



PHARMACY MEDICAL POLICY

Policy #: 108

**Original policy date: 1/1/09
Posted date: 7/1/09**

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Title

Medicare Advantage Prescription Drug Prior Authorization Criteria

Note: All requests for **outpatient retail pharmacy** for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the **Prior Authorization Form** on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department to request a review for prior authorization for patients at (800)366-7778. Patients must have pharmacy benefits under their subscriber certificates.

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When services are covered for Medicare HMO Blue, Medicare PPO Blue, and Blue Medicare PFFS PlusRx plans; see below for coverage for these products

ALGLUCERASE

Affected Drugs

CEREDASE®
CEREZYME®

Covered Uses

Gaucher Disease Type 1

Exclusion Criteria

We do not cover Alglucerase therapy for patients who have Gaucher disease but do not have at least a minimal level of disease severity, because treatment has not been proven to improve health outcome for patients without signs or symptoms of disease. We do not cover Alglucerase therapy for patients who have Type 2 or Type 3 Gaucher disease, because alglucerase therapy has not been proven to improve the nerve problems associated with these types of Gaucher disease.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year

Other Criteria

N/A

ALPHA-1 ANTITRYPSIN

Affected Drugs

ARALAST®
PROLASTIN®

Covered Uses

We cover alpha-1 antitrypsin in adult emphysema patients with documented alpha-1 antitrypsin deficiency, as demonstrated by blood levels less than 80mg/dL (11umol/L). (A CT scan showing significant emphysema disease must also be documented.)

Exclusion Criteria

We do not cover this therapy for patients with emphysema that is not due to documented Alpha-1 Antitrypsin deficiency

Required Medical Information

Alpha-1 antitrypsin plasma levels less than 80mg/dL (11 umol/L), FEV1/FVC less than 70%, and non-smoker

Age Restrictions

18 years of age of older

Prescriber Restrictions

N/A

Coverage Duration

1 year

Other Criteria

N/A

ANTIFUNGALS (ORAL)

Affected Drugs

ITRACONAZOLE
LAMISIL®
TERBINAFINE HCL

Covered Uses

We cover Terbinafine for a diagnosis of onychomycosis of fingernails or toenails. We cover Lamisil granules for a diagnosis of tinea capitis. We cover Itraconazole for a diagnosis of onychomycosis of fingernails or toenails and for all other FDA approved indications not otherwise excluded for Part D.

Exclusion Criteria

We do not cover oral antifungals for conditions not listed.

Required Medical Information

Diagnostic confirmation of onychomycosis defined as one of the following: positive KOH preparation, positive fungal culture, positive nail biopsy, positive PAS, or positive histological exam.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

12 weeks of therapy per authorization

Other Criteria

N/A

ANTIFUNGALS (TOPICAL)

Affected Drugs

CICLOPIROX

Covered Uses

Confirmed diagnosis of onychomycosis of fingernails or toenails without lunula involvement.

Exclusion Criteria

We do not cover topical antifungals for conditions not listed.

Required Medical Information

Diagnostic confirmation of onychomycosis defined as one of the following: positive KOH preparation, positive fungal culture, positive nail biopsy, positive PAS, or positive histological exam and diagnosis of diabetes mellitus or a compromised immune system due to disease, drug therapy or radiation.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

48 week of therapy per year

Other Criteria

Coverage of Penlac will only be approved if the patient meets the pharmacy medical policy criteria and has tried and failed treatment with a covered formulary alternative.

B VS D - PART B VERSUS PART D COVERAGE PA

Affected Drugs

AZATHIOPRINE
CELLCEPT®
CYCLOSPORINE
GENGRAF
METHOTREXATE
MYFORTIC®
PROGRAF®
RAPAMUNE®
ZENAPAX®

Covered Uses

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

ERYTHROPOIETIN (EPOTIEN ALPHA)

Affected Drugs

ARANESP®
EPOGEN®
PROCRIPT®

Covered Uses

Epotein Alpha: Anemia of chronic renal failure, anemia due to AZT treatment in AIDS, anemia due to ribavirin therapy in the treatment of Hepatitis C, myelodysplastic syndromes, anemia due to the effects of concurrently administered chemotherapy in patients with non-myeloid malignancies, anemia due to allogenic bone transplant, and anemic surgical patients. Darbepoetin alpha: Anemia associated with chronic renal failure, including patients on and not on dialysis and anemia due to the effects of concurrently administered chemotherapy in patient with non-myeloid malignancies.

Exclusion Criteria

We do not cover Epoetin alpha or Darbepoetin for anemias due to hemolysis, nutritional deficiencies, GI bleeds, iron deficiency anemia and other anemias not covered under the medical policy.

Required Medical Information

Target hemoglobin level less than or equal to 12g/dL. Anemic surgical patients must meet the following criteria: surgery must be elective, non-cardiac, and non-vascular, target hemoglobin level between 10 and 13 g/dL, and not willing to donate blood.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year

Other Criteria

N/A

GROWTH HORMONE

Affected Drugs

GENOTROPIN®
NORDITROPIN NORDIFLEX®
NORDITROPIN®
NUTROPIN AQ®
NUTROPIN®
SAIZEN®
TEV-TROPIN®
ZORBTIVE®

Covered Uses

We cover growth hormone therapy for short stature in GH deficient patients, short stature in children with chronic renal insufficiency and end stage renal disease prior to successful renal transplantation, Turner's Syndrome, Prader-Willi Syndrome, HIV wasting syndrome, adult patients with documented congenital or acquired GH deficiency, pediatric patients born small for gestational age (SGA) or for pediatric patients with intrauterine growth retardation (IUGR), promotion of wound healing in burn patients, prevention of growth delay in children with severe burns. Zorbtive is covered in the treatment of short bowel syndrome in adults.

Exclusion Criteria

We do not cover GH therapy for other conditions not listed in Medical Policy, including: short children who are not GH deficient, growth hormone insensitivity (Laron Syndrome), Noonan syndrome, children with constitutional growth delay, children with growth failure caused by glucocorticoids, children who are not growth hormone deficient but have short stature associated with chronic disease, children with functioning renal transplants, children with chromosomal and genetic disorders (except Turner's and Prader Willi Syndromes) or familial short stature, Russell Silver syndrome, anabolic therapy to enhance body mass or strength for professional, recreational or social reasons, anabolic therapy, except for AIDS, provided to counteract acute or chronic catabolic illness (e.g., surgery outcomes, trauma, cancer, chronic hemodialysis) producing catabolic (protein wasting) changes in both adult and pediatric patients, altered body habitus such as buffalo hump associated with antiviral therapy in HIV-infected patients, in conjunction with GnRH (gonadotropin releasing hormone) analogs as a treatment of precocious puberty, obesity, cystic fibrosis, cardiomyopathy, juvenile idiopathic arthritis, congestive heart failure and age related GH deficiency.

Required Medical Information

Short stature in GH deficiency: Bone age 2 standard deviations (SD) or more below the mean, height more than 2 SD below the mean (or less than the 3rd percentile), growth deceleration, measured over a minimum of 1 year, with bone-age-specific growth rate less than the 25th percentile, evidence that the patient does not have other reasons for short stature, and documentation of subnormal response to 2 GH stimulation tests or 1 GH stimulation test and serum levels of IGF-1 and IGFBP-3 levels more than 2 SD below the mean. Short stature in children with chronic renal insufficiency: height less than 3 SD below the mean or moderate growth retardation with height between -2 and -3 SD below the mean (growth velocity over one year below 25th percentile) or severe deceleration in growth rate (growth velocity over one year -2 SD below the mean). Turner's Syndrome: Height greater than 2 SD below the mean, or growth velocity less than 25% for bone age and bone age less than 14 year. HIV Wasting Syndrome: AIDS, weight loss of at least 10% from baseline weight or BMI less than 20 kg/m², wasting syndrome rather than other causes for weight loss, and concomitant anti-viral therapy. Adult patients with congenital or acquired GH deficiency: Pituitary trauma, surgery, radiation, or disease with deficiencies in 3 other pituitary hormones and IGF-1 level below the mean, reconfirmed childhood GH deficiency with documented subnormal response to 2 GH stimulation tests or 1 GH stimulation test and 1 or more additional pituitary hormone defects or documented congenital hypopituitarism. SGA and IUGR: Birth weight and/or length more than 2 SD below the mean for gestational age and child is over 2 years old and still more than 2 SD below the mean. Wound healing in burn patients: Patients with 3rd-degree burns. Prevention of growth delay in children with severe burns: Successful treatment with 0.05 to 0.2mg/kg rhGH per day during acute hospitalization and for up to 1 year after burn.

Age Restrictions

Zorbtive for short bowel syndrome is covered for member's 18 years of age or older.

Prescriber Restrictions

N/A

Coverage Duration

Authorizations for 1 year. Authorization for Zorbtive is 4 weeks.

Other Criteria

We cover continuation of GH for short stature when all the following are met: result of the first year of therapy: A doubling of the pre-treatment growth rate or an increase in pre-treatment growth rate by at least 3 cm/year. For therapy continuing past the first year: growth rate remains above 2.5 cm/year. For children over age 10: an X-ray report with evidence that epiphyses have not yet closed (does not apply to children with prior documented hypopituitarism). We cover continuation of GH therapy in girls with Turner's Syndrome until: bone age is over 14 years or bone age specific growth velocity, measured over a minimum of one year, is less than 2.5 cm/year or attainment of height satisfactory to patient and family, or consistent with genetic potential. Zorbtive is covered for the treatment of short bowel syndrome for adult members that are currently receiving specialized nutritional support such as dietary adjustments, enteral feedings, parenteral nutrition, or micronutrient supplementation.

GROWTH HORMONE (INSULIN LIKE GROWTH FACTOR)**Affected Drugs**

INCRELEX®

IPLIX®

Covered Uses

We cover mecasermin rinfabate (rDNA origin), Iplex® or mecasermin (rDNA origin), Increlex® for the treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGF1D) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.

Exclusion Criteria

We do not cover Insulin-like Growth Factor for secondary forms of IGF-1 deficiency to include (but not limited to): GH deficiency, malnutrition, hypothyroidism, or for chronic treatment with pharmacologic doses of anti-inflammatory steroids

Required Medical Information

Height standard deviation score less than or equal to -3 for age and sex, basal IGF-1 standard deviation score less than or equal to -3 for age and sex, and normal or elevated growth hormone (defined as stimulated serum GH peak level of greater than 10 ng/ml or basal (unstimulated) serum GH level greater than 5ng/ml).

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year

Other Criteria

N/A

IGE RECEPTOR INHIBITORS

Affected Drugs

XOLAIR®

Covered Uses

We cover Xolair for allergic mediated moderate to severe asthma caused by perennial aeroallergens

Exclusion Criteria

Xolair is not covered for conditions not listed in Medical Policy.

Required Medical Information

Asthma symptoms not adequately controlled by greater than 3 months of continuous therapy of high dose inhaled steroids or oral steroids, recent IgE level within the range of 30 to 700 IU/mL (recent defined as the previous 6 months), positive skin test or in vitro testing for one or more perennial aeroallergen.

Age Restrictions

12 years of age or older

Prescriber Restrictions

Pulmonologist or allergist

Coverage Duration

1 year

Other Criteria

N/A

IMMUNE MODULATING DRUGS

Affected Drugs

CIMZIA®

ORENCIA®

REMICADE®

RITUXAN®

Covered Uses

We cover Cimzia for the treatment of active crohn's disease. We cover Orencia for the treatment of rheumatoid arthritis and juvenile idiopathic arthritis. We cover Rituxan for the treatment of rheumatoid arthritis and all other FDA approved indications not otherwise excluded for Part D. We cover Remicade for the treatment of rheumatoid arthritis, psoriatic arthritis, active crohn's disease, fistulizing Crohn's disease, pediatric crohn's disease, ulcerative colitis, ankylosing spondylitis, and plaque psoriasis. Amevive is covered for the treatment of plaque psoriasis.

Exclusion Criteria

We do not cover Cimzia, Orencia, Rituxan, Remicade, or Amevive for conditions not listed in Medical Policy.

Required Medical Information

Cimzia: Active crohn's disease: treatment or treatment failure with or contraindication to 2 or more of the following drugs: Corticosteroids, 5-Aminosalicylates, or Immunosuppressants/Immunomodulators.

Orencia: Adult rheumatoid arthritis: concurrent treatment with, treatment failure with, or contraindication to one traditional DMARD agent within the previous 6 months, and treatment failure with or contraindication to one biological DMARD agent within the previous 6 months. Juvenile idiopathic arthritis: treatment failure or contraindication to methotrexate, and treatment failure or contraindication to one biological DMARD agent with the last 6 months. Rituxan: for a diagnosis of adult rheumatoid arthritis, prescribed in combination with methotrexate, treatment failure with or contraindication to one traditional DMARD agent within the previous 6 months, and treatment failure with or contraindication to one biological DMARD agent within the previous 6 months. Remicade: Rheumatoid arthritis and psoriatic arthritis: treatment failure with or contraindication to one traditional DMARD agent within the previous 6 months. Active Crohn's disease and Ulcerative Colitis: treatment or treatment failure with or contraindication to 2 or more of the following drugs: Corticosteroids, 5-Aminosalicylates, or Immunosuppressants/Immunomodulators. Fistulizing Crohn's Disease and Pediatric Crohn's Disease: treatment or treatment failure with or contraindication to one or more immunosuppressant/immunomodulator. Ankylosing Spondylitis: previous treatment failure with one prescription NSAID within the past 6 months. Plaque Psoriasis: previous treatment failure with one course of systemic therapy for psoriasis within the previous 6 months or previous use of Raptiva, Amevive, Enbrel, Humira or Remicade within the previous 180 days. Amevive: documented diagnosis of plaque psoriasis, previous treatment failure with one course of systemic therapy for psoriasis within the previous 6 months or previous use of Raptiva, Amevive, Enbrel, Humira or Remicade within the previous 180 days.

Age Restrictions

Cimzia: 18 years and older. Orencia: adult rheumatoid arthritis: Adults 18 years of age or older. Orencia: juvenile rheumatoid arthritis: 6 years of age or older. Rituxan for rheumatoid arthritis: Adults 18 years or older. Remicade for rheumatoid arthritis, psoriatic arthritis, active Crohn's disease, fistulizing Crohn's disease, ulcerative colitis, ankylosing spondylitis, and plaque psoriasis: Adults 18 years or older. Remicade for pediatric crohn's disease: Children age 6-17 years. Amevive: 16 years or older.

Prescriber Restrictions

Cimzia: Gastroenterologist. Orencia adult and juvenile Rheumatoid arthritis: Rheumatologist. Rituxan for rheumatoid arthritis: Rheumatologist. Remicade for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis: Rheumatologist. Remicade for Active Crohn's disease, Fistulizing Crohn's disease, Pediatric Crohn's disease, and Ulcerative Colitis: Gastroenterologist. Remicade for plaque psoriasis: dermatologist. Amevive: Dermatologist.

Coverage Duration

Authorization valid as long as member's plan remains active (lifetime of the policy).

Other Criteria

N/A

INTERFERONS (INTERFERON ALPHA)

Affected Drugs

ALFERON N®
INFERGEN®

Covered Uses

We cover interferon alpha for hairy cell leukemia, genital warts (condylomata acuminata), Kaposi's sarcoma, chronic hepatitis B, acute/chronic hepatitis C, malignant melanoma, chronic myelogenous leukemia (CML) given alone as first line therapy for patients in the first chronic phase of CML, multiple myeloma in previously untreated patients when given in combination with cytotoxic agents as first line therapy, multiple myeloma which has previously responded to first line therapy (given as maintenance treatment), Non-Hodgkins Lymphoma: low grade (follicular) or intermediate grade type, when given in combination with cytotoxic agents as first line therapy, polycythemia vera, idiopathic progressive polyneuropathy, HIV and AIDS, carcinoid syndrome, chronic lymphocytic leukemia, recurrent respiratory laryngeal papillomatosis and laryngeal papilloma, skin cancer, malignant melanoma, mycosis fungoides, cutaneous T-cell lymphoma, and cancer of the bladder, kidney (renal), cervix, brain, colorectal, head and neck, ovary, pancreas and bone (osteosarcoma) and all FDA approved indications not otherwise excluded for part D.

Exclusion Criteria

We do not cover Interferon alpha for conditions not listed in Medical Policy.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year

Other Criteria

N/A

INTERFERONS (INTERFERON ALPHA-2A AND ALPHA 2-B)**Affected Drugs**

INTRON A®
PEGASYS®
PEGINTRON REDIPEN®
PEGINTRON®

Covered Uses

We cover peginterferon alpha-2a and alpha-2b for the treatment of Hepatitis C and all FDA approved indications not otherwise excluded for part D.

Exclusion Criteria

We do not cover peginterferon alpha-2a or alpha 2-b for conditions not listed in Medical Policy.

Required Medical Information

Member must have a definitive diagnosis of Hepatitis C, hepatitis C viral genotype, and HCV RNA viral titer. For genotype 1 and 4 initial authorization will be approved for 16 weeks. After 12 weeks of active

treatment another HCV RNA viral titer must be drawn to assess Early Viral Response (EVR) and continuation of therapy may be approved for an additional 32 weeks (48 weeks total) if one of the following criteria is met: member demonstrates an HCV viral titer reduction greater than 2 log₁₀ or member demonstrates an HCV viral reduction that is below the detectable level of the assay. We may cover peginterferon alpha-2a and alpha-2b in the treatment of relapsers or nonresponders in member's that have failed treatment with interferon alpha monotherapy or in combination with ribavirin when the following information is provided: HCV viral genotype, HCV viral load, member's response/lack of response to previous therapy, member's adverse effects associated with previous treatment (if any), results of liver biopsy to assess liver severity of liver disease and contributing factors such as cryoglobulinemia or liver transplant.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Genotype 1 and 4, HIV coinfection and retreatment: 48 weeks total. Genotype 2 and 3: 24 weeks.

Other Criteria

N/A

INTERFERONS (INTERFERON GAMMA)

Affected Drugs

ACTIMMUNE®

Covered Uses

We cover interferon gamma for chronic granulomatous disease to reduce the frequency and severity of infections and all FDA approved indications not otherwise excluded for part D.

Exclusion Criteria

We do not cover interferon gamma for conditions not listed in Medical Policy.

Required Medical Information

Documented diagnosis of chronic granulomatous disease

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year

Other Criteria

N/A

IVIG

Affected Drugs

GAMASTAN S-D®
GAMMAGARD LIQUID®
GAMUNEX®
OCTAGAM®

Covered Uses

We cover intravenous immunoglobulin (IVIg) for the following diagnoses: bone marrow transplant patients (for prevention of infection or GVH prevention), multiple myeloma and immunoproliferative neoplasms, immune neutropenia, multiple myeloma without mention of remission, multiple myeloma in remission, plasma cell leukemia without mention of remission, plasma cell leukemia in remission, other immunoproliferative neoplasms without mention of remission, other immunoproliferative neoplasms in remission, agranulocytosis, common variable immunodeficiency, severe combined immunodeficiency, Wiskott-Aldrich syndrome, and X-linked immunodeficiency, prevention of infection in patients with primary defective antibody synthesis, fetal alloimmune thrombocytopenia, autoimmune hemolytic anemia, Agammaglobulinemia -primary humoral immunodeficiency, Hypogammaglobulinemia -primary humoral immunodeficiency, chronic lymphocytic leukemia (CLL) with frequent infections, idiopathic thrombocytopenic purpura (ITP), HIV and AIDS, prevention of infection in HIV-infected children, solid organ transplant recipients at risk for cytomegalovirus infections and pneumonia, Guillain Barre Syndrome (GBS), chronic severe myasthenia gravis, for severe exacerbations causing disability, myasthenic crisis in patients with contraindication to plasma exchange, hereditary and idiopathic peripheral neuropathy, Peroneal muscular atrophy, hereditary sensory neuropathy, Refsum's disease, idiopathic progressive polyneuropathy, Multiple Sclerosis: for patients with relapsing-remitting disease (not primary or secondary progressive MS), chronic inflammatory demyelinating polyneuropathy, demyelinating polyneuropathy associated with IgM paraproteinemia, multifocal motor neuropathy in patients with GM1 antibodies and conduction block, dermatomyositis/polymyositis, Kawasaki syndrome, pemphigus vulgaris, prior to solid organ transplant: treatment of patients at high risk of antibody-mediated rejection, including highly sensitized patients, and those receiving an ABO incompatible organ, following solid organ transplant: treatment of antibody-mediated rejection, pemphigus foliaceus, Bullous pemphigoid, mucous membrane pemphigoid (also known as Cicatrical pemphigoid), and epidermolysis bullosa acquisita.

Exclusion Criteria

We do not cover intravenous immunoglobulin in the following conditions: acquired factor VIII inhibitors, acute lymphoblastic leukemia, aplastic anemia, Diamond-Blackfan anemia, hemophagocytic syndrome, nonimmune thrombocytopenia, red cell aplasia, thrombotic thrombocytopenic purpura, Behcet's syndrome, inclusion body myositis, rheumatoid arthritis, scleroderma, systemic lupus erythematosus, other vasculitides besides Kawasaki disease: including vasculitis associated with anti-neutrophil cytoplasmic antibodies (Wegener's granulomatosis, polyarteritis nodosa), Goodpasture's syndrome, and vasculitis associated with other connective tissue diseases, epilepsy, multiple sclerosis: primary progressive or secondary progressive types, because it has not been shown to offer additional health benefits to patients with these types of MS, paraneoplastic syndromes including but not limited to Lambert-Eaton syndrome, stiff person syndrome, chronic sinusitis, recurrent otitis media, adrenoleukodystrophy, asthma, chronic fatigue syndrome, cystic fibrosis, diabetes mellitus, hemolytic uremic syndrome, idiopathic lumbosacral flexopathy, recurrent fetal loss, recurrent spontaneous abortion, recurrent spontaneous pregnancy loss, idiopathic environmental illness, myasthenia gravis in patients responsive to immunosuppressive treatment, post-infectious sequelae, organ transplant rejection, uveitis, demyelinating optic neuritis, recent-onset dilated cardiomyopathy and other disorders not listed above.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year

Other Criteria

N/A

ORPHAN DRUGS**Affected Drugs**

ALDURAZYME®

ARCALYST®

FABRAZYME®

NAGLAZYME®

SOMATULINE DEPOT®

SOMAVERT®

Covered Uses

We cover Aldurazyme for patient with a diagnosis of Hurler and Hurler-Scheie forms of mucopolysaccharidosis I or patients with the Scheie form who have moderate to severe symptoms. We cover Fabrazyme for patients with a diagnosis of Fabry Disease. We cover Naglazyme for patient with a diagnosis of Mucopolysaccharidosis VI (MPS VI). We cover Somatuline and Somavert for patients with diagnosis of Acromegaly.

Exclusion Criteria

We do not cover listed medications for conditions not listed.

Required Medical Information

Somatuline and Somavert : physician documented diagnosis of Acromegaly and documented inadequate response to surgery and/or radiation therapy and/or other medical therapies (e.g. octreotide, cabergoline, or bromocriptine) or for patient in which these therapies are not appropriate or the patient had previous use of Somatuline or Somavert within the previous 180 days.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year

Other Criteria

N/A

PHOSPHODIESTERASE INHIB.

Affected Drugs

REVATIO®

Covered Uses

We cover Revatio (sildenafil) for patients in the treatment of pulmonary arterial hypertension.

Exclusion Criteria

We do not cover Revatio (sildenafil) for the treatment of erectile dysfunction of any other conditions.

Required Medical Information

Documented diagnosis of pulmonary arterial hypertension.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Lifetime of policy

Other Criteria

N/A

RETINOIC ACID DERIVATIVES

Affected Drugs

TRETINOIN

Covered Uses

Retinoic acid derivatives are covered for acne and actinic keratosis

Exclusion Criteria

Coverage for all ages is restricted to non-cosmetic purposes only.

Required Medical Information

Documented diagnosis of acne or actinic keratosis.

Age Restrictions

Prior authorization is only required for patients over 30 years of age.

Prescriber Restrictions

N/A

Coverage Duration

1 year

TERIPARATIDE

Affected Drugs

FORTEO®

Covered Uses

Treatment of osteoporosis in post menopausal women at high risk of fractures determined by having multiple risk factors or having a history of fractures or treatment of primary hypogonadal osteoporosis in men who are at high risk of fractures by having multiple risk factors or having a history of fractures.

Exclusion Criteria

Prevention of osteoporosis in women and men, patients with Paget's disease, patients that have received prior radiation therapy involving the skeleton, patients with bone metastases, a history of skeletal malignancies, and/or metabolic bone disease other than osteoporosis, patients with hypercalcemia and other conditions not listed in Medical Policy.

Required Medical Information

Documented treatment failure or intolerance to other medications used to treat osteoporosis within the previous 6 months.

Age Restrictions

18 years of age or older

Prescriber Restrictions

N/A

Coverage Duration

2 years

Other Criteria

N/A

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When services are not covered for Medicare HMO Blue, Medicare PPO Blue, and Blue Medicare PFFS PlusRx products

Refer to individual drug for exclusion criteria.

Individual consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. For consideration of an individual patient, physicians may send relevant clinical information to:

Blue Cross Blue Shield of Massachusetts
Clinical Pharmacy Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-866-463-7700

Policy update history

New Policy, effective 1/1/09. Posted to web site 7/1/09.

This document is designed for informational purposes only and is not an authorization, or an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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Medicare Part D Coverage Determination Request Form

This form cannot be used to request:

- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- **Medications requiring prior authorization for which drug-specific forms are required. [See <Part D plan website.>] OR [See links to plan websites at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp]**

Patient Information		Prescriber Information	
Patient Name:		Physician name:	
Member ID# :		Specialty and Provider #:	
DOB:	Sex(circle): M F	Fax:	Phone:
Diagnosis:	Allergies:	Contact person (first and last name):	

Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
<input type="checkbox"/> New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Qty:
Prescriber's Signature:		Date:

Rationale for Exception Request or Prior authorization(FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION)

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, ortherapeutic failure)
 →**Specify below:** (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);
 - Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change
 →**Specify below:** Anticipated significant adverse clinical outcome
 - Medical need for different dosage form and/or higher dosage
 →**Specify below:** (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason
 - Request for formulary tier exception
 →**Specify below:** (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome
- Other: _____ → Explain below

REQUIRED EXPLANATION:

Request for Expedited Review

- REQUEST FOR EXPEDITED REVIEW [24 HOURS]
 → BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THEMEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

CMS 0690