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ACAMPROSATE

Affected Drugs

CAMPRAL®

Covered Uses

Not covered >> RBHA

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ACARBOSE

Affected Drugs

PRECOSE®

Covered Uses

Non-Insulin Dependent Diabetes Mellitus

Exclusions Criteria

No documentation of failure/intolerance to two preferred oral anti-diabetic agents.

Required Medical Information

Rx history or clinical notes documenting previous failure/intolerance.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ACITRETIN

Affected Drugs

SORIATANE®

Covered Uses

Severe recalcitrant psoriasis

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Dermatologist

Coverage Duration

Other Criteria

ACYCLOVIR OINT.

Affected Drugs

ZOVIRAX®

Covered Uses

Management of initial genital herpes and in limited non–life-threatening mucocutaneous herpes simplex virus infections in immunocompromised patients.

Exclusions Criteria

Herpes labialis (cold sores)

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ADALIMUMAB

Affected Drugs

HUMIRA®

Covered Uses

Rheumatoid Arthritis, Psoriasis, Crohn's

Exclusions Criteria

Required Medical Information

Documented failure of methotrexate (not necessary for Crohn's)

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ADAPALENE

Affected Drugs

DIFFERIN®

Covered Uses

Facial acne

Exclusions Criteria

Required Medical Information

Documented 12 week compliant trial of tretinoin

Age Restrictions

> 18 y.o.

Prescriber Restrictions

Coverage Duration

Other Criteria

ADEFOVIR

Affected Drugs

HEPSERA®

Covered Uses

Chronic Hepatitis B with active viral replication.

Exclusions Criteria

Required Medical Information

Lamivudine resistance, persistent elevations of ALT/AST, HBV-RNA and/or histology

Age Restrictions

Prescriber Restrictions

Gastroenterologist

Coverage Duration

Other Criteria

ALISKIREN

Affected Drugs

TEKTURNA®

Covered Uses

Hypertension after documented failure of formulary antihypertensives.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ALITRETINOIN

Affected Drugs

PANRETIN®

Covered Uses

Kaposi's sarcoma cutaneous lesions

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ALPHA1 PROTEINASE INHIBITOR

Affected Drugs

PROLASTIN®

Covered Uses

Alpha-1 antitrypsin deficiency with clinically evident emphysema.

Exclusions Criteria

Required Medical Information

Age Restrictions

< 18 y.o.

Prescriber Restrictions

Coverage Duration

Other Criteria

AMBRISENTAN

Affected Drugs

LETAIRIS®

Covered Uses

Improve the 6 -minute walk distance in patients with Pulmonary Arterial Hypertension and WHO class II or III who have failed bosentan.

Exclusions Criteria

Required Medical Information

Echocardiogram and/or right heart catheterization (mean pulmonary artery pressure > 25 mmHg), six-minute walk test.

Age Restrictions

Prescriber Restrictions

Pulmonologist or Cardiologist

Coverage Duration

Other Criteria

AMINOLEVULINIC ACID

Affected Drugs

LEVULAN®

Covered Uses

Non-hyperkeratotic actinic keratoses in conjunction with blue light illumination after failure of 5FU.

Exclusions Criteria

Self-administration

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ANAKINRA

Affected Drugs

KINERET®

Covered Uses

Rheumatoid Arthritis after documented failure of Enbrel or Humira.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

APREPITANT

Affected Drugs

EMEND®

Covered Uses

Prevention of nausea/vomiting associated with highly emetogenic cancer chemotherapy.

Exclusions Criteria

Required Medical Information

Chemotherapy regimen

Age Restrictions

Prescriber Restrictions

Oncologist

Coverage Duration

Other Criteria

ATOMOXETINE

Affected Drugs

STRATTERA®

Covered Uses

Attention deficit hyperactivity disorder after documented failure of first-line formulary alternatives.

Exclusions Criteria

Required Medical Information

Age Restrictions

>5 y.o.

Prescriber Restrictions

Coverage Duration

Other Criteria

BALSALAZIDE

Affected Drugs

COLAZAL®

Covered Uses

Mild to moderate ulcerative colitis after failure of formulary alternatives.

Exclusions Criteria

Required Medical Information

Age Restrictions

< 5 y.o.

Prescriber Restrictions

Coverage Duration

No longer than 8 weeks for patients 5-17 and no longer than 12 weeks for adults.

Other Criteria

BECAPLERMIN

Affected Drugs

REGRANEX®

Covered Uses

For the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply. Initial authorization x 10 weeks.

Exclusions Criteria

Required Medical Information

Length, width and depth of ulcer.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Ulcer < 10cm². A renewal for an additional 10 weeks of therapy must show a 30% reduction in size.

BEVACIZUMBAB

Affected Drugs

AVASTIN®

Covered Uses

Glioblastoma (as second line); in combination with intravenous (IV) 5-fluorouracil–based chemotherapy for first- or second-line treatment of patients with metastatic carcinoma of the colon or rectum; in combination with interferon alfa for the treatment of patients with metastatic renal cell carcinoma; in combination with carboplatin and paclitaxel for the first-line treatment of patients with unresectable, locally advanced, recurrent or metastatic nonsquamous non–small cell lung cancer.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Oncologist

Coverage Duration

Other Criteria

Authorizations are for 3 months at a time.

BORTEZOMIB

Affected Drugs

VELCADE®

Covered Uses

For the treatment of patients with mantle cell lymphoma who have received at least 1 prior therapy; multiple myeloma.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Oncologist

Other Criteria

Authorizations are for 3 months at a time.

BOSENTAN

Affected Drugs

TRACLEER®

Covered Uses

For the treatment of pulmonary arterial hypertension (PAH) in patients with World Health Organization (WHO) class II to IV symptoms, to improve exercise ability and decrease the rate of clinical worsening

Exclusions Criteria

Required Medical Information

Echocardiogram and/or right heart catheterization (mean pulmonary artery pressure > 25 mmHg), six-minute walk test; baseline liver function tests.

Age Restrictions

Prescriber Restrictions

Pulmonologist or Cardiologist

Coverage Duration

Other Criteria

CALCIPOTRIENE

Affected Drugs

DOVONEX®

Covered Uses

Plaque psoriasis in adults after failure of at least two month trials of topicals such as fluocinonide or clobetasol.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Dermatologist

Coverage Duration

Other Criteria

CELECOXIB

Affected Drugs

CELEBREX®

Covered Uses

Moderate to severe pain with a history of previous GI bleed, gastric or duodenal ulcers, concurrent Rx for warfarin or chronic steroids and failure of formulary analgesics.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

CINACALCET

Affected Drugs

SENSIPAR®

Covered Uses

For the treatment of secondary hyperparathyroidism in patients with chronic kidney disease on dialysis and documented trials and failure of calcitriol and for hypercalcemia in parathyroid carcinoma.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Nephrologist

Coverage Duration

Other Criteria

CYCLOSPORINE (ORAL AND OPHTH.)

Affected Drugs

NEORAL®
RESTASIS®

Covered Uses

For the treatment of adult, nonimmunocompromised patients with severe (ie, extensive and/or disabling), recalcitrant, plaque psoriasis who have failed to respond to at least 1 systemic therapy (eg, PUVA, retinoids, methotrexate) or in patients for whom other systemic therapies are contraindicated or cannot be tolerated; for the treatment of patients with severe, active, RA where the disease has not adequately responded to methotrexate. Keratoconjunctivitis sicca secondary to Sjogren's syndrome, Keratoconjunctivitis sicca in whom patients have failed formulary alternatives.

Exclusions Criteria

For KCS - no concurrent prescriptions for drugs that may contribute to dry eye symptoms; such as, anticholinergic agents and estrogen/estradiol.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Other Criteria

DARBOEPOETIN

Affected Drugs

ARANESP®

Covered Uses

Prescriptions for darboepoetin may be approved for coverage for members who cannot tolerate or have previously failed therapy with epoetin and with the following diagnosis: Anemia associated Chronic Renal Failure, Anemia associated with chemotherapy for nonmyeloid malignancies AND Current iron therapy, adequate serum iron(>40), transferrin saturation (>20%) or serum ferritin (>100 ng/ml) and Hgb less than 10mg/dl.

Exclusions Criteria

Required Medical Information

CBC w/ differential, serum Fe, transferrin saturation, serum ferritin.

Age Restrictions

Prescriber Restrictions

Other Criteria

DASTANIB

Affected Drugs

SPRYCEL®

Covered Uses

Treatment of adults with chronic, accelerated, or myeloid or lymphoid blast phase chronic myeloid leukemia (CML) with resistance or intolerance to prior therapy including imatinib and for the treatment of adults with Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) with resistance or intolerance to prior therapy.

Exclusions Criteria

Treatment naïve.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Heme/Onc

Coverage Duration

Other Criteria

DEFERASIROX

Affected Drugs

EXJADE®

Covered Uses

For the treatment of chronic iron overload caused by blood transfusions (transfusional hemosiderosis) in patients 2 years of age and older

Exclusions Criteria

Required Medical Information

serum creatinine and/or creatinine clearance (CrCl), serum transaminases and bilirubin prior to initiation of therapy

Age Restrictions

> 2

Prescriber Restrictions

Coverage Duration

Other Criteria

serum creatinine and/or creatinine clearance (CrCl) prior to initiation of therapy and monthly thereafter; monitor creatinine and/or CrCl weekly for the first month, then monthly thereafter in patients with underlying renal impairment or risk factors for renal impairment; serum transaminases and bilirubin prior to initiation of therapy, every 2 weeks during the first month, and monthly thereafter

Warnings

Deferasirox may cause renal impairment and failure, hepatic impairment and failure, and GI hemorrhage. In some reported cases, these reactions were fatal. These reactions were more frequently observed in patients with advanced age, high-risk myelodysplast

DESMOPRESSIN

Affected Drugs

DDAVP®

Covered Uses

Oral - Nocturnal enuresis, diabetes insipidus. Intranasal (DDAVP) - central diabetes insipidus. Intranasal (Stimate) - Hemophilia A , von Willebrand disease (type 1)

Exclusions Criteria

Nasal spray for nocturnal enuresis.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

DICLOFENAC TOPICAL

Affected Drugs

SOLARAZE®
VOLTAREN®
FLECTOR®

Covered Uses

Actinic keratosis, osteoarthritis w/ intolerance to oral NSAIDs, acetaminophen and lidocaine ointment.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

DIFLUPREDNATE OPHTHALMIC EMULSION 0.05%

Affected Drugs

DUREZOL®

Covered Uses

A Refill prescription for difluprednate (Durezol®) may be approved for coverage for one 5 ml vial (28 day supply) for patients who have already filled one vial of difluprednate for the treatment of inflammation and pain associated with ocular surgery and notes/documentation that a medical provider examined the patient with the aid of magnification, such as slit-lamp biomicroscopy to evaluate for corticosteroid associated ADRs/infections, etc.

Exclusions Criteria

Required Medical Information

Notes/documentation that a medical provider examined the patient with the aid of magnification, such as slit-lamp biomicroscopy to evaluate for corticosteroid associated ADRs/infections, etc

Age Restrictions

Prescriber Restrictions

Ophthalmology

Coverage Duration

Other Criteria

Max 2 fills

DOFETILIDE

Affected Drugs

TIKOSYN®

Covered Uses

Maintenance of normal sinus rhythm (delay in time to recurrence of atrial fibrillation/atrial flutter [AF/AFI]) in patients with atrial fibrillation/atrial flutter of more than 1 week duration who have been converted to normal sinus rhythm. Conversion of atrial fibrillation and atrial flutter to normal sinus rhythm.

Exclusions Criteria

Paroxysmal atrial fibrillation

Required Medical Information

Age Restrictions

Prescriber Restrictions

Other Criteria

Warnings

To minimize the risk of induced arrhythmia, patients initiated or re-initiated on dofetilide should be placed for a minimum of 3 days in a facility that can provide calculations of creatinine clearance, continuous electrocardiographic monitoring, and cardiac resuscitation

DONEPEZIL

Affected Drugs

ARICEPT®

Covered Uses

Alzheimer's dementia with a current MMSE of ≥ 5 and at least 3 ADLs AND have failed/intolerant to galantamine.

Exclusions Criteria

Concurrent therapy with drugs with significant anticholinergic activity and/or drugs (drug doses) that can impair cognition.

Required Medical Information

MMSE and ADLs

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ADLs= feeding, bathing toileting, dressing, transferring

added galantamine as preferred

DORNASE ALFA

Affected Drugs

PULMOZYME®

Covered Uses

Cystic Fibrosis

Exclusions Criteria

Members < 18 y.o.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

DULOXETINE

Affected Drugs

CYMBALTA®

Covered Uses

After failure of formulary alternatives such as gabapentin, venlafaxine and amitriptyline.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

DUTASTERIDE

Affected Drugs

AVODART®

Covered Uses

BPH after failure of finasteride and terazosin.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

added finasteride and terazosin as preferred

ELTROMBOPAG

Affected Drugs

PROMACTA®

Covered Uses

May be approved for coverage for a six (6) week trial period for patients with moderate or severe thrombocytopenia due to chronic immune (idiopathic) thrombocytopenic purpura (ITP) who have had documented trials and failures of corticosteroids or immunoglobulins and splenectomy and are bleeding or whose clinical condition increases the risk of bleeding (e.g., pt. will start myelosuppressive or immunosuppressive agents.)

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Heme/Onc

Coverage Duration

Other Criteria

Warning

“Because of the risk of hepatotoxicity and other risks, Promacta® is available only through a restricted distribution program called Promacta Cares. Under Promacta Cares, only prescribers, pharmacies and patients registered with the program are able to prescribe, dispense, and receive Promacta®.” 1-877-977-6622 (1-877-9-PROMACTA)

ENFUVRTIDE

Affected Drugs

FUZEON®

Covered Uses

In combination with other antiretroviral agents, for the treatment of HIV-1 infection in treatment-experienced patients with evidence of HIV-1 replication despite ongoing antiretroviral therapy.

Exclusions Criteria

Treatment naïve.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ENOXAPARIN

Affected Drugs

LOVENOX®

Covered Uses

Deep Vein Thrombosis (DVT) - treatment limit 5 day supply at a time until INR is at goal.
DVT prophylaxis as needed prior to surgery for patients on warfarin. DVT prophylaxis post surgery x 10 days.

Exclusions Criteria

Required Medical Information

INR

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

EPOETIN ALPHA

Affected Drugs

PROCRIT®

Covered Uses

Prescriptions for epoetin alpha may be approved for coverage for members with the following diagnosis: Anemia associated Chronic Renal Failure, Anemia associated with chemotherapy for nonmyeloid malignancies AND Current iron therapy, adequate serum iron(>40), transferrin saturation (>20%) or serum ferritin (>100 ng/ml) and Hgb less than 10mg/dl.

Exclusions Criteria

Required Medical Information

CBC w/ differential, serum Fe, transferrin saturation, serum ferritin.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ERLOTINIB

Affected Drugs

TARCEVA®

Covered Uses

May be approved for the treatment of locally advanced or metastatic nonsmall cell lung cancer and Documentation of failure of at least one prior chemotherapy regimen or for the first-line treatment of patients with locally advanced, unresectable or metastatic pancreatic cancer in combination with gemcitabine.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Heme/Onc

Coverage Duration

Other Criteria

ETANERCEPT

Affected Drugs

ENBREL®

Covered Uses

May be approved for members under the care of a specialist and the documented trial and failure of methotrexate.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Rheumatology/Dermatology/Gastroenterology

Coverage Duration

Other Criteria

EXENATIDE

Affected Drugs

BYETTA®

Covered Uses

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 and insulin therapies AND HbA1c \leq 8.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Endocrinology

Coverage Duration

Other Criteria

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 Documented diagnosis of myopathy with unexplained muscle pain, tenderness, and/or weakness with malaise and/or fever, with severe symptoms or increased CPK levels >10 time ULN (upper limit of normal) OR Documented hepatotoxicity with increased liver function tests (LFTs) ALT or AST >3 times ULN (upper limit of normal) OR Concomitant use of an interacting drug.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

EZETIMBE/SIMVASTATIN

Affected Drugs

VYTORIN®

Covered Uses

May be approved for coverage for members with a documented diagnosis of hypercholesterolemia and failure of simvastatin alone.

Exclusions Criteria

Required Medical Information

Lipid Panel

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

FENTANYL PATCHES

Affected Drugs

DURAGESIC®

Covered Uses

Allergy/intolerance to morphine.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Limit #10 patches per month

Other Criteria

FILGRASTIM

Affected Drugs

NEUPOGEN®

Covered Uses

May be approved for coverage for members with the following documented diagnosis and a ANC < 1,000/mm³: chemotherapy-induced neutropenia or febrile neutropenia, bone-marrow transplantation, peripheral blood stem cell (PBSC) mobilization, Acute myeloid leukemia (AML) receiving induction or consolidation chemotherapy, severe chronic neutropenia.

Exclusions Criteria

Required Medical Information

CBC w/ differential

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

FONDAPARINUX

Affected Drugs

ARIXTRA®

Covered Uses

May be approved for coverage: In the prevention of postoperative deep vein thrombosis, which may lead to pulmonary embolism, in patients undergoing hip fracture, hip replacement, or knee replacement surgery AND in patients who have intolerance or documented and compliant trials and failures of enoxaparin (Lovenox) for the prevention and treatment of deep vein thrombosis.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

GALANTAMINE

Affected Drugs

RAZADYNE®
REMINYL®

Covered Uses

Alzheimer's dementia with a current MMSE of ≥ 5 and at least 3 ADLs.

Exclusions Criteria

Concurrent therapy with drugs with significant anticholinergic activity and/or drugs (drug doses) that can impair cognition.

Required Medical Information

MMSE and ADLs

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ADLs= feeding, bathing toileting, dressing, transferring

GANCICLOVIR

Affected Drugs

CYTOVENE®

Covered Uses

Prescriptions for ganciclovir may be approved for coverage in patients with: CMV retinitis in AIDS; OR CMV retinitis in patients that are immunocompromised OR Prevention of CMV disease after organ transplant; OR Prevention of CMV disease in advanced HIV patients.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

GLATIRAMER ACETATE

Affected Drugs

COPAXONE®

Covered Uses

For the reduction of the frequency of relapses in patients with relapsing remitting multiple sclerosis (MS), including patients who have experienced a first clinical episode and have magnetic resonance imaging (MRI) features consistent with MS

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Authorizations are for 3 month trial period, then 6 months at a time.

Other Criteria

GOSERELIN

Affected Drugs

ZOLADEX®

Covered Uses

May be approved for coverage for patients with advanced prostatic and breast carcinomas.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

GRANISETRON

Affected Drugs

KYTRIL®

Covered Uses

May be approved for coverage for members that 48 to 72 hours post highly emetogenic chemotherapy or radiation induced nausea and vomiting. Documented trials and failures of ondansetron Max quantity covered per treatment is 1 evry 12 hours for 3 days/not for chronic use.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

HYALURONIC ACID

Affected Drugs

HYALURONAN®

Covered Uses

May be approved for coverage for members that have documented and current compliance with muscle strengthening, physical therapy, dietary and exercise programs, AND Have a documented weight loss of at least 10 pounds, AND Have tried and failed a first line agent from each class of medications such as: Analgesics, Acetaminophen ≤ 4gms (equal efficacy to Naprosyn), AND/OR Nonacetylated salicylate: Disalcid, NSAIDS such as Naprosyn, Ibuprofen, Voltaren, Sulindac AND/OR Non-narcotics and Narcotics: Topical anesthetics: lidocaine 5% ointment, capsacin, methylsalicylate AND/OR Glucocorticoid injection.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

IBANDRONATE

Affected Drugs

BONIVA®

Covered Uses

May be approved for coverage for members that have documented trial and failures of Actonel and Fosamax and have documented current compliance with calcium supplementation.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

IMATIBIB

Affected Drugs

GLEEVAC®

Covered Uses

May be approved for coverage for the following: Adults with relapsed or refractory Philadelphia chromosome–positive (Ph+) acute lymphoblastic leukemia (ALL), Newly diagnosed adults and children with Ph+ chronic myeloid leukemia (CML) in chronic phase; adults with Ph+ CML in blast crisis, accelerated phase, or in chronic phase after failure of interferon alpha therapy; children with Ph+ chronic phase CML whose disease has recurred after stem cell transplant or who are resistant to interferon alpha therapy, Adults with unresectable, recurrent, and/or metastatic dermatofibrosarcoma protuberans, Patients with Kit (CD117)–positive unresectable and/or metastatic malignant GI stromal tumors (GIST); adjuvant treatment of patients following complete gross resection of Kit (CD117)–positive GIST, Adults with hypereosinophilic syndrome and/or chronic eosinophilic leukemia who have the FIP1L1-platelet–derived growth factor receptor (PDGFR) α fusion kinase (mutational analysis or fluorescent in situ hybridization [FISH] demonstration of CHIC2 allele deletion) and for patients with hypereosinophilic syndrome and/or chronic eosinophilic leukemia who are FIP1L1-PDGFR α fusion kinase negative or unknown, Adults with myelodysplastic/myeloproliferative diseases associated with PDGFR gene rearrangements.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

The use of concomitant strong CYP3A4 inducers should be avoided (eg, carbamazepine, dexamethasone, phenobarbital, phenytoin, rifampin, St. John's wort). Limited to 3 month authorization at a time.

IMIGLUCERASE

Affected Drugs

CEREZYME®

Covered Uses

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.

Exclusions Criteria

< 21 y.o. ((CRS < 21)

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

IMIQUIMOD

Affected Drugs

ALDARA®

Covered Uses

May be approved with coverage for members with: biopsy-confirmed, superficial basal cell carcinoma in immunocompetent adults only when when methods are medically less appropriate and patient follow-up is reasonably certain. The target tumor should be no larger than 2 centimeters in diameter and located on the trunk (except anogenital skin), neck, or extremities (excluding hands and feet) OR condyloma acuminata, AND documented trial and failures of chemical burn, loop electrocautery excision, surgery, laser excision, cryotherapy, intralesional interferon, and tissue-destructive drugs such as podofilox and podophyllin.

Exclusions Criteria

Molluscum contagiosum.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

INFLIXIMAB

Affected Drugs

REMICADE®

Covered Uses

Active Crohn's disease, Rheumatoid arthritis, Psoriatic Arthritis, Ankylosing Spondylitis and Other Spondyloarthropathies with an inadequate response to conventional oral therapy (NSAIDS and DMARDS). Moderate to severe Plaque Psoriasis Plaque psoriasis has been present for more than 1 year, ten percent or more body surface area is affected by plaque psoriasis, 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 phototherapy. Ulcerative Colitis - inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Rheumatology/Dermatology/Gastroenterology

Coverage Duration

Other Criteria

INSULIN DETEMIR

Affected Drugs

LEVEMIR®

Covered Uses

Documented trial and failure of Lantus.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

INSULIN GLULISINE

Affected Drugs

APIDRA®

Covered Uses

Documented trial and failure of Novolog.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

INTERFERON ALPHA

Affected Drugs

INTRON A®

Covered Uses

May be approved for coverage for members with the following indications: 1. AIDS-associated Kaposi's sarcoma 2. Hairy cell leukemia; 3. Condylomata acuminata (genital warts) (intralesional only); 4. Hepatitis C, in persons with compensated liver disease (laboratory parameters are all within the following ranges: bilirubin < 2 mg/dL; albumin stable and within normal limits; PT < 3; WBC > 3000/mm³; platelets > 70,000/mm³; no history of hepatic encephalopathy, variceal bleeding, ascites, or other clinical signs of decompensation; serum creatinine normal or near normal) (the safety and efficacy have not been established for treatment of persons with decompensated liver disease or for immune suppressed transplant recipients). Continued treatment with interferon alpha is considered not medically necessary for persons with HCV genotypes 1 and 4 who have failed to attain an early virologic response after 12 weeks of treatment (where early virologic response is indicated by achievement of at least a 100-fold (2 log₁₀) decrease in serum HCV from pretreatment baseline). Up to a maximum of 24 weeks of interferon alpha is considered medically necessary for persons with HCV genotypes 2 and 3, and up to a maximum of 48 weeks of interferon alpha is considered medically necessary for persons with HCV genotypes 1 and 4; 5. Persons with chronic hepatitis B who meet all of the following criteria: a. Hepatitis Be antigen (HBe Ag) present in serum for at least 6 months; b. Serum aminotransferase (AST) greater than double the upper limit of normal range (AST normal range 0-35 u/l); c. Member has compensated liver disease (laboratory parameters are all within the following range: bilirubin <2mg/dL; albumin stable and within normal limits; PT < 3 seconds prolonged or INR < 2; WBC > 3000/mm³; platelets > 70,000/mm³; no history of hepatic encephalopathy, variceal bleeding, ascites, or other clinical signs of decompensation; serum creatinine normal or near normal).

Exclusions Criteria

(The use of interferon alpha is considered contraindicated in the following persons with hepatitis B: those who are HIV positive; hepatitis B surface antigen (HBs Ag) positive persons undergoing liver transplantation; and those with a history of or currently active autoimmune hepatitis)

Required Medical Information

Age Restrictions

Prescriber Restrictions

Hematology/Oncology, Gastroenterology

Coverage Duration

Authorizations are for 3 month trial period, then 6 months at a time.

Other Criteria

Authorizations are for 3 month trial period, then 6 months at a time.

INTERFERON BETA

Affected Drugs

AVONEX®
REBIF®
BETASERON®

Covered Uses

May be approved for coverage for treatment of members with relapsing forms of MS

Exclusions Criteria

Required Medical Information

magnetic resonance imaging (MRI) features consistent with MS

Age Restrictions

Prescriber Restrictions

Neurology

Coverage Duration

Authorizations are for 3 month trial period, then 6 months at a time.

Other Criteria

ISOTRETINOIN, ORAL

Affected Drugs

ACCUTANE®
AMNESTEEM®
CLARAVIS®
SOTRET®

Covered Uses

May be approved for coverage for members < 25 years of age who have documented compliant trials and failures of the following first line agents: benzoyl peroxide, clindamycin, solution, salicylic acid 2%, doxycycline, tetracycline.

Exclusions Criteria

Required Medical Information

LFTs and vision clearance; documented clearance of reproduction/pregnancy and depression or IPLEDGE

Age Restrictions

Prescriber Restrictions

Coverage Duration

Approved for 20 weeks maximum

Other Criteria

ITRACONAZOLE

Affected Drugs

SPORANOX®

Covered Uses

May be approved for coverage after failure of fluconazole or for the treatment of aspergillosis or 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

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Infectious Disease Specialist Exempt

LACOSAMIDE

Affected Drugs

VIMPAT®

Covered Uses

May be approved for coverage as adjunctive therapy for the treatment of refractory partial-onset seizures in patients 17 years or older AND failure of the following: divalproex sodium, gabapentin, lamotrigine, levetiracetam, oxcarbazine, topiramate, zonisamide AND baseline ECG if serious cardiac comorbidities exist or the patient has a concurrent prescription for drugs that can prolong the PR interval such as: Amantadine, holinesterase inhibitors, Digoxin, Diltiazem, Flecainide, Procainamide, Quinidine, Quinine, Ritonavir, Tricyclic antidepressants (amitriptyline, nortriptyline, imipramine, desipramine.)

Exclusions Criteria

Required Medical Information

Baseline ECG if serious cardiac comorbidities exist or the patient has a concurrent prescription for drugs that can prolong the PR interval

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Neurology

LAMOTRIGINE

Affected Drugs

LAMICTAL®

Covered Uses

May be approved for coverage for seizures.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Neurologist exempt

LANSOPRAZOLE

Affected Drugs

PREVACID®

Covered Uses

Prevacid 24hr OTC may be covered for members who have a documented trial/ failure of omeprazole OTC or intolerance.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

LANTHANUM CARBONATE

Affected Drugs

FORSENOL®

Covered Uses

May be approved for coverage for ESRD hemodialysis patients with hyperphosphatemia who have documented trial and failure of: Dietary restriction compliance, AND Documented 2 month compliance with formulary agents like PhosLo gel caps, AND Concomittant phosphate lowering agents.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

LEFLUNOMIDE

Affected Drugs

ARAVA®

Covered Uses

May be approved for coverage for the members with documented rheumatoid arthritis AND Contraindication to two (2) preferred alternative agents indicated for the member's condition OR Intolerance to methotrexate.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

LENALIDOMIDE

Affected Drugs

REVLIMID®

Covered Uses

May be approved for coverage for members for the treatment of transfusion-dependent patients with 5q-myelodysplastic syndrome and in combination with dexamethasone for the treatment of multiple myeloma patients who have received at least 1 prior therapy. Lenalidomide can only be prescribed by licensed health care providers who are registered in the RevAssist program and understand the potential risk of teratogenicity if lenalidomide is used during pregnancy.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Hematology/Oncology

Coverage Duration

Other Criteria

LEVETIRACETAM

Affected Drugs

KEPPRA®

Covered Uses

May be approved for coverage for adjunctive therapy in the treatment of myoclonic seizures in adults and adolescents 12 years of age and older with juvenile myoclonic epilepsy and adjunctive therapy in the treatment of partial-onset seizures in adults and children 4 years of age and older with epilepsy

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Neurology exempt

LINEZOLID

Affected Drugs

ZYVOX®

Covered Uses

May be approved for coverage for a documented diagnosis of vancomycin-resistant *Enterococcus faecium* infection or a documented diagnosis of methicillin-resistant *Staphylococcus aureus* infection and failure/allergy to IV vancomycin.

Exclusions Criteria

Catheter-related site infections.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

MODAFANIL

Affected Drugs

PROVIGIL®

Covered Uses

May be approved for coverage for members with excessive sleepiness associated with narcolepsy or obstructive sleep apnea (OSA)/hypopnea syndrome and has already had an adequate therapeutic trial of twelve (12) weeks of continuous positive airway pressure (CPAP) and treatment after failure of formulary stimulants such as methylphenidate

Exclusions Criteria

No concurrent prescriptions for drugs that may contribute to daytime drowsiness or fatigue.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

MYCOPHENOLATE

Affected Drugs

CELLCEPT®

Covered Uses

May be approved for coverage for the prophylaxis of organ rejection in patients receiving allogeneic renal, cardiac, or hepatic transplants. Use mycophenolate concomitantly with cyclosporine and corticosteroids

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

OMALIZUMAB

Affected Drugs

XOLAIR®

Covered Uses

May be approved for coverage for members with moderate to severe persistent asthma who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids and long-acting beta agonist, leukotriene inhibitors and theophylline and Pretreatment IgE levels 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 and peak flow.

Exclusions Criteria

Required Medical Information

Pretreatment IgE levels, skin testing (or invitro testing) sensitization to perennial aeroallergen (ie., dust mites, animal danders, cockroach, molds), baseline FEV1, peak flow, or other pulmonary function tests.

Age Restrictions

>= 12

Prescriber Restrictions

Pulmonology

Coverage Duration

Other Criteria

ONDANSETRON

Affected Drugs

ZOFRAN®

Covered Uses

May be approved for coverage for members with nausea and vomiting and failure of first line agent such as promethazine and metoclopramide.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Hemetology/Oncology exempt

OXCARBAZEPINE

Affected Drugs

TRILEPTAL®

Covered Uses

May be approved for use as monotherapy or adjunctive therapy in the treatment of partial seizures in adults and as monotherapy in the treatment of partial seizures in children 4 years of age and older with epilepsy, and as adjunctive therapy in children 2 years of age and older with epilepsy.

Exclusions Criteria

Required Medical Information

Age Restrictions

< 2

Prescriber Restrictions

Coverage Duration

Other Criteria

Neurology exempt

OXYCODONE ER

Affected Drugs

OXYCONTIN®

Covered Uses

May be approved for coverage for members with an allergy or intolerance to long-acting morphine sulfate and fentanyl patches.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Limit #60 per month

Other Criteria

Limit #60 per month

PALIVIZUMAB

Affected Drugs

SYNAGIS®

Covered Uses

May be approved for the prevention of serious lower respiratory tract disease caused by RSV in pediatric patients at high risk of RSV disease per the current American Academy of Pediatrics Guidelines.

Exclusions Criteria

Required Medical Information

Age Restrictions

>= 2

Prescriber Restrictions

Pediatrics

Coverage Duration

Other Criteria

PANTOPRAZOLE

Affected Drugs

PROTONIX®

Covered Uses

May be approved for coverage after failure of omeprazole OTC (80mg/d) and Prevacid 24hr OTC (30mg/d).

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

PEGFILGRASTIM

Affected Drugs

NEULASTA®

Covered Uses

May be approved for coverage to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anticancer drugs associated with a clinically significant incidence of febrile neutropenia.

Exclusions Criteria

Required Medical Information

CBC w/ differential to include ANC.

Age Restrictions

Prescriber Restrictions

Hematology/Oncology

Coverage Duration

Authorizations are for 3 months at a time.

Other Criteria

PEGYLATED INTERFERON ALPHA 2A OR 2B

Affected Drugs

PEGASYS
PEG-INTRON®

Covered Uses

May be approved for the treatment of adults with chronic hepatitis C virus (HCV) infection who have compensated liver disease and have not been previously treated with interferon alpha. 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 “FibroSURE test” showing moderate fibrosis and moderate inflammation, Fibrosis score > 0.48 (Fibrosis stage F 2, 3, or 4), 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 and currently not being treated for depression or clearance from behavioral health for treatment. For continued treatment: Members with Genotype 1 maybe approved for additional 36 weeks with a documented decrease in their HCV titer. (Lack of response is indicated by failure to achieve at least a 2 log₁₀ decrease in serum HCV RNA from pretreatment baseline.) Members with Genotype 2 – 6 maybe 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 log₁₀ decrease in serum HCV RNA from pretreatment baseline.)

Exclusions Criteria

Treatment will not be approved for members with decompensated liver disease as manifested by bilirubin > 2 mg/dL; PT > 3 seconds prolonged or INR > 2; WBC < 3000/mm³; platelets <> 70,000/mm³; history of hepatic encephalopathy, variceal bleeding, ascites, or other clinical signs of decompensation.

Required Medical Information

Liver biopsy, genotype, HCV RNA, LTFs, CBC, 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; willing to work with contracted Hepatitis C programs, home health visits, if needed, to monitor compliance. Documented understanding that if he/she is not compliant with medical or medication regime, authorization will be terminated.

Age Restrictions

Prescriber Restrictions

Gastroenterologist

Coverage Duration

Initial authorization is for 12 weeks.

Other Criteria

Warnings

PENTOSAN POLYSULFATE SOLDIUM

Affected Drugs

ELMIRON®

Covered Uses

May be approved for coverage for a 3 month trial period for patients with interstitial cystitis who have documented trials and failures of: bladder training, dietary modification, at least one NSAID documented in the pharmacy fill records and at least 12 weeks of amitriptyline (escalating doses as needed).

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Initial authorization for 3 months

Other Criteria

PIMECROLIMUS

Affected Drugs

ELIDEL®

Covered Uses

May be approved for coverage for a documented diagnosis of atopic dermatitis of the face or groin area in a patient and second line for other areas after failure of emollients, escalating topical steroids.

Exclusions Criteria

Required Medical Information

Age Restrictions

> 2

Prescriber Restrictions

Coverage Duration

Other Criteria

PRAMLINTIDE

Affected Drugs

SYMLIN®

Covered Uses

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.

Exclusions Criteria

Required Medical Information

HgbA1c

Age Restrictions

Prescriber Restrictions

Endocrinology

Coverage Duration

Other Criteria

PREGABALIN

Affected Drugs

LYRICA®

Covered Uses

May be approved for coverage for members needing adjunctive therapy for documented partial-onset seizures; fibromyalgia - failure of muscle relaxants, venlafaxine and gabapentin; diabetic and peripheral neuropathy - failure of formulary agents such as gabapentin, amitriptyline, venlafaxine, nortriptyline; post-herpetic neuralgia - failure of formulary agents such as nortriptyline, amitriptyline, lidocaine ointment.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

RANOLAZINE

Affected Drugs

RANEXA®

Covered Uses

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.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

REPAGLINIDE

Affected Drugs

PRANDIN®

Covered Uses

May be approved for coverage as a second line agent for members with a documented diagnosis of Type 2 diabetes mellitus who have failed concomitant use of maximal doses of metformin and/or a sulfonylurea or has renal failure.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

RIBAVIRON

Affected Drugs

REBETOL®

Covered Uses

May be approved for coverage in conjunction with PEG interferon for the treatment of chronic hepatitis C.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

RIVASTIGMINE

Affected Drugs

EXELON®

Covered Uses

May be approved for coverage for Alzheimer's dementia with a current MMSE of ≥ 5 and at least 3 ADLs

Exclusions Criteria

Concurrent therapy with drugs with significant anticholinergic activity and/or drugs (drug doses) that can impair cognition.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Neurology

Coverage Duration

Other Criteria

ADLs= feeding, bathing toileting, dressing, transferring

RUFINAMIDE

Affected Drugs

BANZEL®

Covered Uses

May be approved for coverage as adjunctive treatment of seizures associated with Lennox-Gestaut Syndrome AND failure of valproic acid plus at least two of the following: lamotrigine, felbamate, topiramate.

Exclusions Criteria

Required Medical Information

Baseline LFTs

Age Restrictions

Prescriber Restrictions

Neurology

Coverage Duration

Other Criteria

SEVELAMER

Affected Drugs

RENVELA®

Covered Uses

May be approved for coverage for use in patients with hyperphosphatemia who are documented compliant and not at target with formulary first line agents (i.e., calcium and Phoslo gel caps) or formulary second line agents IAND have a Calcium Phosphate Product of ≥ 55 mg/dl and compliance with dietary restrictions is documented.

Exclusions Criteria

Required Medical Information

Calcium Phosphate product

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

SILDENAFIL

Affected Drugs

REVATIO®

Covered Uses

May be approved for coverage for pulmonary hypertension only. Only the brand, Revatio, is covered.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Pulmonology/Cardiology

Coverage Duration

Other Criteria

SIROLIMUS

Affected Drugs

RAPAMUNE®

Covered Uses

May be approved for coverage for use in the prophylaxis of organ rejection concomitantly with cyclosporine and corticosteroids in patients receiving allogenic renal, cardiac or hepatic transplants.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

SITAGLIPTIN

Affected Drugs

JANUVIA®

Covered Uses

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 metformin, sulfonylureas, Actos, and all formulary insulin products.

Exclusions Criteria

HgbA1c > 8%

Required Medical Information

HgbA1c

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

SODIUM OXYBATE

Affected Drugs

XYREM®

Covered Uses

May be approved for coverage for cataplexy associated narcolepsy.

Exclusions Criteria

Current prescriptions for sedating medications.

Required Medical Information

Age Restrictions

Prescriber Restrictions

Neurology

Coverage Duration

Other Criteria

Xyrem is available only through the Xyrem Success Program. Call 1-866-997-3688 for more information.

SOMATROPIN

Affected Drugs

NUTROPIN®
SAIZEN®
HUMATROPE®

Covered Uses

May be approved for coverage for: Growth Hormone Deficiency in Children and Adolescents - Idiopathic growth hormone deficiency:

- May be approved for members who have failed to respond to at least two standard GH stimulation tests, defined as a serum GH level (peak level) of less than 10 nanograms per milliliter (ng/ml), after stimulation with insulin, levodopa, arginine, propranolol, clonidine, or glucagon.* (However, one abnormal GH test is sufficient for children with defined CNS pathology, history of irradiation, multiple pituitary hormone deficiency (MPHD) or a genetic defect affecting the GH axis);

AND

- Appropriate imaging (magnetic resonance imaging (MRI) or computed tomography (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).

NOTE: Given the above criteria, further laboratory testing of children without classic GHD to diagnose “partial” GHD, or other abnormalities of GH secretion or bioactivity, is

considered not medically necessary. This includes overnight hospitalization of children for testing of spontaneous GH secretion.

NOTE: Measurement of insulin-like growth factor I (IGF-I) is considered medically necessary to determine adequacy of growth hormone therapy in adults and children. However, the diagnosis of growth hormone deficiency should not rely solely on IGF-I measurements, but must be confirmed by provocative tests solely for growth hormone secretion. Measurement of IGF binding protein-2 (IGFBP-2), IGF binding protein-3 (IGFBP-3), and the acid labile subunit of IGF-I are considered experimental and investigational.

Chronic renal insufficiency:

■ Child's nutritional status has been optimized, metabolic abnormalities have been corrected, and steroid usage has been reduced to a minimum;

AND

- At least one of the following criteria is met:
- Child has severe growth retardation with height 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 (GV measured over one year below 25th percentile for age and sex); or
 - Child exhibits severe deceleration in growth rate (GV measured over one year - 2 SDS below the mean for age and sex).

NOTE: Consistent with established guidelines for children with chronic renal insufficiency after renal transplantation, 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.

Turner's syndrome:

Will be approved 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;

AND

- At least one of the following criteria is met:
- Child has severe growth retardation with height 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 (GV measured over one year below 25th percentile for age and sex); or
 - Child exhibits severe deceleration in growth rate (GV measured over one year - 2 SDS below the mean for age and sex).

Prader Willi syndrome:

Will be approved for children with Prader Willi syndrome and growth retardation who meet all of the following criteria:

- The diagnosis of Prader Willi syndrome is confirmed by appropriate genetic testing;

AND

- Child has GH deficiency;

AND

- At least one of the following criteria is met:
 - Child has severe growth retardation with height SDS less than 3 SDS below the mean for chronological age and sex; or
 - Child has moderate growth retardation with height SDS
 - Child has severe growth retardation with height 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 (GV measured over one year below 25th percentile for age and sex); or
 - Child exhibits severe deceleration in growth rate (GV measured over one year - 2 SDS below the mean for age and sex

AIDS-related wasting:

Will be approved for HIV-infected persons with involuntary weight loss of greater than 10% of pre-illness baseline body weight or body mass index (BMI) less than 20 kg/m², 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).

Exclusions Criteria

Short stature

Required Medical Information

Age Restrictions

Prescriber Restrictions

Endocrinology

Coverage Duration

Other Criteria

SORAFENIB

Affected Drugs

NEXAVAR®

Covered Uses

May be approved for coverage for members with advanced renal cell carcinoma or unresectable hepatocellular carcinoma.

Exclusions Criteria

Short Stature

Required Medical Information

Age Restrictions

Prescriber Restrictions

Hematology/Oncology

Coverage Duration

Authorizations are for 3 months at a time.

Other Criteria

SUMATRIPTAN (NASAL SPRAY AND INJECTABLE)

Affected Drugs

IMITREX®

Covered Uses

May be approved for coverage for migraine patients: with documented trials and inability to take oral sumatriptan, Amerge or Maxalt and with documented and compliant fills of prophylactic migraine medications such as divalproex, atenolol.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

SUNITINIB

Affected Drugs

SUTENT®

Covered Uses

May be approved for coverage advanced renal cell carcinoma or GI stromal tumor after disease progression or intolerance to imatinib.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Hematology/Oncology

Coverage Duration

Authorizations are for 3 months at a time.

Other Criteria

TACROLIMUS

Affected Drugs

PROGRAF®

Covered Uses

May be approved for coverage for use in the prophylaxis of organ rejection concomitantly with cyclosporine and corticosteroids in patients receiving allogenic renal, cardiac or hepatic transplants.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

TAMSULOSIN

Affected Drugs

FLOMAX®

Covered Uses

May be approved for coverage for patients with benign prostatic hypertrophy with documented trials and failures of formulary alpha blockers, terazosin and doxazosin ie., documentation of hypotension or propensity for hypotension.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

TEMOZOLAMIDE

Affected Drugs

TEMODAR®

Covered Uses

May be approved for coverage for the treatment of adult patients with refractory anaplastic astrocytoma (ie, patients who have experienced disease progression on a drug regimen containing a nitrosourea and procarbazine) or for the treatment of adults with newly diagnosed glioblastoma multiforme concomitantly with radiotherapy and then as maintenance treatment.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Hematology/Oncology

Coverage Duration

Authorizations are for 3 months at a time.

Other Criteria

TERBINAFINE

Affected Drugs

LAMISIL®

Covered Uses

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

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

TERIPARATIDE

Affected Drugs

FORTEO®

Covered Uses

May be approved for coverage for patients diagnosed with osteoporosis and that have documented compliance with biphosphonates and calcium and vitamin D.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

TESTOSTERONE, TRANSDERMAL

Affected Drugs

ANDROGEL®

Covered Uses

May be approved for coverage for documented symptomatic hypogonadism and failure/intolerance to testosterone cypionate injectable.

Exclusions Criteria

Erectile dysfunction is specifically prohibited from coverage by AHCCCS and CMS.

Required Medical Information

testosterone levels and clinical notes

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

TETRABENAZINE

Affected Drugs

XENAZINE®

Covered Uses

May be approved for coverage for the treatment of chorea associated with Huntington disease and documented symptoms of Huntington disease: Neurologic- Chorea, Dystonia, Eye movement slowing, Hyperreflexia, Gait abnormality, Myoclonus (rare), Parkinsonism (late stages); Psychiatric - Apathy, Irritability, Depression, Delusions, Aggression, Anxiety, Disinhibition, Paranoia; Cognitive - Poor judgment, Inflexibility of thought, Loss of insight, Decreased concentration, Memory loss, Subcortical dementia AND Genetic testing confirmation AND Genotype testing for CYP2D6 poor metabolizers for doses exceeding 50mg/d.

Exclusions Criteria

Tetrabenazine is contraindicated and will not be approved under the following conditions: Patients who are actively suicidal, Patients with untreated or inadequately treated depression, Impaired hepatic function or Concurrent use of monoamine oxidase inhibitors: isocarboxazid (Marplan)

- linezolid (Zyvox)
- phenelzine (Nardil)
- rasagiline (Azilect)
- reserpine
- selegiline (Eldepryl)
- tranylcypromine (Parnate)

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

TIOTROPIUM

Affected Drugs

SPIRIVA®

Covered Uses

May be approved for coverage for a member with moderate or worse COPD (FEV1/FVC < 70 and FEV1 < 80% of predicted value) when there is a documented compliance to ipratropium (Atrovent) and long-acting beta agonists (with or without steroid.)

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

TRETINOIN

Affected Drugs

RETIN-A®

Covered Uses

May be approved for coverage for members with acne vulgaris after failure of topical anti-infectives and oral antibiotic acne therapy.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

TROSPIUM

Affected Drugs

SANCTURA®

Covered Uses

May be approved for coverage for patients with urinary incontinence and failure of oxybutynin.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ZONISAMIDE

Affected Drugs

ZONEGRAN®

Covered Uses

May be approved for coverage for partial seizures.

Exclusions Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria