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ACTIQ/FENTORA

Affected Drugs

FENTANYL CITRATE
FENTORA®
ONSOLIS®

Covered Uses

1) Actiq or Fentora will be approved for all FDA approved indications not otherwise excluded from Part D. As specified in FDA approved indications: for opioid tolerant patients only, defined as: greater than 60 mg/day oral morphine, greater than 25 mcg/h transdermal fentanyl, greater than 30 mg/day oral oxycodone, greater than 8 mg/day oral hydromorphone, or greater than 25 mg/day oral oxymorphone or equianalgesic dose of other opioid for greater than 1wk.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

Prescriber must document inability to swallow.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

AMTURNIDE

Affected Drugs

AMTURNIDE®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prescriber must document that medication compliance issue exists.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

ANABOLIC STEROIDS

Affected Drugs

ANADROL-50®
ANDROXY®
OXANDROLONE

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

ARANESP

Affected Drugs

ARANESP®

Covered Uses

All FDA approved indications not otherwise excluded from Part D worded as anemia associated with CRF [Chronic Renal Failure], including patients on dialysis and not on dialysis, if hemoglobin (Hb) is less than or equal to 11.0 g/dL for therapy initiation. If the patient has previously been receiving darbepoetin or epoetin alfa, approve only if Hb is less than or equal to 12.0 g/dL. Deny darbepoetin if hemoglobin exceeds 12.0 g/dL if previously receiving the product for this indication and in any situation (continuation or initiation). Anemia in cancer due to chemotherapy approve for 4 months if the patient has a Hb less than or equal to 10.0 g/dL or Hb is greater than 10.0 g/dL but less than or equal to 12.0 g/dL and the physician anticipates a Hb decrease or the patient has comorbidities that require higher Hb levels. Also, deny darbepoetin if Hb is greater than 12.0 g/dL if previously receiving the product for this indication and in any situation (continuation or initiation). Anemia due to myelodysplastic syndrome (MDS) but do not approve if Hb is greater than 12.0 g/dL if previously receiving the product for this indication and in any situation (continuation or initiation).

Exclusion Criteria

Anemia associated with cancer such as AML [Acute Myeloid Lymphoma], CML [Chronic Myeloid Leukemia] or other myeloid cancers where there is no chemotherapy. Anemia associated with radiotherapy in cancer without chemotherapy. To enhance athletic performance. Treatment of anemia in inflammatory bowel disease (eg, ulcerative colitis, Crohn's disease). Anemia in patients due to acute blood loss. Anemia in heart failure. Anemia associated with the use of ribavirin therapy for hepatitis C (in combination with interferon or pegylated interferon alfa 2a/2b products). Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

Hb value of less than or equal to 11.0 g/dL required for initiation of therapy in chronic renal failure (CRF). Also, in CRF [Chronic Renal Failure] Hb has to be less than or equal to 12.0 g/dL if previously receiving epoetin alfa or darbepoetin. CRF [Chronic Renal Failure] indication should be denied if Hb exceeds 12.0 g/dL for this condition and in any situation (continuation or initiation). For anemia in cancer patients due to chemotherapy a Hb of less than or equal to 10.0 g/dL is required or if Hb is greater than 10.0 g/dL but less than or equal to 12.0 g/dL the physician must anticipate a Hb decrease or the patient has comorbidities that require higher Hb levels. Deny

darbepoetin in any situation that Hb is greater than 12.0 g/dL in cancer due to chemotherapy. For MDS [Myelodysplastic syndrome], deny darbepoetin if hemoglobin is greater than 12.0 g/dL.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 3 months unless requested by prescriber for a period less than 3 months.

Other Criteria

N/A

ARZERRA

Affected Drugs

ARZERRA®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months unless requested by prescriber for a period of less than 12 months.

Other Criteria

N/A

AZOR

Affected Drugs

AZOR®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prescriber must document that medication compliance issue exists.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

B VS D - PART B VERSUS PART D COVERAGE PA

Affected Drugs

AZASAN®
AZATHIOPRINE
CALCITRIOL
CARIMUNE NF NANOFILTERED®
CELLCEPT®
CYCLOPHOSPHAMIDE
CYCLOSPORINE
CYCLOSPORINE MODIFIED
EMEND®
GAMASTAN S-D®
GAMMAGARD LIQUID®
GAMUNEX®
GENGRAF
GRANISETRON HCL
GRANISOL
HECTOROL®
HEPARIN SODIUM
HEPARIN SODIUM IN 0.45% NACL
HEPARIN SODIUM IN 0.9% NACL
HEPARIN SODIUM IN 5% DEXTROSE
LEVOCARNITINE
METHOTREXATE
MIACALCIN®
MYCOPHENOLATE MOFETIL
MYFORTIC®
ONDANSETRON HCL
ONDANSETRON ODT
PAMIDRONATE DISODIUM
PRIVIGEN®
PULMOZYME®
RAPAMUNE®
TACROLIMUS
TOBI®
VANCOMYCIN HCL
ZORTRESS®

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.

BOTOX

Affected Drugs

BOTOX®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Cosmetic uses (eg, facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platysmal bands, rejuvenation of the peri-orbital region. Allergic rhinitis. Gait freezing in Parkinsons disease. Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Tinnitus if prescribed by ENT. Headache if prescribed by, or after consultation with, a neurologist or HA [Headache] specialist.

Coverage Duration

12 weeks. On reauthorization, approval will be for 12 months.

Other Criteria

Documentation of effectiveness of therapy at 3 months.

CADUET

Affected Drugs

CADUET®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prescriber must document that medication compliance issue exists.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

CEREZYME

Affected Drugs

CEREZYME®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Prescribed by or after consultation with, a physician that specializes in the treatment of inherited metabolic disorders.

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

COREG CR

Affected Drugs

COREG CR®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prescriber must document that medication compliance issue exists.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

DRONABINOL

Affected Drugs

DRONABINOL

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

EMSAM

Affected Drugs

EMSAM®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Must be prescribed by psychiatrist or under the supervision of a psychiatrist.

Coverage Duration

Authorization will be for 12 months unless requested by prescriber for a period of less than 12 months.

Other Criteria

N/A

ERYTHROID STIMULANTS

Affected Drugs

PROCRIT®

Covered Uses

All FDA approved indications not otherwise excluded from Part D . Current indications include anemia secondary to chronic kidney disease, chemotherapy induced anemia, myelodysplastic syndrome, anemia associated with the use of zidovudine, and peri-surgery.

Exclusion Criteria

Will not be approved for patients with iron deficiency that are not on iron replacement therapy. Iron deficiency is defined as a TSat less than 20% or Serum Ferritin less than 100 ng/mL.

Required Medical Information

For starting therapies for: CKD [Chronic Kidney Disease], anemia secondary to chemo, myelodysplastic syndrome and anemia associated with zidovudine Hg less than or equal to 10, for chemo dx the chemo duration must be greater than 3 months, for anemia with zidovudine an erythropoitin level of less than or equal to 500munits/ml will also be accepted, for continuation of therapy for CKD [Chronic Kidney Disease] Hgb less than 11, chemo less than 12, myelodysplastic syndrome less than 12 and zidovudine hg less than or equal to 12, for peri surgery hgb should be between 10 and 13 and patient at high risk for eriooperative blood loss. All lab work should be within 30 days of request.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

One year for all indications except Perisurgery (one-time auth).

Other Criteria

If drug is prescribed in conjunction with dialysis, it will be denied as a Part D drug and be covered under the bundled dialysis rate.

EXFORGE

Affected Drugs

EXFORGE HCT®
EXFORGE®

Covered Uses

Exforge or Exforge HCT will be approved for all FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prescriber must document that medication compliance issue exists.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

FABRAZYME

Affected Drugs

FABRAZYME®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

FORTEO

Affected Drugs

FORTEO®

Covered Uses

All FDA approved indications not otherwise excluded from Part D. For the treatment of osteoporosis in patients (women and men) who are at high risk for fracture. Patients at high risk include those with a history of osteoporotic fracture, those with a medical condition that has resulted in bone loss significantly greater than would be expected for the patient's age (eg, chronic liver disease), patients with a very low BMD [Bone mass density] (defined as (ie, BMD [Bone mass density] T-score below -2.0 or), and those using medicine that resulted in bone loss (eg, steroids [prednisone]). For use in hypoparathyroidism (primary or secondary) if the patient is under the care of an endocrinologist.

Exclusion Criteria

Prevention of osteoporosis (women and men). Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

T-score below -2.0. For hypoparathyroidism.

Age Restrictions

N/A

Prescriber Restrictions

For hypoparathyroidism that patient must be under the care of an endocrinologist.

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

Patients that have tried other medications for the treatment of osteoporosis (eg, bisphosphonates, intranasal calcitonin, raloxifene), are currently receiving such medications, or are intolerant to these agents may receive Forteo regardless of risk status of the treatment of osteoporosis.

GROWTH HORMONES

Affected Drugs

NORDITROPIN FLEXPRO®
NORDITROPIN NORDIFLEX®
SAIZEN®

Covered Uses

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

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

INCRELEX

Affected Drugs

INCRELEX®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

INVEGA

Affected Drugs

INVEGA®

Covered Uses

All FDA approved indications not otherwise excluded from Part D. For a stabilized patient that is new to the plan or patients with compliance and/or failure issues of other drugs within the class.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months unless requested by prescriber for a period of less than 12 months.

Other Criteria

N/A

LAMICTAL XR

Affected Drugs

LAMICTAL XR (BLUE)®
LAMICTAL XR (GREEN)®
LAMICTAL XR (ORANGE)®
LAMICTAL XR®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prescriber must document that medication compliance issue exists.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

LATUDA

Affected Drugs

LATUDA®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prior authorization for diagnosis only.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

LEUPROLIDE (LONG ACTING)

Affected Drugs

ELIGARD®
LUPRON DEPOT®
LUPRON DEPOT-PED®

Covered Uses

All FDA approved indications.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

For dysfunctional uterine bleeding approve for up to 6 months and all other indications x 12 months.

Other Criteria

N/A

MIRAPEX ER

Affected Drugs

MIRAPEX ER®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prescriber must document that medication compliance issue exists.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

MULTAQ

Affected Drugs

MULTAQ®

Covered Uses

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

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Must be prescribed by a cardiologist or under consult of a cardiologist.

Coverage Duration

3 years.

Other Criteria

N/A

NEULASTA

Affected Drugs

NEULASTA®

Covered Uses

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

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

NEUPOGEN

Affected Drugs

NEUPOGEN®

Covered Uses

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

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

NOXAFIL

Affected Drugs

NOXAFIL®

Covered Uses

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

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 3 months unless requested by prescriber for a period less than 3 months.

Other Criteria

N/A

PROVIGIL

Affected Drugs

NUVIGIL®
PROVIGIL®
XYREM®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months unless requested by prescriber for a period of less than 12 months.

Other Criteria

N/A

REGRANEX

Affected Drugs

REGRANEX®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Must be prescribed by a wound care specialist or under consult of a wound care nurse.

Coverage Duration

Authorization will be for 10 weeks.

Other Criteria

N/A

RELISTOR

Affected Drugs

RELISTOR®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 4 months, unless requested for less than 4 months by prescriber.

Other Criteria

N/A

REQUIP XL

Affected Drugs

REQUIP XL®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prescriber must document that medication compliance issue exists.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

REVATIO/ADCIRCA

Affected Drugs

ADCIRCA®

Covered Uses

Adcirca or Revatio will be approved for all FDA approved indications not otherwise excluded from Part D plus Eisenmenger syndrome with pulmonary arterial hypertension (PAH) [men or women].

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses. Revatio will not be approved for erectile dysfunction.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

N/A

SCHIZOP

Affected Drugs

FANAPT®

SAPHRIS®

Covered Uses

Fanapt or Saphris will be approved for all FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses. Fanapt or Saphris will not be approved for the treatment of patients with dementia related psychosis.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Prescribed by a psychiatrist or in consultation with a psychiatrist.

Coverage Duration

3 years.

Other Criteria

N/A

SIMVASTATIN

Affected Drugs

SIMVASTATIN
VYTORIN®

Covered Uses

All FDA indications.

Exclusion Criteria

N/A

Required Medical Information

Failure or inability to tolerate Crestor or Lipitor.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

N/A

SOLARAZE

Affected Drugs

SOLARAZE®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not allowed for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 months, unless requested by prescriber for a period of less than 12 months.

Other Criteria

N/A

SOMAVERT

Affected Drugs

SOMAVERT®

Covered Uses

All FDA approved indications not otherwise excluded from Part D including Acromegaly and treatment of excess growth hormone associated with McCune-Albright syndrome.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Prescribed by an endocrinologist or in consultation with an endocrinologist.

Coverage Duration

12 months.

Other Criteria

N/A

SYMLIN

Affected Drugs

SYMLIN®

SYMLINPEN 120®

SYMLINPEN 60®

Covered Uses

All FDA approved indications not otherwise excluded from Part D worded as patient has type 1 or 2 diabetes mellitus. Pramlintide is FDA-approved in patients with type 1 or 2 diabetes mellitus using insulin therapy. In type 2 diabetics, it is FDA-approved as combination therapy with metformin and/or sulfonylureas (in addition to insulin).

Exclusion Criteria

Weight loss treatment. Coverage not recommended for anything not listed under Covered Uses. Clinical review will be required in patients with known gastroparesis or with hypoglycemia unawareness, patients who: have an HbA1c greater than 9%, and those who require the use of drugs that stimulate GI motility.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Prescribed by an endocrinologist or in consultation with an endocrinologist.

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

TAZORAC

Affected Drugs

TAZORAC®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Cosmetic skin conditions (eg, alopecia, hyperpigmentation, liver spots, melasma/cholasma, seborrheic keratosis, stretch marks, scarring, wrinkles, premature aging, photo-aged or photo-damaged skin, mottled hyper- and hypopigmentation, benign facial lentigines, roughness, telangiectasia, skin laxity, keratinocytic atypia, melanocytic atypia, dermal elastosis). Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

Acne vulgaris after a trial with at least 1 other topical retinoid product (eg, tretinoin cream/gel/solution/microgel, adapalene). For the treatment of other non-cosmetic conditions exceptions can be made if the patient has tried at least 1 other therapy (eg, actinic keratoses, skin neoplasms, warts, dermatitis/eczema, folliculitis, acne rosacea, cystic acne, comedonal acne).

TEKAMLO

Affected Drugs

TEKAMLO®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prescriber must document that medication compliance issue exists.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

TOPICAL TRETINOIN PRODUCTS

Affected Drugs

TRETINOIN

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. Plus acne rosacea. Actinic keratosis/treatment of precancerous skin lesions. Ichthyosis. Diabetic foot ulcers. Mucositis. Warts. Keloids. Lichen planus. Lichen sclerosus. Pseudofolliculitis. Oral leukoplakia. Molluscum contagiosum. Darier's disease (keratosis follicularis). For treatment of other non-cosmetic conditions not listed above (eg, dermatitis/eczema, folliculitis, milia, keratosis pilaris, sebaceous hyperplasia/cyst, basal cell carcinoma [skin cancer], confluent and reticulated papillomatosis) exceptions can be made if the patient has tried at least 1 other therapy. Coverage of the combination of clindamycin plus tretinoin (ZianaÖ) is recommended for acne vulgaris ONLY.

Exclusion Criteria

Cosmetic conditions (e. g. , liver spots, stretch marks, scarring, solar elastosis, premature aging, treatment of photo-aged or photo-damaged skin, solar lentigines, skin roughness, mottled hyperpigmentation, age spots, wrinkles, geographic tongue, hyperpigmentation caused by folliculitis, acne, or eczema, melasma/cholasma, alopecia androgenetic, alopecia areata, seborrheic keratosis). Psoriasis. Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

TWYNSTA

Affected Drugs

TWYNSTA®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prescriber must document that medication compliance issue exists.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

VALTURNA

Affected Drugs

VALTURNA®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Prescriber must document that medication compliance issue exists.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Members entering plan on this medication will be grandfathered-in.

VOLTAREN GEL

Affected Drugs

VOLTAREN®

Covered Uses

1) All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not allowed for anything not listed under Covered Uses.

Required Medical Information

1) MD must document that LFT's will be monitored 2) MD must train and patient/caregiver must be able to demonstrate proper administration.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

3 years.

Other Criteria

Approval requires the prescriber to document the patients or caregivers ability to properly administer the gel based on the manufactures dosing instructions. This restriction is based on the FDA announcement of the potential for increase in liver dysfunction from use of diclofenac products including the gel formulation.

VPRIV

Affected Drugs

VPRIV®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Up to 12 months unless requested by prescriber for a period less than 12 months.

Other Criteria

N/A

XOLAIR

Affected Drugs

XOLAIR®

Covered Uses

All FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

Coverage not recommended for anything not listed under Covered Uses.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

Must be prescribed by, or in consultation with an allergist, immunologist, or pulmonologist.

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

N/A

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