MASSACHUSETTS

2013 Prior Authorization Criteria for Medicare HMO Blue℠ (HMO) and Medicare PPO Blue℠ (PPO) Plans

Definition of Prior Authorization

For certain drugs your doctor or health care provider will need to contact us before you fill your prescription.

The following list of Prescription Drugs are subject to the Prior Authorization.

Blue Cross and Blue Shield of Massachusetts is a Medicare Advantage organization with a Medicare contract.

Y0014_12229R1 Approved

BCBS of MA 2013 PA Criteria

ACTEMRA

Affected Drugs

ACTEMRA®

Covered Uses

Actemra for adults with rheumatoid arthritis and all other 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

1 year.

Other Criteria

N/A

ALGLUCERASE

Affected Drugs

CEREZYME®

Covered Uses

Gaucher Disease Type 1 and for all other FDA approved indications not otherwise excluded from Part D.

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 NP®
GLASSIA®
PROLASTIN C®

Covered Uses

We cover alpha-1 antitrypsin in adult emphysema patients with documented alpha-1 antitrypsin deficiency and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

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

AMPYRA

Affected Drugs

AMPYRA®

Covered Uses

We cover Ampyra for Multiple Sclerosis and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

The patient has a documented diagnosis of Multiple Sclerosis, no history of seizure disorder, the patient does not have moderate or severe renal impairment (defined as creatinine clearance less than 50ml/min), medication prescribed by a neurologist and must meet one of the following: patient must be able to walk 25 feet in 8-60 seconds with walking aids if needed (timed 25-Foot Walk test) or patient has an expanded disability status score (EDSS) of greater than or equal to 4.5 but less than 7.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

ASTHMA MANAGEMENT

Affected Drugs

ADVAIR DISKUS®
ADVAIR HFA®
DULERA®
SYMBICORT®
ZAFIRLUKAST

Covered Uses

We cover Advair Diskus, Advair HFA, Dulera, Symbicort, Zafirlukast for asthma and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

The patient has a documented diagnosis of asthma. Advair Diskus, Advair HFA, Dulera, Symbicort: Previous treatment with one of the following: inhaled corticosteroid, beta2 agonist, inhaled mast cell stabilizer, oral albuterol, oral theophylline.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

B VS D - PART B VERSUS PART D COVERAGE PA

Affected Drugs

ACETYLCYSTEINE
ALBUTEROL SULFATE
AZATHIOPRINE
AZATHIOPRINE SODIUM
BROVANA®
BUDESONIDE
CELLCEPT®
CROMOLYN SODIUM
CYCLOSPORINE
CYCLOSPORINE MODIFIED
ENGERIX-B®
GENGRAF
IPRATROPIUM BROMIDE
IPRATROPIUM-ALBUTEROL
LEVALBUTEROL CONCENTRATE
LEVALBUTEROL HCL
METHOTREXATE
MYCOPHENOLATE MOFETIL
MYFORTIC®
NEBUPENT®
NULOJIX®
PERFOROMIST®
PROGRAF®
PULMOZYME®
RAPAMUNE®
RECOMBIVAX HB®
SIMULECT®
TACROLIMUS
TOBI®
TYVASO®
VENTAVIS®
XOPENEX®

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.

BISPHOSPHONATES AND MONOCLONAL ANTIBODIES, INFUSION/INJECTION

Affected Drugs

PROLIA®

Covered Uses

We cover Prolia for osteoporosis in postmenopausal women and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

The patient has a documented diagnosis of osteoporosis (ICD-9 CM 733.00-733.09).

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

There must be evidence of a paid claim or physician documented use of one or more oral bisphosphonates (e.g. alendronate) or inability to swallow or inability to remain in an upright position during post oral bisphosphonate administration.

BOTULINUN TOXIN

Affected Drugs

BOTOX®
DYSPORT®
XEOMIN®

Covered Uses

We cover botulinum toxin A and botulinum toxin B injections for any of the following conditions: Eye: Confirmed diagnosis of strabismus or blepharospasm (including benign essential blepharospasm) associated with dystonia or neuromyelitis optica. Face: Cranial nerve VII disorders such as hemifacial spasm, jaw-closing oromandibular dystonia, masseter spasticity, orofacial dyskinesia, and other conditions demonstrating increased muscle activity that impairs bodily functions. Neck: Spasmodic torticollis or cervical dystonia, in adults. Throat: Spasmodic dysphonia or laryngeal dysphonia, laryngeal dystonia. Esophagus: Achalasia patients who have not responded to dilatation therapy, or who are poor candidates for surgery. Anal spasm and anal fissure. Segmental spasticity in adults or children. Multiple sclerosis. Segmental peripheral dystonias, or focal limb dystonias such as organic writer's cramp, or other hand or foot dystonias Cerebral palsy: Treatment of dynamic muscle contracture in pediatric cerebral palsy patients. Severe uncontrolled limb spasticity. Severe symptomatic hyperhidrosis. Urinary Incontinence: due to detrusor overreactivity caused by spinal cord injury that is inadequately controlled with anticholinergic therapy and for all other FDA approved indications not otherwise excluded from Part D. We cover Xeomin for the following conditions of Neck: cervical dystonia in both toxin-naive and previously treated patients and for Eye: confirmed diagnosis of blepharospasm and previous treatment failure with onabotulinumtoxin A and for all other 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

1 year.

Other Criteria

N/A

CNS STIMULANTS AND PSYCHOTHERAPEUTIC AGENTS

Affected Drugs

MODAFINIL
STRATTERA®

Covered Uses

We cover Strattera for Attention-deficit hyperactivity disorder and for all other FDA approved indications not otherwise excluded from Part D. We cover modafinil for narcolepsy, obstructive sleep apnea, hypopnea syndrome, or shift work sleep disorder and for all other FDA approved indications otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

The patient has a documented diagnosis of Attention-deficit hyperactivity disorder. We cover Strattera after previous treatment with one of the following: methylphenidate, dexmethylphenidate, amphetamine or has history of stimulant drug abuse or other substance abuse.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

COX II INHIBITORS

Affected Drugs

CELEBREX®

Covered Uses

We cover Celebrex for rheumatoid arthritis, osteoarthritis and familial adenomatous polyposis and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

We cover Celebrex for patients who have a documented diagnosis of rheumatoid arthritis, osteoarthritis and familial adenomatous polyposis or any one of the following risk factors: age over 60, history of gastrointestinal ulcer or bleeding, thrombocytopenia, inflammatory bowel disease, previous treatment with 2 NSAIDs, concurrent treatment with any one of the following: warfarin, heparin, Lovenox, Fragmin, Innohep, Arixtra, high dose aspirin, methotrexate, gold, Enbrel, Remicade, Humira, Kineret, sulfasalazine, azatioprine, cyclosporine, hydroxychloroquine, Arave, Cupramine, misoprotol, Supartz, Synvisc, Hyalagan,, Euflexxa, Orthvisc., Plavix. Ticlid, Pletal, dipyridamole, Aggrenox, Agrylin, mesalamine, osalazine, 6-mercaptopurine, basalazide.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

ERYTHROPOIETIN

Affected Drugs

ARANESP®
EPOGEN®
PROCRIT®

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 and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

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

FENTANYL, ORAL/TRANSMUCOSAL

Affected Drugs

FENTANYL CITRATE

Covered Uses

We cover fentanyl, oral/transmucosal for breakthrough pain due to cancer and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

We cover Fentanyl, oral/transmucosal when the patient is already receiveng and is tolerant to other opioids. Opioid tolerance defined as taking one or more of the following medications at or above the listed doses for at least one week: oral morphine 60mg/day, transdermal fentanyl 25mcg/hr, oral hydromorphone 8mg/day or any equianalgesic dose of another opioid.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

Requests meeting criteria will be approved for up to 120 units per 30 days.

GATTEX

Affected Drugs

GATTEX®

Covered Uses

We cover Gattex for the treatment of adult patients with Short Bowel Syndrome (SBS) who are dependent on parenteral support and for all other 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

1 year.

Other Criteria

N/A

GILENYA

Affected Drugs

GILENYA®

Covered Uses

We cover Gilenya for a relapsing form of Multiple Sclerosis including: relapsing-remitting, secondary progressive with relapses and progressive relapsing and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

The patient has a documented diagnosis of relapsing form of Multiple Sclerosis.

Age Restrictions

N/A

Prescriber Restrictions

Neurologist.

Coverage Duration

1 year.

Other Criteria

N/A

GROWTH HORMONE

Affected Drugs

HUMATROPE®
NUTROPIN AQ NUSPIN®
NUTROPIN AQ®
NUTROPIN®
SAIZEN®
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 sucessful renal transplantation, Turner's Syndrome, Prader-Willi Syndrome, HIV wasting syndrome, adult patients with congenital or acquired GH deficiency, pediatric patients born small for gestational age (SGA) or for pediatric patients with intrauterine growth retardation (IUGR), promotion of would 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 and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

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

N/A

GROWTH HORMONE (INSULIN LIKE GROWTH FACTOR)

Affected Drugs

INCRELEX®

Covered Uses

We cover Insulin like growth factor for the treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH and for all other FDA approved indications not otherwise excluded from Part D.

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

HIGH RISK MEDICATIONS - BENZODIAZEPINES

Affected Drugs

ALPRAZOLAM
ALPRAZOLAM ER
ALPRAZOLAM INTENSOL
ALPRAZOLAM ODT
CHLORDIAZEPOXIDE HCL
CLONAZEPAM
CLORAZEPATE DIPOTASSIUM
DIAZEPAM
ESTAZOLAM
FLURAZEPAM HCL
LORAZEPAM
LORAZEPAM INTENSOL
ONFI®
OXAZEPAM
TEMAZEPAM
TRIAZOLAM

Covered Uses

All medically accepted indications not otherwise excluded from Part D. Plus, patients currently taking the benzodiazepine being requested for a Covered Use.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.

Prescriber Restrictions

N/A

Coverage Duration

Procedure-related sedation = 1mo, All other conditions = 12 months.

Other Criteria

Restless Leg Syndrome, approve clonazepam or temazepam if the patient has tried one other agent for this condition (eg, ropinirole, pramipexole, carbidopa-levodopa [immediate-release or extended-release]). Insomnia, approve lorazepam, oxazepam, or temazepam if the patient has had a trial with one of the following - ramelteon, eszopiclone, zolpidem, or zaleplon.

HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES

Affected Drugs

DIPHENHYDRAMINE HCL
HYDROXYZINE HCL
HYDROXYZINE PAMOATE
PROMETHAZINE HCL
PROMETHAZINE VC

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 12 months, unless otherwise specified.

Other Criteria

Approve promethazine hydrochloride tablets or syrup if the patient has tried a prescription oral anti-emetic agent (ondansetron, granisetron, dolasetron, palonosetron, aprepitant) for the current condition. Approve diphenhydramine (capsules or elixir) if the patient has tried at least two other FDA-approved products for the management of insomnia. Approve hydroxyzine hydrochloride (tablets and syrup) or hydroxyzine pamoate (capsules) if the patient has tried at least two other FDA-approved products for the management of anxiety.

HIGH RISK MEDICATIONS - SKELETAL MUSCLE RELAXANTS

Affected Drugs

CHLORZOXAZONE
METHOCARBAMOL
ORPHENADRINE CITRATE
ORPHENADRINE COMPOUND
ORPHENADRINE COMPOUND FORTE

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.

Prescriber Restrictions

N/A

Coverage Duration

Authorization will be for 1 month.

Other Criteria

Musculoskeletal conditions/disorders, approve if the patient has tried two other therapies for the current condition.

IGE RECEPTOR INHIBITORS

Affected Drugs

XOLAIR®

Covered Uses

We cover Xolair for allergic mediated moderate to severe asthma caused by perennial aeroallergens and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Asthma symptoms not adequately controlled by 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 of older.

Prescriber Restrictions

Pulmonoligist or allergist.

Coverage Duration

1 year.

Other Criteria

N/A

IMMUNE MODULATING DRUGS

Affected Drugs

ENBREL®
HUMIRA®
ILARIS®
KINERET®
ORENCIA®
REMICADE®
RITUXAN®

Covered Uses

We cover Enbrel for the treatment of rheumatoid arthrits, psoriatric arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis, plaque psoriasis and all other FDA approved indications not otherwise excluded from Part D. We cover Humira for the treatment of rheumatoid arthritis, psoriatric arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, active Crohn's disease, plaque psoriasis and all other FDA approved indications not otherwise excluded from Part D. We cover Kineret for the treatment of rheumatoid arthritis and all other FDA approved indications not otherwise excluded from Part D. We cover Orencia for the treatment of rheumatoid arthritis and juvenile idiopathic arthritis and all other FDA approved indications not otherwise excluded from Part D. We cover Rituxan for the treatment of rheumatoid arthritis and all other FDA approved indications not otherwise excluded from 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 and all other FDA approved indications not otherwise excluded from Part D. Amevive is covered for the treatment of plaque psoriasis and all other FDA approved indications not otherwise excluded from Part D. Ilaris is covered for the treatment of adults and children (4 years of age and older) with cryopyrin-assiciated periodic syndrome (CAPS) including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome and all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Enbrel:Rheumatoid/psoriatric arthritis: failure/contraindication to 1 traditional DMARD. Juvenile rheumatoid arthritis: failure/contraindication to methotrexate Ankylosing Spondylitis: failure with 1 prescription NSAID. Plaque Psoriasis: failure with

1 course of systemic therapy for psoriasis Humira: Rheumatoid/psoriatic arthritis: failure/contraindication to 1 traditional DMARD. Ankylosing Spondylitis: failure with 1 prescription NSAID. Plaque Psoriasis: failure with 1 course of systemic therapy for psoriasis, juvenile idiopathic arthritis: failure/contraindication to methotrexate. Kineret: Rheumatoid arthritis: failure/contraindication to 1 traditional DMARD. Orencia: Rheumatoid arthritis: failure/contraindication to 1 traditional DMARD, failure/contraindication to 1 biologic DMARD. Juvenile idiopathic arthritis: failure/contraindication to methotrexate, failure/contraindication to 1 biological DMARD. Rituxan: taken with methotrexate, failure/contraindication to 1 traditional DMARD, failure/contraindication to 1 biologic DMARD. Remicade: Rheumatoid/psoriatic arthritis:failure/contraindication to 1 traditional DMARD. Ankylosing Spondylitis: failure with 1 prescription NSAID. Plaque Psoriasis: failure with 1 course of systemic therapy for psoriasis, prior use of Amevive, Enbrel, Humira or Remicade. Amevive: failure with 1 course of systemic therapy for psoriasis or prior use of Amevive, Enbrel, Humira or Remicade. Illaris: a documented diagnosis of cryopyrin-assiciated periodic syndrome (CAPS), familial cold autoinflammatory syndrome (FCAS) or Muckle-Wells syndrome and the drug is prescribed by a board-certified or board-eligible rheumatologist or dermatologist.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

INTERFERONS (INTERFERON ALPHA)

Affected Drugs

INFERGEN®

Covered Uses

We cover interferon alpha for hairy cell leukemia, genital warts (condylomata acuminate), 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 intermediatre grade type, when given in combination with cytotoxic agents as first line therapy, polycythemia vera, idiopathic progressive polyneuropathy, HIV and AIDS, carinoid syndrome, chronic lympocytic 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 from part D.

Exclusion Criteria

N/A

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 PROCLICK®
PEGASYS®
PEGINTRON REDIPEN®
PEGINTRON®
SYLATRON®

Covered Uses

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

Exclusion Criteria

N/A

Required Medical Information

For membes with a diagnosis of Hepatitis C, need 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 interferon 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. We cover interferon alpha-2a and alpha-2b for the treatment of Hepatitis C and all FDA approved indications not otherwise excluded for part D with no additional medical information required.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Genotype 1 and 4, HIV coinfection and retretment 48 wks. Genotype 2 and 3: 24 wks. All other: 1 year.

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 from part D.

Exclusion Criteria

N/A

Required Medical Information

Documented diagnosis of chronic granulomatous disease or other FDA approved indications not otherwise excluded for Part D.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

INTERLEUKIN-2 (IL-2)

Affected Drugs

PROLEUKIN®

Covered Uses

We cover Proleukin for metastatic renal cell carcinoma, metastatic melanoma amd for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

18 years of age of older.

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

IVIG

Affected Drugs

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

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 and for all other 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

1 year.

Other Criteria

N/A

KALYDECO

Affected Drugs

KALYDECO®

Covered Uses

We cover Kalydeco for the treatment of cystic fibrosis and all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Documentation of a G551D mutation of the CFTR gene as confirmed by an FDA-cleared cystic fibrosis mutation test.

Age Restrictions

6 years of age or older.

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

KORLYM

Affected Drugs

KORLYM®

Covered Uses

We cover Korlym to control hyperglycemia occurring secondary to hypercortisolism in patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and who failed surgery or who are not surgical candidates.

Exclusion Criteria

N/A

Required Medical Information

N/A

Age Restrictions

18 years of age or older.

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

NEUDEXTA

Affected Drugs

NUEDEXTA®

Covered Uses

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

Exclusion Criteria

Use in the management of neuropathic pain. Use in the management of heroin detoxification.

Required Medical Information

N/A

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

PHOSPHODIESTERASE INHIB.

Affected Drugs

ADCIRCA®
REVATIO®
SILDENAFIL

Covered Uses

We cover phosphodiesterase inhibitors for patients in the treatment of pulmonary arterial hypertension and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

We do not cover phosphodiesterase inhibitors for the treatment of erectile dysfuntion of any other conditions.

Required Medical Information

Documented diagnosis of pulmonary arterial hypertension.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

PREGABALIN (LYRICA)

Affected Drugs

LYRICA®

Covered Uses

We cover Lyrica (pregabalin) for fibromyalgia and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

A diagnosis of fibromyalgia (ICD-9-CM diagnosis codes: 729.1).

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

PROTEASE INHIBITORS

Affected Drugs

INCIVEK®
VICTRELIS®

Covered Uses

We cover protease inhibitors for treatment of Hepatitis C Genotype 1 and all FDA approved indications not otherwise excluded from part D.

Exclusion Criteria

N/A

Required Medical Information

For membes with a diagnosis of Hepatitis C, need hepatitis C viral genotype, and HCV RNA viral titer. We cover protease inhbitors for the treatment of Hepatitis C when given in combination with peginterferon and ribavirin and for all FDA approved indications not otherwise excluded for part D with no additional medical information required.

Age Restrictions

N/A

Prescriber Restrictions

N/A

Coverage Duration

Incivek: 12 weeks of therapy. Victrelis: up to 44 weeks.

Other Criteria

N/A

RETINOIC ACID DERIVATIVES

Affected Drugs

TRETINOIN

Covered Uses

Retinoic acid derivatives are covered for acne and actinic keratosis and for all other FDA approved indications not otherwise excluded from Part D.

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 in order to evaluate for non-cosmetic uses.

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

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 and for all other FDA approved indications not otherwise excluded from Part D.

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 skeletel malignancies, and/or metabolic bone disease other than osteoporosis, patients with hypercalcemia and other conditions not listed in Medical Policy.

Required Medical Information

N/A

Age Restrictions

18 years of age of older.

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

N/A

TOPICAL IMMUNOMODULATORS

Affected Drugs

ELIDEL®
PROTOPIC®

Covered Uses

We cover topical immunomodulators for the FDA approved indication of atopic dermatitis or eczema and for all other FDA approved indications not otherwise excluded from Part D.

Exclusion Criteria

N/A

Required Medical Information

Documented treatment failure with a 30 day trial of a prescription topical corticosteroid within the previous 90 days.

Age Restrictions

2 years of age or older.

Prescriber Restrictions

N/A

Coverage Duration

1 year.

Other Criteria

Member has demonstrated treatment failure with a 30 day trial of a prescription topical corticosteroid within the previous 90 days.

XGEVA

Affected Drugs

XGEVA®

Covered Uses

We cover Xgeva for the prevention of skeletal related events in bone metastases from solid tumors and for all other 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

1 year.

Other Criteria

N/A

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MASSACHUSETTS

130582M (10/13)