



VillageHealth (HMO-POS) 2009 Prior Authorization Criteria

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ADAGEN

Affected Drugs

ADAGEN®

Covered Uses

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

Exclusion Criteria

The patient is a candidate for and has not failed bone marrow transplant therapy. Adagen is furnished “incident to” a physician service, or Home Health, or Outpatient Services.

Required Medical Information

The diagnosis of Adenosine Deaminase Deficiency must be confirmed by Immunologic, or Imaging, or Genetic studies.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for administration in the home.

ADCIRCA

Affected Drugs

ADCIRCA®

Covered Uses

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

Exclusion Criteria

The concurrent use of nitrates. The concomitant use of potent CYP 3A inhibitors, such as ketoconazole and itraconazole. Co-administration with PDE5 inhibitors, such as Cialis, Viagra.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Pulmonologist, Cardiologist.

Coverage Duration

12 Months.

Other Criteria

N/A

AFINITOR

Affected Drugs

AFINITOR®

Covered Uses

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

Exclusion Criteria

Co-administration of Afinitor with strong or moderate inhibitors of CYP3A4 and PgP, such as ketoconazole, itraconazole, erythromycin, verapamil, diltiazem.

Required Medical Information

CBC, SrCr, BUN, serum glucose, lipid panel.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist.

Coverage Duration

12 Months.

Other Criteria

The documented use of Sutent or Nexavar or both is required prior to the initiation of Afinitor.

ALDURAZYME

Affected Drugs

ALDURAZYME®

Covered Uses

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

Exclusion Criteria

Aldurazyme is furnished “incident to” a physician service.

Required Medical Information

The diagnosis of Mucopolysaccharidosis I must be confirmed by Laboratory, or Imaging, or Genetic studies.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail pharmacy, or Home Infusion pharmacy, or LTC pharmacy, or other pharmacies.

ANADROL-50

Affected Drugs

ANADROL-50®

Covered Uses

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

Exclusion Criteria

The patient's iron, folic acid, vitamin B12 or pyridoxine deficiencies have not been corrected prior to the initiation of treatment with Anadrol-50. Documented history of one of the following: prostate cancer, breast cancer, severe hepatic dysfunction, liver cell tumors, coronary arterial disease, hyperlipidemia.

Required Medical Information

Corrected Reticulocyte Count or Reticulocyte Index.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

ANAGRELIDE

Affected Drugs

ANAGRELIDE HCL

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist.

Coverage Duration

12 Months.

Other Criteria

N/A

ANCOBON

Affected Drugs

ANCOBON®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Infectious Disease Specialist.

Coverage Duration

12 Months.

Other Criteria

N/A

ARANESP

Affected Drugs

ARANESP®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as treatment of anemia in low or intermediate-1 risk Myelodysplastic Syndrome patients that are transfusion-dependent or symptomatic from anemia.

Exclusion Criteria

The patient has not tried and failed Procrit for greater than one month. In patients with Chronic Kidney Disease, the exclusion criteria is the following: the patient is on dialysis, the patient's serum creatinine is less than 2.0 mg per dl or clearance creatinine is more than 45 ml per min, the patient's iron deficiency has not been corrected, the patient's current hemoglobin level is 10 g per dl or greater unless this is a diabetic patient with a symptomatic anemia, the patient's target hemoglobin level is not within the range of 10-12 g per dl. In patients with Non-Myeloid malignancies receiving the concomitant myelosuppressive chemotherapy, the exclusion criteria is the following: the anticipated outcome of myelosuppressive chemotherapy is cure, the patient's current hemoglobin level is 10 g per dl or greater.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

B VS D - PART B VERSUS PART D COVERAGE PA

Affected Drugs

AZATHIOPRINE
CARIMUNE NF NANOFILTERED®
CELLCEPT®
CYCLOPHOSPHAMIDE
CYCLOSPORINE
ENGERIX-B®
GENGRAF
GRANISETRON HCL
GRANISOL
METHOTREXATE
MYCOPHENOLATE MOFETIL
MYFORTIC®
NEORAL®
ONDANSETRON HCL
ONDANSETRON ODT
PROGRAF®
RAPAMUNE®
RECOMBIVAX HB®
SANDIMMUNE®
TACROLIMUS ANHYDROUS
VIDAZA®

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.

BETASERON

Affected Drugs

BETASERON®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Neurologist, Multiple Sclerosis Specialist.

Coverage Duration

12 Months.

Other Criteria

N/A

BYETTA

Affected Drugs

BYETTA®

Covered Uses

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

Exclusion Criteria

The patient's hemoglobin A1C is less than 8. Byetta will not be used in combination with metformin, a sulfonylurea, or both. The patient has a diagnosis of end-stage renal disease or clearance creatinine of less than 30 ml per min. The patient has a diagnosis of gastroparesis. The patient has an acute pancreatitis or the history of pancreatitis.

Required Medical Information

Hemoglobin A1C.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

CAMPATH

Affected Drugs

CAMPATH®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as treatment of rheumatoid arthritis and multiple sclerosis.

Exclusion Criteria

Campath is furnished “incident to” a physician service, or Home Health, or Outpatient Services, or administered by an infusion pump in the home.

Required Medical Information

CBC. Concurrent use of medications indicated for PCP and herpes viral prophylaxis.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for administration in the home under the supervision of a Healthcare Professional who is experienced in the use of antineoplastic therapy.

CANCIDAS

Affected Drugs

CANCIDAS®

Covered Uses

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

Exclusion Criteria

Cancidas is furnished "incident to" a physician service.

Required Medical Information

The diagnosis must be confirmed by laboratory testing.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Infectious Disease Specialist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for administration in the home (self-administration or via IV drip or push).

CELEBREX

Affected Drugs

CELEBREX®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Documented history of the following diagnoses: gastrointestinal ulcer, gastrointestinal bleed, or Helicobacter Pylori infection. Documented history of H2 blockers or proton pump inhibitors use. Documented history NSAIDs [Non-steroidal anti-inflammatory drugs] use. Documented current use of warfarin (Coumadin), Heparin, Lovenox, Aggrenox, or Plavix.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

COPAXONE

Affected Drugs

COPAXONE®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Neurologist, Multiple Sclerosis Specialist.

Coverage Duration

12 Months.

Other Criteria

N/A

ELITEK

Affected Drugs

ELITEK®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as prevention and reduction of chemotherapy-induced tumor lysis syndrome and elevated plasma uric acid concentrations in adults with leukemia, lymphoma, or solid tumors.

Exclusion Criteria

Elitek is furnished “incident to” a physician service, or Home Health, or Outpatient Services, or administered by an infusion pump in the home. In patients deficient in glucose-6-phosphate dehydrogenase (G6PD).

Required Medical Information

Plasma Uric acid.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for administration in the home.

ELMIRON

Affected Drugs

ELMIRON®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Urologist.

Coverage Duration

12 Months.

Other Criteria

N/A

EMEND

Affected Drugs

EMEND®

Covered Uses

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

Exclusion Criteria

If used as full therapeutic replacement for IV anti-emetic drugs within 2 hours prior to administration of the anti-cancer treatment and will not exceed 48 hours after the treatment. If used in combination with a 5-HT3 antagonist (ondansetron (Zofran), granisetron (Kytril), or Anzemet)) and dexamethasone and when patient is receiving one or more of the following anti-cancer agents: BiCNU, Gliadel, Cisplatin, Cyclophosphamide, Dacarbazine, Doxorubicin, Ellence, CeeNU, Mustargen, Zanosar (Part B Benefit). The patient has not tried one the following formulary 5-HT3 antagonists: ondansetron, granisetron.

Required Medical Information

Documented history of 5-HT3 antagonists use.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

ENBREL

Affected Drugs

ENBREL®

Covered Uses

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

Exclusion Criteria

The patient has not tried and failed Humira for greater than one month. The concurrent administration of the following drugs: Humira, Kineret, Orencia or Infliximab with Enbrel. In patients with active Rheumatoid Arthritis, the exclusion criteria is the following: the patient has not tried and failed at least one Disease-Modifying Anti-Rheumatic Drug for the current condition. In patients with Psoriatic Arthritis, Ankylosing Spondylitis, Polyarticular-Course Juvenile Rheumatoid Arthritis, the exclusion criteria is the following: the patient has not tried and failed methotrexate for the current condition. In patients with plaque psoriasis, the exclusion criteria is the following: the patient is a candidate for phototherapy or systemic therapy and the patient has not tried and failed phototherapy or systemic therapy.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

ENTOCORT EC

Affected Drugs

ENTOCORT EC®

Covered Uses

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

Exclusion Criteria

The patient has not tried and failed oral aminosalicylates and oral prednisone/prednisolone.

Required Medical Information

Documented history of aminosalicylates use.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

FENTANYL CITRATE TRANSMUCOSAL

Affected Drugs

FENTANYL CITRATE

Covered Uses

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

Exclusion Criteria

Management of acute or postoperative pain. Opioid naïve patients. Patients who are not taking at least 60 mg morphine per day, or 25 mcg transdermal fentanyl per hour, or 30 mg oxycodone per day, or 8 mg oral hydromorphone daily, or an equianalgesic dose of another opioid for a week or longer.

Required Medical Information

Documented history of Opioid use.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Pain Specialist.

Coverage Duration

12 Months.

Other Criteria

N/A

FORTEO

Affected Drugs

FORTEO®

Covered Uses

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

Exclusion Criteria

Patient has increased baseline risk for osteosarcoma. The patient is not at high risk for fractures or doesn't have a history of two or more osteoporotic fractures. The patient is a candidate for the formulary Bisphosphonates: Alendronate, Actonel, Boniva and has not tried and failed them or were intolerant to them. The patient didn't have a fracture and/or 10% or greater loss in bone density while on either Alendronate, Actonel, Fosamax, Boniva, or Evista for at least one year.

Required Medical Information

Bone Density SCAN (DXA or DEXA). Documented history of osteoporotic fractures. Documented history of esophageal pain. Documented history of medications' use: Alendronate, Actonel, Boniva, Evista.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

GAMMAGARD

Affected Drugs

GAMMAGARD LIQUID®

Covered Uses

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

Exclusion Criteria

Diagnosis of Primary Immunodeficiency Syndrome. Gammagard is furnished “incident to” a physician service, or Home Health, or Outpatient Services, or administered by an infusion pump in the home.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for administration in the home (self-administration or via IV drip or push).

GLEEVEC

Affected Drugs

GLEEVEC®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

N/A

HUMIRA

Affected Drugs

HUMIRA®

Covered Uses

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

Exclusion Criteria

The concurrent administration of the following drugs: Enbrel, Kineret, Orencia, or Infliximab with Humira. In patients with active Rheumatoid Arthritis, the exclusion criteria is the following: the patient has not tried and failed at least one Disease-Modifying Anti-Rheumatic Drug for the current condition. In patients with Psoriatic Arthritis, Ankylosing Spondylitis, Polyarticular-Course Juvenile Rheumatoid Arthritis, the exclusion criteria is the following: the patient has not tried and failed methotrexate for the current condition. In patients with plaque psoriasis, the exclusion criteria is the following: the patient is a candidate for phototherapy or systemic therapy and the patient has not tried and failed phototherapy or systemic therapy. In patients with Crohn's disease, the exclusion criteria is the following: the patient has not tried and failed conventional therapy agents: aminosalicylates, corticosteroids, immunomodulators or Infliximab.

Required Medical Information

Documented history of Disease-Modifying Anti-Rheumatic Drug Use. Documented history of phototherapy use. Documented history aminosalicylates, corticosteroids, immunomodulators or Infliximab use.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

HUMIRA CROHNS

Affected Drugs

HUMIRA®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

Documented history of aminosaliclates, corticosteroids, immunomodulators or Infliximab use.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

IPLEX

Affected Drugs

IPLEX®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

The diagnosis must be confirmed by Laboratory or Genetic testing.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for self-administration in the home.

JANUMET

Affected Drugs

JANUMET®

Covered Uses

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

Exclusion Criteria

The patient does not have a functioning transplanted kidney. The patient's serum creatinine is 1.4 mg/dl or higher in females or 1.5 mg/dl or higher in males.

Required Medical Information

Serum Creatinine.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

LIPITOR (80MG ONLY)

Affected Drugs

LIPITOR®

Covered Uses

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

Exclusion Criteria

Patient has not tried and failed Vytorin 10/40 mg per day or 10/80 mg per day for at least one month.

Required Medical Information

Documented history of Vytorin 10/40 mg per day or Vytorin 10/80 mg per day use for at least one month.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

LOVAZA

Affected Drugs

LOVAZA®

Covered Uses

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

Exclusion Criteria

Patient has not tried and failed for at least three months or doesn't have a contraindication to a formulary fibrates (for example, Fenofibrate, Tricor, Triglide, Gemfibrozil). The patient's current triglyceride levels is not greater than 500 mg/dl.

Required Medical Information

Documented history of formulary fibrates use for at least three months. Current triglyceride level.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

LYRICA

Affected Drugs

LYRICA®

Covered Uses

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

Exclusion Criteria

Patient has not tried and failed the total daily dose of gabapentin of 600 mg or greater and any other formulary agent (tricyclic antidepressants, opioid analgesics, Cymbalta, Cabamazepine) for the current condition.

Required Medical Information

Documented history of the total daily dose of gabapentin of 600 mg or greater and any other formulary agent (tricyclic antidepressants, opioid analgesics, Cymbalta, Cabamazepine) use for the current condition.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist, Endocrinologist, Fibromyalgia Disease Specialist. Multiple Sclerosis Disease Specialist, Oncologist.

Coverage Duration

12 Months.

Other Criteria

N/A

MIACALCIN INJECTION

Affected Drugs

MIACALCIN®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

NAGLAZYME

Affected Drugs

NAGLAZYME®

Covered Uses

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

Exclusion Criteria

Naglazyme is furnished “incident to” a physician service, or Home Health, or Outpatient Services, or administered by an infusion pump in the home.

Required Medical Information

The diagnosis must be confirmed by laboratory or genetic testing.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for administration in the home (self-administration or via IV drip or push).

NEUPOGEN

Affected Drugs

NEUPOGEN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as treatment of graft failure after bone marrow transplantation, neutropenia associated with myelodysplastic syndrome, hairy cell leukemia, aplastic anemia, severe neutropenia in HIV-infected patients on antiretroviral therapy.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

NEUTREXIN

Affected Drugs

NEUTREXIN®

Covered Uses

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

Exclusion Criteria

The patient has not tried and failed and doesn't have contraindications to trimethoprim-sulfamethaxazole therapy. Neutrexin is not being administered concurrently with Leucovorin. Neutrexin is furnished "incident to" a physician service, or Home Health, or Outpatient Services, or administered by an infusion pump in the home.

Required Medical Information

Documented history of trimethoprim-sulfamethaxazole therapy use.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for administration in the home (self-administration or via IV drip or push).

NEXAVAR

Affected Drugs

NEXAVAR®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Oncologist.

Coverage Duration

12 Months.

Other Criteria

N/A

NOXAFIL

Affected Drugs

NOXAFIL®

Covered Uses

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

Exclusion Criteria

The patient has not tried and failed or does not have contraindications to itraconazole, or fluconazole for the current condition. Current use of one of the following: Orap, quinidine, or ergot alkaloids.

Required Medical Information

Documented history of itraconazole, or fluconazole for the current condition. High risk patients due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy.

Age Restrictions

Approve if 13 years old or older.

Prescriber Restrictions

The prescription is recommended or initially written by Infectious Disease Specialist.

Coverage Duration

12 Months.

Other Criteria

N/A

ONTAK

Affected Drugs

ONTAK®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as treatment of chronic lymphocytic leukemia refractory to fludarabine, non-Hodgkin lymphoma.

Exclusion Criteria

Ontak is furnished “incident to” a physician service, or Home Health, or Outpatient Services, or administered by an infusion pump in the home.

Required Medical Information

CD [Chron's Disease]25 expression laboratory testing, CBC, ALT, AST, serum albumin, chem panel.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for administration in the home under the supervision of a Healthcare Professional who is experienced in the use of antineoplastic therapy. The home must be equipped for cardiopulmonary resuscitation and the patient must be closely monitored.

ORFADIN

Affected Drugs

ORFADIN®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

The diagnosis must be confirmed by laboratory or genetic testing.

Age Restrictions

N/A

Prescriber Restrictions

The prescription is recommended or initially written by a specialist experienced in the treatment of Hereditary Tyrosinemia type 1.

Coverage Duration

12 Months.

Other Criteria

N/A

PEGASYS

Affected Drugs

PEGASYS®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as Renal Cell Carcinoma and Chronic Myelogenous Leukemia.

Exclusion Criteria

N/A

Required Medical Information

Hepatitis B or Hepatitis C Serology.

Age Restrictions

N/A

Prescriber Restrictions

Infectious Disease Specialist, Oncologist, Nephrologist, Transplant Physician, Gastroenterologist.

Coverage Duration

12 Months.

Other Criteria

N/A

PEG-INTRON

Affected Drugs

PEGINTRON REDIPEN®

Covered Uses

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

Exclusion Criteria

The previous use of interferon alpha in patients using Peg-Intron as monotherapy. HCV RNA level is 50 IU per ml or less.

Required Medical Information

HCV RNA levels.

Age Restrictions

Approve if 3 years old or older if Peg-Intron is used as combination therapy with ribavirin. Approve if 18 years old or older if Peg-Intron is used as monotherapy in patients previously untreated with intereron alpha.

Prescriber Restrictions

Infectious Disease Specialist, Gastroenterologist.

Coverage Duration

12 Months.

Other Criteria

N/A

PROCRIT

Affected Drugs

PROCRIT®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as treatment of anemia in low or intermediate-1 risk Myelodysplastic Syndrome patients that are transfusion-dependent or symptomatic from anemia.

Exclusion Criteria

In patients with Chronic Kidney Disease, the exclusion criteria is the following: the patient is on dialysis, the patient's serum creatinine is less than 2.0 mg/dl or clearance creatinine is more than 45 ml/min, the patient's iron deficiency has not been corrected, the patient's current hemoglobin level is 10 g/dl or greater unless this is a diabetic patient with a symptomatic anemia, the patient's target hemoglobin level is not within the range of 10-12 g/dl. In patients with Non-Myeloid malignancies receiving the concomitant myelosuppressive chemotherapy, the exclusion criteria is the following: the anticipated outcome of myelosuppressive chemotherapy is cure, the patient's current hemoglobin level is 10 g/dl or greater. In patients scheduled to undergo noncardiac, nonvascular surgery, the exclusion criteria is the following: the antithrombotic prophylaxis is not considered. In HIV-infected patients with anemia related to zidovudine-treatment, the exclusion criteria is the following: the pretreatment endogenous serum erythropoietin level is greater than 500 microunits/ml.

Required Medical Information

Serum Creatinine, Weight, Height, Clearance Creatinine, cbc, hemaglobin, hematocrit, Serum Erythropoietin level.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

PROLEUKIN

Affected Drugs

PROLEUKIN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as in HIV patients in combination with highly active antiretroviral therapy, in combination for treatment of cutaneous T-cell lymphoma, in treatment of colorectal cancer, non-Hodgkin lymphoma, Acute Myelogenous Leukemia, after autologous bone marrow transplantation.

Exclusion Criteria

ECOG performance status greater than 1. The patient's cardiac and pulmonary function defined by thallium stress testing and pulmonary function testing are not within normal limits. Proleukin is furnished "incident to" a physician service, or Home Health, or Outpatient Services.

Required Medical Information

ECOG Performance Status. Thallium Stress and Pulmonary Function Tests.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies and administered under the supervision of a specialist experienced in the use of anticancer agents. Specialists skilled in cardiopulmonary or intensive care medicine must be available.

PROVIGIL

Affected Drugs

PROVIGIL®

Covered Uses

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

Exclusion Criteria

In patients with excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome, the exclusion criteria is the following: the patient has not tried and failed continuous positive airway pressure (CPAP). In patients with narcolepsy, the exclusion criteria is the following: the patient has not tried and failed both methylphenidate and dextroamphetamine.

Required Medical Information

In patients with excessive sleepiness associated with obstructive sleep apnea/hypopnea syndrome, documented history of CPAP [Continuous positive airway pressure] use. In patients with narcolepsy, documented history of methylphenidate and dextroamphetamine use.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

RANEXA

Affected Drugs

RANEXA®

Covered Uses

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

Exclusion Criteria

Current use of drugs that prolong QTc interval. Current use of diltiazem or verapamil.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

RELISTOR

Affected Drugs

RELISTOR®

Covered Uses

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

Exclusion Criteria

The patient was not prescribed at least one formulary laxative: lactulose or polyethylene glycol 3350 for the current condition.

Required Medical Information

Documented history of opioid-induced constipation. Documented history of one of the following primary diagnoses: incurable cancer, end-stage COPD [Chronic Obstructive Pulmonary Disease], emphysema, cardiovascular disease, heart failure, Alzheimer's disease, Alzheimer's dementia, HIV, AIDS, or any other advanced illness that requires a palliative opioid therapy.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

REVATIO

Affected Drugs

REVATIO®

Covered Uses

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

Exclusion Criteria

Current use of nitrates if potential risks outweigh the potential benefits.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

RILUTEK

Affected Drugs

RILUTEK®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

RITUXAN

Affected Drugs

RITUXAN®

Covered Uses

All FDA-approved indications not otherwise excluded from Part D and other medically accepted indications, such as treatment of moderately- to severely- active rheumatoid arthritis in adult patients who have had an inadequate response to one or more TNF [Tumor necrosis factor] antagonist therapies.

Exclusion Criteria

Rituxan is furnished "incident to" a physician service, or Home Health, or Outpatient Services, or administered by an infusion pump in the home. For the treatment of Rheumatoid Arthritis indication, the patient has not tried and failed or does not have contraindications to at least one TNF [Tumor necrosis factor] antagonist therapy.

Required Medical Information

The diagnosis of CD20 positive follicular B-cell non-Hodgkin's lymphoma must be confirmed by histologic testing. CBC, platelet count must be obtained. If used for the treatment of Rheumatoid Arthritis, documented history of one or more TNF [Tumor necrosis factor] antagonist use must be present.

Age Restrictions

N/A

Prescriber Restrictions

Oncologist, Hematologist, Rheumatoid Arthritis Specialist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for administration in the home under the supervision of a Healthcare Professional who is experienced in the use of Rituxan therapy and will monitor the patient for the infusion reactions.

SEROSTIM

Affected Drugs

SEROSTIM®

Covered Uses

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

Exclusion Criteria

The patient has lowered growth hormone level secondary to the normal aging process, obesity or depression.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

SIMPONI

Affected Drugs

SIMPONI®

Covered Uses

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

Exclusion Criteria

The concurrent administration of the following drugs: Kineret and Orencia with Simponi.

Required Medical Information

In patients with moderately to severely active Rheumatoid Arthritis, the concurrent use of methotrexate with Simponi.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

In patients who don't have contraindications to Humira, the documented use of Humira for at least three months is required prior to the initiation of Simponi. In patients with moderately to severely active Rheumatoid Arthritis, the documented use of at least one Disease-Modifying Anti-Rheumatic Drug is required for the current condition prior to the initiation of Simponi. In patients with active Psoriatic Arthritis, the documented use of methotrexate is required for the current condition prior to the initiation of Simponi. In patients with active Ankylosing Spondylitis, the documented use of at least 2 NSAIDs [Non-steroidal anti-inflammatory drugs] is required for the current condition prior to the initiation of Simponi.

SOMAVERT

Affected Drugs

SOMAVERT®

Covered Uses

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

Exclusion Criteria

The patient has not tried and failed surgery and /or radiation therapy within the past 6 months if the patient is a candidate for these therapies.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for self-administration in the home.

SORIATANE CK

Affected Drugs

SORIATANE CK®

Covered Uses

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

Exclusion Criteria

The patient has not tried and failed a three month trial of formulary topical corticosteroids for the current condition.

Required Medical Information

Documented history of formulary topical corticosteroids use for at least three months.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

SPRYCEL

Affected Drugs

SPRYCEL®

Covered Uses

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

Exclusion Criteria

The patient has not tried and failed Gleevec for the current condition.

Required Medical Information

Documented history of Gleevec use.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

STRATTERA

Affected Drugs

STRATTERA®

Covered Uses

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

Exclusion Criteria

The patient who doesn't have a documented history of stimulant drug abuse and dependence has not tried and failed both methylphenidate and dextroamphetamine for the current condition.

Required Medical Information

Documented history of methylphenidate and dextroamphetamine use.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

SUTENT

Affected Drugs

SUTENT®

Covered Uses

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

Exclusion Criteria

In patient's with gastrointestinal stromal tumors (GIST), the exclusion criteria is the following: the patient has not tried and failed Gleevec.

Required Medical Information

Documented history of Gleevec use in patients with GIST.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

N/A

SYMLIN

Affected Drugs

SYMLIN®

Covered Uses

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

Exclusion Criteria

The patient is currently not using insulin. The patient has a poor compliance with the current oral hypoglycemic agents or insulin regimen and with self-blood glucose monitoring. The patient's current hemoglobin A1C is 9 or greater. The patient has a history of a recurrent severe hypoglycemia requiring assistance in the last 6 months. The patient has a diagnosis of gastroparesis. The patient is currently taking metoclopramide.

Required Medical Information

Hemoglobin A1C.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Endocrinologist.

Coverage Duration

12 Months.

Other Criteria

N/A

SYMLINPEN

Affected Drugs

SYMLINPEN 120®

SYMLINPEN 60®

Covered Uses

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

Exclusion Criteria

The patient is currently not using insulin. The patient has a poor compliance with the current oral hypoglycemic agents or insulin regimen and with self-blood glucose monitoring. The patient's current hemoglobin A1C is 9 or greater. The patient has a history of a recurrent severe hypoglycemia requiring assistance in the last 6 months. The patient has a diagnosis of gastroparesis. The patient is currently taking metoclopramide.

Required Medical Information

Hemoglobin A1C.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Endocrinologist.

Coverage Duration

12 Months.

Other Criteria

N/A

TARGRETIN

Affected Drugs

TARGRETIN®

Covered Uses

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

Exclusion Criteria

The patient was not prescribed at least one systemic or topical therapy for the current condition prior to initiation of Targretin.

Required Medical Information

The documented history of one systemic or topical therapy use for the current condition. In patients requesting oral Targretin, Liver function tests: ALT/AST, Fasting lipid panel, WBC, thyroid function tests.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist or Dermatologist.

Coverage Duration

12 Months.

Other Criteria

N/A

TASIGNA

Affected Drugs

TASIGNA®

Covered Uses

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

Exclusion Criteria

The patient is not resistant to prior therapy with Gleevec. The patient's QTc interval 480 msec or greater. The patient's baseline potassium and magnesium levels are not within normal limits. Concurrent use of strong CYP3A4 Inhibitors or drugs that prolong QT interval. Hepatic impairment defined as the following: ALT/ST are greater than 2. 5 (or greater than 5, if related to disease) times the upper limit of the normal range and/ or total bilirubin greater than 1. 5 times the upper normal limit of the normal range.

Required Medical Information

Documented history of resistance to Gleevec that is defined as one of the following: failure to achieve a complete hematologic response by 3 months, failure to achieve a cytogenic response by 6 months or major cytogenic response by 12 months, progression of disease after a previous cytogenic or hematologic response. Baseline ECG. Baseline Potassium and Magnesium levels. Hepatic Function tests: ALT/AST, total bilirubin.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

A trial of Gleevec is not required if patient is intolerant to Gleevec.

THALOMID

Affected Drugs

THALOMID®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist or Hematologist.

Coverage Duration

12 Months.

Other Criteria

N/A

THIOGUANINE

Affected Drugs

THIOGUANINE®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

N/A

TRISENOX

Affected Drugs

TRISENOX®

Covered Uses

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

Exclusion Criteria

The patient's Acute Promyelocytic Leukemia is not characterized by the presence of the t(15, 17) translocation or PML/RAR-alpha gene expression. The patient is not refractory to (or have not relapsed from) retinoid and anthracycline chemotherapy. The patient's baseline ECG and electrolytes (potassium, calcium, and magnesium) are not within normal limits. Trisenox is furnished "incident to" a physician service, or Home Health, or Outpatient Services.

Required Medical Information

Presence of the t(15, 17) translocation or PML/RAR-alpha gene expression.
Documented history of retinoid and anthracycline chemotherapy use. Baseline ECG and electrolytes.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for administration in the home under the supervision of a physician who is experienced in the management of patients with acute leukemia.

TYKERB

Affected Drugs

TYKERB®

Covered Uses

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

Exclusion Criteria

The patient's tumor does not overexpress Human Epidermal Receptor Type 2 (HER2). The patient has not tried and failed prior therapy with anthracycline, taxane, and Herceptin. The Tykerb is not given in combination with Xeloda. The patient's baseline LVEF is less than 50%. The patient's baseline potassium and magnesium levels are not within normal limits.

Required Medical Information

Laboratory testing based on the new HER2 Testing Guidelines from the College of American Pathologists (CAP) and the American Society of Clinical Oncology (ASCO) that confirms HER2 overexpression. Documented history of anthracycline, taxane, and Herceptin use. MUGA testing. Baseline electrolytes.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

N/A

VELCADE

Affected Drugs

VELCADE®

Covered Uses

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

Exclusion Criteria

The prescription must be initially written or recommended by the Oncologist.

Required Medical Information

Documented history of at least one prior therapy use for the current condition.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

Part D coverage if furnished by Retail, or Home Infusion, or LTC Pharmacies for administration in the home (IV push) under the supervision of a Healthcare Professional who is experienced in the use of antineoplastic therapy.

ZAVESCA

Affected Drugs

ZAVESCA®

Covered Uses

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

Exclusion Criteria

The patient who doesn't have contraindications to Enzyme Replacement Therapy, such as allergy, hypersensitivity, or poor venous access.

Required Medical Information

The diagnosis must be confirmed by laboratory or Genetic testing. Documented intolerance to Enzyme Replacement Therapy, such as allergy, hypersensitivity, or poor venous access. .

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 Months.

Other Criteria

N/A

ZOLINZA

Affected Drugs

ZOLINZA®

Covered Uses

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

Exclusion Criteria

The patient has not tried and failed two or more systemic therapies for the current condition: Targretin, Actimmune, Roferon-A, methotrexate.

Required Medical Information

Documented history of two or more systemic therapies use for the current condition.

Age Restrictions

N/A

Prescriber Restrictions

The prescription must be initially written or recommended by the Oncologist.

Coverage Duration

12 Months.

Other Criteria

N/A

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