPATITIS B VACCINE BVD DETERMINATION

**Drug Name:** ENGERIX-B, RECOMBIVAX HB

**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.

## IMIQUIMOD

**Drug Name:** IMIQUIMOD

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** PERIANAL GENITAL WARTS: PATIENT HAS NOT TRIED/FAILED CONDYLOX. NON-HYPERKERATOTIC, NON-HYPERTROPHIC ACTINIC KERATOSES ON THE FACE OR SCALP: HAS NOT TRIED/FAILED OR CONTRAINDICATION TO TOPICAL 5-FLUOROURACIL. SUPERFICIAL BASAL CELL CARCINOMA: GREATER THAN 2CM IN SIZE AND ON THE FACE

**Age Restrictions:** EXTERNAL GENITAL OR PERIANAL WARTS: GREATER THAN OR EQUAL TO 12 YEARS OF AGE. ACTINIC KERATOSIS: GREATER THAN OR EQUAL TO 18 YEARS OF AGE

**Prescriber Restrictions:** ACTINIC KERATOSIS: DERMATOLOGIST ONLY. SUPERFICIAL BASAL CELL CARCINOMA: DERMATOLOGIST OR ONCOLOGIST ONLY.

**Coverage Duration:** 4 MONTHS

**Other Criteria:** CRITERIA APPLIES TO NEW STARTS ONLY

### IMMUNE GLOBULIN BVD DETERMINATION

**Drug Name:** CARIMUNE NF NANOFILTERED, FLEBOGAMMA DIF, GAMASTAN S-D, GAMMAGARD LIQUID, GAMUNEX, OCTAGAM, POLYGAM S-D, PRIVIGEN, VIVAGLOBIN

**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.

### IMMUNOSUPPRESSANT BVD DETERMINATION

**Drug Name:** AZATHIOPRINE, AZATHIOPRINE SODIUM, CELLCEPT, CYCLOSPORINE, CYCLOSPORINE MODIFIED, GENGRAF, MYCOPHENOLATE MOFETIL, MYFORTIC, ORTHOCLONE OKT-3, PROGRAF, RAPAMUNE, SIMULECT, TACROLIMUS, TORISEL, ZENAPAX

**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.

### INFUSIBLE DRUG BVD DETERMINATION

**Drug Name:** ABELCET, ACYCLOVIR SODIUM, ADRIAMYCIN, AMBISOME, AMPHOTEC, AMPHOTERICIN B, BLEOMYCIN SULFATE, CLADRIBINE, CYCLOPHOSPHAMIDE, CYTARABINE, CYTOVENE, DOXIL, DOXORUBICIN HCL, FLUOROURACIL, FOSCARNET SODIUM, HERCEPTIN, IFOSFAMIDE, IFOSFAMIDE-MESNA, METHOTREXATE, MITOMYCIN, REMICADE, REMODULIN, VINBLASTINE SULFATE, VINCRISTINE SULFATE

**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.

### INTERFERON AGENTS, OTHER

**Drug Name:** INFERGEN, PEGASYS, PEGINTRON, PEGINTRON REDIPEN

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Required Medical Information:** INITIAL: PATIENT WITH DETECTABLE PRETREATMENT HCV RNA LEVEL/VIRAL LOAD OF GREATER THAN OR EQUAL TO 50 IU/ML, AND EITHER RIBAVIRIN BEING USED IN COMBINATION WITH PEG-INTRON OR PEGASYS, OR CONTRAINDICATION TO COMBINATION (RIBAVIRIN + INTERFERON) THERAPY, AND GENOTYPE 1,2,3,4,5 OR 6. FOR PATIENTS WITH GENOTYPE 1,4,5, OR 6: PATIENT'S LIVER BIOPSY MUST SHOW CHRONIC HEPATITIS WITH SIGNIFICANT FIBROSIS (METAVIR SCORE GREATER THAN OR EQUAL TO 2 OR ISHAK SCORE GREATER THAN OR EQUAL TO 3), CHRONIC HEPATITIS C RENEWAL: UNLESS THERE IS A CONTRAINDICATION TO COMBINATION THERAPY, THE REQUEST IS FOR CONTINUING TREATMENT FOR COMBINATION THERAPY WITH RIBAVIRIN AND AN INTERFERON, PATIENT ACHIEVED A GREATER THAN OR EQUAL TO 2 LOG REDUCTION IN HCV RNA FROM BASELINE VALUE IN THE FIRST 12 WEEKS OF TREATMENT, GENOTYPE 1,4,5,6 HEPATITIS C

**Prescriber Restrictions:** GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) ONLY

**Coverage Duration:** HEP C GENOTYPE 1,4,5,6 INITIAL 16 WEEKS, RENEWAL 32 WEEKS, GENOTYPE 2, 3: 24 WEEKS

## INTERFERON ALFA-2A AND 2B MONOTHERAPY AGENTS

**Drug Name:** INTRON A

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** HEPATITIS C INITIAL: PRETREATMENT HCV RNA LEVEL/VIRAL LOAD LESS THAN 50 IU/ML, RIBAVIRIN NOT USED IN COMBINATION WITH INTRON A UNLESS THERE IS A CONTRAINDICATION TO RIBAVIRIN AND THE PATIENT'S LIVER BIOPSY SHOWS CHRONIC HEPATITIS WITH SIGNIFICANT FIBROSIS (METAVIR SCORE EQUAL TO OR GREATER THAN 2 OR ISHAK SCORE EQUAL TO OR GREATER THAN 3). IF USED IN COMBINATION, THE PATIENT OR THE PATIENT'S PARTNER IS PREGNANT, LIVER BIOPSY WITHOUT SIGNIFICANT FIBROSIS FOR GENOTYPE 1,4,5, OR 6. HEPATITIS C RENEWAL: PATIENT INFECTED WITH HEPATITIS C AND REQUEST IS FOR MONOTHERAPY UNLESS RIBAVIRIN IS CONTRAINDICATED, PATIENT DID NOT ACHIEVED A MINIMUM 2 LOG DECREASE IN VIRAL LOAD DURING THE FIRST 12 WEEKS OF TREATMENT, PATIENT INFECTED WITH GENOTYPE 2,3

**Required Medical Information:** DIAGNOSIS: HAIRY CELL LEUKEMIA, OR CONDYLOMATA ACUMINATA, OR AIDS-RELATED KAPOSÍ'S SARCOMA, OR CHRONIC HEPATITIS B, NON-HODGKIN'S LYMPHOMA, OR MALIGNANT MELANOMA OR CHRONIC PHASE, OR PHILADELPHIA CHROMOSOME (PH) POSITIVE CHRONIC MYELOGENOUS LEUKEMIA (CML) PATIENTS WHO ARE MINIMALLY PRETREATED (WITHIN 1 YEAR OF DIAGNOSIS), OR FOLLICULAR LYMPHOMA.

**Age Restrictions:** FOR HEPATITIS C DIAGNOSIS: EQUAL TO OR GREATER THAN 3 YEARS OF AGE

**Prescriber Restrictions:** GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST) ONLY

**Coverage Duration:** HEP C:GENOTYPE 1,4,5,6: INITIAL 16 WKS. RENEW: 32 WKS, GENOTYPE 2, 3:

24 WEEKS.

## LOW MOLECULAR WEIGHT HEPARIN AGENTS

**Drug Name:** FRAGMIN, INNOHEP, LOVENOX

**Covered Uses:** ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** ALL LMWH: CURRENTLY ON WARFARIN AND SCHEDULED FOR MINOR SURGERY OR MAJOR SURGERY AND HAS A THERAPEUTIC INR (GREATER THAN 2 FOR AT LEAST 2 DAYS).

**Required Medical Information:** ALL AGENTS: PREGNANCY TEST, INR.

CANCER:LIFETIME HIP REPLACEMENT/FRACTURE SURGERY UP TO 30 DAYS OTHER FDA INDICATIONS UP TO 17 DAYS

## MEASLES VIRUS LIVE VACCINE BVD DETERMINATION

**Drug Name:** ATTENUVAX VACCINE WITH DILUENT

**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.

## MEMANTINE

**Drug Name:** NAMENDA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** MINI MENTAL STATE EXAM (MMSE) SCORE GREATER THAN 19

**Coverage Duration:** 12 MONTHS

## METHYLNALTREXONE

**Drug Name:** RELISTOR

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** NOT ON PALLIATIVE CARE OR LIFE EXPECTANCY OF GREATER THAN 6 MONTHS

**Required Medical Information:** CONSTIPATION DUE TO OPIOIDS

**Coverage Duration:** UP TO 6 MONTHS

## MODAFINIL

**Drug Name:** PROVIGIL

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CHRONIC FATIGUE SYNDROME RELATED TO MULTIPLE SCLEROSIS.

**Exclusion Criteria:** OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME: NO TRIAL OF CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP). NARCOLEPSY: NO TRIAL/FAILURE OR CONTRAINDICATION TO AMPHETAMINE, DEXTROAMPHETAMINE AND/OR METHYLPHENIDATE.

**Coverage Duration:** 12 MONTHS

## OFATUMUMAB

**Drug Name:** ARZERRA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Exclusion Criteria:** CHRONIC LYMPHOCYTIC LEUKEMIA: NO FAILED TREATMENT WITH FLUDARABINE AND ALEMTUZUMAB

**Coverage Duration:** 6 MONTHS

## OMALIZUMAB

**Drug Name:** XOLAIR

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Required Medical Information:** INITIAL: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, NON-SMOKER, FEV1 LESS THAN 80%, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML. RENEWAL: PATIENT REDUCED EXACERBATIONS BY AT LEAST 25% FROM BASELINE, REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE FROM BASELINE.

**Age Restrictions:** PATIENT 12 YEARS OF AGE OR OLDER

**Prescriber Restrictions:** SPECIALIST IN ALLERGY OR PULMONARY MEDICINE ONLY

**Coverage Duration:** 12 MONTHS

## PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

**Drug Name:** ADCIRCA, REVATIO

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Required Medical Information:** PULMONARY ARTERIAL HYPERTENSION: WHO CLASS I-IV SYMPTOMS

**Prescriber Restrictions:** CARDIOLOGIST OR PULMONOLOGIST

**Coverage Duration:** 12 MONTHS

**Other Criteria:** 2 TABLETS PER DAY PER MONTH

## PLERIXAFOR

**Drug Name:** MOZOBIL

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Required Medical Information:** USE IN COMBINATION WITH GRANULOCYTE-COLONY STIMULATING FACTOR (G-CSF) TO MOBILIZE HEMATOPOIETIC STEM CELLS TO THE PERIPHERAL BLOOD FOR COLLECTION AND SUBSEQUENT AUTOLOGOUS TRANSPLANTATION IN PATIENTS WITH NON-HODGKIN'S LYMPHOMA AND MULTIPLE MYELOMA

**Prescriber Restrictions:** HEMATOLOGIST OR ONCOLOGIST

**Coverage Duration:** 4 DOSES (UP TO 8 VIALS) FOR ONE FILL

## PRAMLINTIDE

**Drug Name:** SYMLIN, SYMLINPEN 120, SYMLINPEN 60

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Required Medical Information:** TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL

**Coverage Duration:** 12 MONTHS

## QUININE SULFATE

**Drug Name:** QUALAQUIN

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Coverage Duration:** 12 MONTHS

## RABIES VACCINE BVD DETERMINATION

**Drug Name:** IMOVAX RABIES VACCINE, RABAVERT

**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.

## RANOLAZINE

**Drug Name:** RANEXA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Coverage Duration:** 12 MONTHS

**Other Criteria:** PATIENT HAS NOT TRIED/FAILED OR HAVE CONTRAINDICATION TO 1 ANTI-ANGINA AGENT (BETA-BLOCKER, AMLODIPINE, NIFEDIPINE, ISOSORBIDE, OR LONG ACTING NITROGLYCERIN).

## SAPROPTERIN

**Drug Name:** KUVAN

**Covered Uses:** ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Exclusion Criteria:** INITIAL: HAS NOT TRIED DIETARY MODIFICATIONS. RENEWAL: PATIENT HAS NOT ACHIEVED AT LEAST 20% REDUCTION IN BLOOD PHENYLALANINE WITH INITIAL TREATMENT

**Prescriber Restrictions:** ENDOCRINOLOGIST ONLY

**Coverage Duration:** INITIAL: 4 WEEKS. RENEWAL: 6 MONTHS

## SILDENAFIL

**Drug Name:** REVATIO

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Required Medical Information:** PULMONARY ARTERIAL HYPERTENSION: WHO CLASS I-IV SYMPTOMS

**Prescriber Restrictions:** CARDIOLOGIST OR PULMONOLOGIST ONLY

**Coverage Duration:** 12 MONTHS

## SOMATROPIN

**Drug Name:** GENOTROPIN, HUMATROPE, NORDITROPIN NORDIFLEX, NUTROPIN, NUTROPIN AQ, OMNITROPE, SAIZEN, SEROSTIM, TEV-TROPIN, ZORBTIVE

**Covered Uses:** ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** ATHLETIC ENHANCEMENT OR ANTI-AGING PURPOSE. GROWTH FAILURE DUE TO CHRONIC RENAL INSUFFICIENCY(CRI) IF PATIENT HAS HAD A RENAL TRANSPLANT

**Required Medical Information:** FOR GROWTH FAILURE DUE TO (CRI): PATIENT HAS NOT UNDERGONE A RENAL TRANSPLANT, PATIENT'S HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER, LACK OF RESPONSE FROM PREVIOUS YEAR, PATIENT HAS REACHED 50TH PERCENTILE FOR TARGET HEIGHT FOLLOWING GROWTH HORMONE THERAPY. FOR HIV/WASTING: THE PATIENT ON ANTIRETROVIRAL THERAPY, MEETS CRITERIA OF WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, 7.5% OVER 6 MONTHS, 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OR 23% (WOMEN) OF TOTAL BODY WT. AND A BODY MASS INDEX (BMI) LESS THAN 27KG/M<sup>2</sup>, OR BMI LESS THAN 20KG/M<sup>2</sup>. IF CURRENTLY ON GROWTH HORMONE, PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT OR IF NOT ON GROWTH HORMONE, PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. FOR SHORT-BOWEL SYNDROME: CURRENTLY ON SPECIALIZED NUTRITIONAL SUPPORT

**Coverage Duration:** HIV/AIDS: 3 MONTHS. SHORT BOWEL: 4 WEEK ONCE. ALL OTHER DIAGNOSES: 12 MONTHS.

## TERIPARATIDE

**Drug Name:** FORTEO

**Covered Uses:** ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Required Medical Information:** A PATIENT WITH EITHER A DIAGNOSIS OF SEVERE OSTEOPOROSIS (T-SCORE LESS THAN -2.5 WITH FRAGILITY FRACTURE) OR A T SCORE EQUAL TO OR LESS THAN -2.5 AND MULTIPLE RISK FACTORS FOR FRACTURE (E.G. HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS), OR FAILED AN ADEQUATE TRIAL OF BISPHOSPHONATES, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BISPHOSPHONATES.

**Coverage Duration:** 12 MONTHS

## TESTOSTERONE AGENTS

**Drug Name:** ANDRODERM, ANDROGEL, TESTOSTERONE, TESTOSTERONE CYPIONATE

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** FEMALE, UNLESS DIAGNOSED WITH METASTATIC BREAST CANCER.

**Required Medical Information:** MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 250NG/DL (8.7NMOL/L) OBTAINED WITHIN 90 DAYS, OR 2) LABORATORY CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL BETWEEN 250NG/DL AND 350NG/DL (12NMOL/L) TOGETHER WITH A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50NG/L (174 PMOL/L) OR 3) MALE DELAYED PUBERTY NOT SECONDARY TO PATHOLOGY.

**Coverage Duration:** 12 MONTHS

## TETANUS TOXOID VACCINE BVD DETERMINATION

**Drug Name:** TETANUS TOXOID ADSORBED

**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.

## TOCILIZUMAB

**Drug Name:** ACTEMRA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** NO FAILURE OF ENBREL, HUMIRA, REMICADE, SIMPONI OR CIMZIA

**Required Medical Information:** DIAGNOSIS: ACTIVE RHEUMATOID ARTHRITIS. RENEWAL: AT LEAST 20% IMPROVEMENT IN TENDER JOINT COUNT AND SWOLLEN JOINT COUNT.

**Prescriber Restrictions:** RHEUMATOLOGIST

**Coverage Duration:** INITIAL: 6 MONTHS. RENEWAL: 6 MONTHS

## TOTAL PARENTERAL NUTRITION AGENT BVD DETERMINATION

**Drug Name:** AMINOSYN, AMINOSYN II, AMINOSYN II 3.5% M-DEXTROSE 5%, AMINOSYN II 3.5%-DEXTROSE 25%, AMINOSYN II 3.5%-DEXTROSE 5%, AMINOSYN II 4.25% M-DEXT 10%, AMINOSYN II 4.25%-DEXTROSE 25%, AMINOSYN II 5% IN 25% DEXTROSE, AMINOSYN II IN DEXTROSE, AMINOSYN II W/ELEC IN DEX W/CA, AMINOSYN M, AMINOSYN W/ELECTROLYTES, AMINOSYN-HBC, AMINOSYN-HF, AMINOSYN-PF, CLINIMIX, CLINIMIX E, CLINISOL, DEXTROSE 10%-1/4NS, DEXTROSE IN WATER, DEXTROSE WITH SODIUM CHLORIDE, FREAMINE HBC, FREAMINE III, FREAMINE III WITH ELECTROLYTES, HEPATAMINE, HEPATASOL, INTRALIPID, LIPO-SYN II, LIPOSYN III, NEPHRAMINE, NOVAMINE, PREMASOL, PROCALAMINE, PROSOL, QUICK MIX WITH LYLES, RENAMIN, TRAVASOL, TRAVASOL W/ELECTROLYTES, TRAVASOL WITH DEXTROSE, TRAVASOL WITH ELECTROLYTES, TROPHAMINE

**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.

## USTEKINUMAB

**Drug Name:** STELARA

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Exclusion Criteria:** INITIAL: PLAQUE PSORIASIS: LESS THAN 10% BODY SURFACE AREA OR PASI SCORE LESS THAN 12. NO TRIAL/FAILURE OF PUVA, UVB, ACITRETIN, METHOTREXATE OR CYCLOSPORIN. RENEWAL: PHYSICIAN'S GLOBAL ASSESMENT GREATER THAN 1 OR LESS THAN 50% DECREASE IN PASI SCORE.

**Required Medical Information:** WEIGHT GREATER THAN 100KG (220LBS).

**Prescriber Restrictions:** DERMATOLOGIST OR RHEUMATOLOGIST

**Coverage Duration:** INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS

## VALGANCICLOVIR

**Drug Name:** VALCYTE

**Covered Uses:** ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D

**Exclusion Criteria:** OVER 16 YEARS OF AGE AND ABLE TO TOLERATE ORAL MEDICATIONS

**Required Medical Information:** PREVENTION OF CYTOMEGALOVIRUS: FOLLOWING KIDNEY OR HEART TRANSPLANT OR TREATMENT OF CYTOMEGALOVIRUS RETINITIS: AIDS

**Coverage Duration:** 6 MONTHS

## VARENICLINE

**Drug Name:** CHANTIX

**Covered Uses:** ALL MEDICALLY ACCEPTED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.

**Exclusion Criteria:** INITIAL: NOT ENROLLED IN A SMOKING CESSATION PROGRAM. RENEWAL: NOT ABSTAINING FROM CIGARETTE USE DURING THE INITIAL 12 WEEK S OF TREATMENT.

**Coverage Duration:** INITIAL: 12 WEEKS RENEWAL:12 WEEKS